

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



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: 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

PRINTED: 03/25/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		245597	B. WING _		03/06/2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES (EACH COSS-REFERENCE)	ULD BE COMPLETION
E 000	Initial Comments		E 00	00	
	Appendix Z, Emerg Requirements, §48 during a standard refacility was IN compared and the facility was IN compared from the facility is enroll signature is not require page of the CMS-28 correction is require acknowledge receiption.	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents.			
F 000	On 3/4/24 to 3/6/24 survey was completed Minnesota Department of 42 CFR Part 483	I, a standard recertification ted at your facility by the nent of Health to determine if compliance with requirements , Subpart B, Requirements for acilities. Your facility was NOT	F OC		
	as your allegation of the asyour allegation of the	f correction (POC) will serve of compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 of submission of the POC will tion of compliance.			
	onsite revisit of you validate substantial regulations has been Resident Rights/Ex	ercise of Rights	F 55	50	4/20/24
SS=D	CFR(s): 483.10(a)(§483.10(a) Resider				
ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

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.

Electronically Signed

03/21/2024

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		ONSTRUCTION	l \	TE SURVEY MPLETED
		245597	B. WING			03	3/06/2024
	PROVIDER OR SUPPLIER			16561	US HIGHWAY 10 E PARK, MN 56554	Œ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550	Continued From pa	ge 1	F 5	550			
	self-determination, access to persons a outside the facility, this section. §483.10(a)(1) A factorist with respect and digresident in a manner promotes maintenather quality of life, reindividuality. The factorist promote the rights of \$483.10(a)(2) The faccess to quality caseverity of condition must establish and practices regarding provision of services.	right to a dignified existence, and communication with and and services inside and including those specified in illity must treat each resident gnity and care for each er and in an environment that nce or enhancement of his or ecognizing each resident's cility must protect and of the resident. Facility must provide equal are regardless of diagnosis, and or payment source. A facility maintain identical policies and transfer, discharge, and the sunder the State plan for all sof payment source.					
	rights as a resident or resident of the U §483.10(b)(1) The fresident can exercise	e right to exercise his or her of the facility and as a citizen					
	§483.10(b)(2) The interference reprisal from the facting the superior of the s	resident has the right to be coercion, discrimination, and cility in exercising his or her oported by the facility in the er rights as required under this					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	· · · ·	E SURVEY PLETED
		245597	B. WING _		03/0	06/2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 16561 US HIGHWAY 10 LAKE PARK, MN 56554	'	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CONTROL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 550	by: Based on observative review, the facility dining experience received assistant room. Findings Include: R16's quarterly Min 1/12/24, identified impairment and has anxiety, depression (CVA/stroke) hemis body), and hemipal body) R16's care plan reself-care performate hemiplegia and hemipl	age 2 NT is not met as evidenced tion, interview and document failed to provide a dignified for 1 of 1 residents (R16) who e with eating in the dining nimum Data Set (MDS) dated R16 had severe cognitive d diagnoses which included: n, cerebral vascular accident plegia (paralysis on one side of resis (weakness on one side of resis (weakness on one side of xised 3/4/24, identified R16 had nce deficit related to miparesis affecting left . R16's interventions included giene, bathing and dressing. entified R16 had potential for status related to CVA and d assistance at times with plan identified R16 received tion on 3/5/24 at 8:56 a.m., sack wheelchair in the dining ursing assistant (NA)-B stood		1. How corrective action of accomplished for those resolved by the practice. R16 Careplan reviewed for dining experience. Education provided to nurwho fed R16 breakfast. 2. How the facility will idented by the same deficients having the potential affected by the same deficient procedure for redining experience. All current resident meal of were reviewed and reveal dining experience. 3. What measures will be or systemic changes mad the deficient practice will resident meals and the deficient practice will resident prac	esidents found to e deficient or dignified esting assistant or tify other or tial to be cient practice. censed nursing or ts regarding resident dignified experiences led a dignified or put into place, le, to ensure that	
	near R16's right side eggs while he remaide. NA-B went to a stool next to a the other resident. walked over to R16	de, and provided 2 spoonful of ained standing on R16's right the other side of the table, sat another resident and assisted At 9:00 a.m., NA-B stood up, and stood at R16's right side a spoonful of eags. NA-B		Current Policy and Proced ensure dignified dining ex residents. Educate all licensed, unlicensed and feeding assistants recommends.	perience for all censed nursing	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245597	B. WING		03/0	06/2024
	OVIDER OR SUPPLIER DE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	wanted the bacon as onto the plate. NAsoda in a can with a standing with left has R16's wheelchair with a full of eggs and drink R16 if done, removed R16 transported R16 out a saisting residents was important not to residents with eating an interview registered nurse (Rexpected to be seasonth eating and have RN-A indicated it was residents their full a RN-A verified it was stand while assisting and have sat while assisting residents their full a RN-A verified it was stand while assisting with eating and have a full a RN-A verified it was stand while assisting with eating and the residents their full a RN-A verified it was stand while assisting with eating and the residents their full a RN-A verified it was stand while assisting with eating and the residents and the residents are with consideration of the residents and the residents are with consideration at the resident at the resi	R16's bacon, asked R16 if he and placed the bacon back B provided R16 a drink of a straw. NA-B remained and resting on the back of hile providing R16 with spoons aks. At 9:05 a.m. NA-B asked ed R16's dishes from the b's clothing protector and tof the dining room. on 3/5/24 at 10:16 a.m., NA-B access was to be seated while with eating. NA-B indicated it to stand while assisting g and indicated NA-B should sting R16 in order to pay d be at eye level. on 3/6/24 at 12:05 p.m., N)-A stated staff were ted while assisting residents as important to give the attention and be at eye level. In an and a dignified practice to g residents with eating. on 3/6/24 at 12:14 p.m., (DON) indicated staff were ted by residents while g as it was important to	F 550	and procedure for resident dignifie experience. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected will not recur. ¿ Audit 10% of meals to ensure digned dining experience for residents (we weeks, then monthly x2 months. Weeks, then monthly x2 months. Weeks, then results and make recommendations to continue audineeded. Corrective action will be monitored by DON or designee. 5. The date that each deficiency we corrected 4/20/2024	e d and ified eekly x4 Vill have its as	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING _		l` ´c	(X3) DATE SURVEY COMPLETED	
		245597	B. WING _		3/06/2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 554	S483.10(c)(7) The medications if the indefined by §483.21 this practice is clinic. This REQUIREMED by: Based on observative review, the facility formedications were at resident (R26, R9) administer a nebulic assessed as safe to Findings include: R26 R26's admission M 12/13/23, identified and had diagnoses sclerosis (chronic donervous system) has side of body), hemiside of body), hemiside of body) and concervous system has side of body). Hemiside of body and breathing identified R26 was mobility.	in Meds-Clinically Approp 7) right to self-administer nterdisciplinary team, as (b)(2)(ii), has determined that	F 55		at	
	performance deficit R26's care plan into	t related to disease processes. erventions included off for bathing, dressing, and		for self administration completed when processing order. If resident is able to seadministration medication, order will be		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	` ′	E SURVEY PLETED
		245597	B. WING		03/0	06/2024
	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 6561 US HIGHWAY 10 AKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 554	infarction (CVA/stro	dentified R26 had a cerebral ke) which affected R26's left,	F 554	obtained. Resident will not be left a	f	
	included orders for	ary Report signed 3/1/24, Ipratropium-Albuterol 0.5-2.5 (3) milligram (MG)/3		administration assessment and ord completed. Educate all licensed and unlicensed nursing staff who administer medical	ed	
	milliliter (ML) 1 vial for while awake.	inhale orally four times a day hary Report lacked an order to		on policy and procedure regarding resident self administration of med		
	self administer med	dication. In the second discrete discr		4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected will not recur. ¿		
	licensed practical n R26's oral medicati 7:21 a.m. LPN-A or Ipratropium-Albuter poured it into the ne R26's nebulizer ma machine, set a time R26 she would retu and went down to t	ion on 3/6/24 at 7:13 a.m., urse (LPN)-A administered ons and topical medication. At pened R26's vial of rol inhalation solution and ebulizer cup. LPN-A applied sk, turned on the nebulizer on her watch and informed irn. LPN-A exited R26's room he end of the hall to the PN-A set up another resident's		Audit 10% of nebulizing medication and self administration assessment ordered and completed (weekly x4 then monthly x2 months. Will have review the results and make recommendations to continue audit needed. Corrective action will be monitored by DON or designee.	ts weeks, QAPI	
	and administered the was observed exiting had rinsed the nebutas unaware if R26	went down a different hallway ne insulin. At 7:38 a.m. LPN-A ng R26's room and stated she ulizer out. LPN-A stated she had an order or SAM nebulizer medication.		5. The date that each deficiency we corrected 4/20/2024	ill be	
	registered nurse (R R26 did not have a	on 3/6/24 at 7:39 a.m., (N)-A and LPN-A confirmed n order for self administration Iding the nebulizer. RN-A				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	· /	ATE SURVEY OMPLETED
		245597	B. WING	i	0	3/06/2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 16561 US HIGHWAY 10 LAKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 554	SAM assessment of she expected staff	age 6 as at the facility currently had a completed and RN-A indicated would remain in the room received a nebulizer	F 5	554		
	12/13/23, indicated impairment and had hemiplegia (a condor spinal cord injury side of the body), a understand or expredamage), and cere (Stroke). Indicated	mum Data Set (MDS) dated R9 had mild cognitive d diagnoses which included ition caused by brain damage that leads to paralysis on one phasia (loss of ability to ess speech, caused by brain bral vascular accident (CVA) R9 required extensive d mobility, transfers, toileting ne.				
	revealed a SAM as	ctronic health record (EHR) sessment had not been did not have an order for self edications.				
	and signed 2/20/24 Ipratropium-albuter (medication used to airways and increase	ephone Orders dated 2/12/24, directed staff to administer of inhalation solution DuoNeb orelax the muscles in the se air flow to the lungs) four and every four hours as needed				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	` ′	E SURVEY IPLETED
		245597	B. WING		03/	/06/2024
	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 6561 US HIGHWAY 10 AKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 554	Continued From pa	age 7	F 554			
	2/12/24 to 3/6/24, in (DuoNeb) 0.5-2.5 3 milliliters (ml) four to R9's care plan date limited mobility and supervision with a During a continuou 7:20 a.m., R9 was room with a mask or running. No staff w 7:26 a.m., trained rentered R9's room machine and remo During an interview stated he had been treatments for a few day. R9 indicated huse the nebulizer in staff did not remain treatment was being nursing staff turned placed the mask or During an interview TMA-A verified she treatment on R9 are stated she was unsubeen completed for have time to sit with nebulizer so she we turned on the mach when the nebulizer indicated sometimes.	Iministration Record dated indicated R9 had been taking is milligrams (mg) per three imes per day. Ed 2/24, indicated R9 had required staff assistance and tivities of daily living (ADL's). Is observation on 3/6/24 at seated in his recliner in his on his face and a nebulizer ere observed in R9's room. At medication aide (TMA)-A and shut off the nebulizer ved the mask from R9's face. For on 3/6/24 at 7:27 a.m., R9 is receiving the DuoNeb weeks now a few times a me had not been taught how to machine. R9 verified nursing in the room while the gradministered. R9 stated in the nebulizer machine and in his face and exited the room. For on 3/6/24 at 7:30 a.m., had placed the nebulizer indexited the room. TMA-A sure if a SAM assessment had in R9. TMA-A stated she did not in R9 while he received his bould place the nebulizer on R9, nine, left the room and returned was done. In addition, TMA es R9 would remove the mask mes she would have to				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION ING	l \ /	E SURVEY IPLETED
		245597	B. WING		03/	06/2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 16561 US HIGHWAY 10 LAKE PARK, MN 56554	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 554	During an interview registered nurse (R did not have a SAM nebulizer treatment current residents have administer the nebulizer's as they administer the nebulizer treatment received the nebulizer treatment received the nebulizer treatment received the nebulizer treatment of nursing (not have SAM asseresident did not have physician's orders, with the resident duadministration. Review of a facility Self-Administration. Review of a facility Self-Administration administration.	on 3/6/24 at 7:39 a.m., N)-A confirmed R9 and R26 I assessment for their s. RN-A stated none of the ad a SAM assessment for were not safe to self Ilizers. RN-A indication her rsing staff would have stayed and R26 while they received nents to ensure R9 and R26 zer treatments appropriately. on 3/6/24 at 7:42 a.m., DON) verified R9 and R26 did essments. DON indicated if the re a SAM assessment or staff were expected to remain ring the entire nebulizer policy titled Resident of Medication dated	F 5	54		
F 641 SS=D	in the medical record Accuracy of Assess CFR(s): 483.20(g)		F 6	41		4/20/24
	§483.20(g) Accurace The assessment m resident's status.	cy of Assessments. ust accurately reflect the				

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		E SURVEY PLETED
SUNNYSIDE CARE CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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) SUMMARY STATEMENT OF DEFICIENCIES (15661 US HIGHWAY 10 LAKE PARK, MN 56554 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD			245597	B. WING		03/0	06/2024
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) Trag PREFIX TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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.					16561 US HIGHWAY 10	•	
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) 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.	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
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	F 641	This REQUIREME by: Based on interview facility failed to accompate Set (MDS) con (R79) reviewed for Findings include: The Centers for Me Long-Term Care Fainstrument (RAI) 3 10/2023, identified Therapy Code contadministered via mala resident to relieve oxygen used in Bi-Pressure/Continuo (BiPAP/CPAP) here R79's admission Malachine R79's admission Malachined R79 had 14 days. Review of R79's calindicated R79 required R79 required R79 required R79 required R79 required R79 required R79's significant R79's signific	NT is not met as evidenced and document review, the curately code the Minimum prectly for 1 of 1 residents resident assessment. Redicare and Medicaid (CMS) acility Resident Assessment acility Resid		1. How corrective action vaccomplished for those rehave been affected by the practice. Modification of MDS to refoxygen use. 2. How the facility will identesidents having the potentaffected by the same deficient will be a systemic changes made the deficient practice will not recorrective actions to ensure to code oxygen use. 4. How the facility will montorective actions to ensure deficient practice is being will not recur. Audit 10% of resident chanweeks, then monthly x2 metals accompleted MDS duri	sidents found to deficient lect accurate tify other stial to be cient practice. ¿ residents in ode of question put into place, e, to ensure that not recur. In responsible ensure they delines for when delines for when that the corrected and on the corrected and on the prior	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	` ′	E SURVEY PLETED
		245597	B. WING		03/0	06/2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554	-	
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F 641	Review of R79's ad 2/21/24, identified Foxygen attached. During an interview coordinator verified	ed to a CPAP machine. mission progress note dated R79 slept with a CPAP with on 3/5/24 at 11:06 a.m., MDS R79 utilized oxygen at two	F 641	results and make recommendation continue audits as needed. Correct action will be monitored by DON or designee. 5.The date that each deficiency will corrected 4/20/2024	tive	
	coordinator verified dated 2/26/24, had MDS stated her exp MDS would have be During an interview director of nursing (received oxygen with DON confirmed R79 not been coded accordinated ac	CPAP machine. MDS Section O of R79's MDS not been coded correctly. Sectation would have been the een coded correctly. on 3/5/24 at 3:41 p.m., DON) verified R79 had the a CPAP machine at night. 9's MDS dated 2/26/24, had curately. DON stated her have been for staff to complete				
F 688 SS=D	Completion dated 8 were assessed, use assessment process needs and to developlan. Indicated personassessment must a section they complete.	ecrease in ROM/Mobility	F 688			4/20/24
	resident who enters	acility must ensure that a the facility without limited es not experience reduction in ess the resident's clinical				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	` ′	E SURVEY PLETED
		245597	B. WING _		03/0	06/2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 688	§483.25(c)(2) A resemble motion receives appropriate services to increase prevent further deceives appropriate assistance to main the maximum practiced reduction in mobility. Based on observative review, the facility from the motion services to range of motion (Reviewed who requirestorative nursing). Findings include: R9's quarterly Minimal 12/13/23, indicated impairment and had hemiplegia (a condor spinal cord injury side of the body), a understand or expressional cord injury side of the body), and cere (Stroke). Indicated assistance with bed toileting.	rates that a reduction in range dable; and sident with limited range of propriate treatment and erange of motion and/or to rease in range of motion. Sident with limited mobility reservices, equipment, and tain or improve mobility with ticable independence unless a y is demonstrably unavoidable. NT is not met as evidenced tion, interview and document ailed to provide range of prevent potential decrease in OM) for 1 of 1 residents (R9) ired range of motion for exercises. The mum Data Set (MDS) dated R9 had mild cognitive diagnosis which included ition caused by brain damage of that leads to paralysis on one phasia (loss of ability to ess speech, caused by brain bral vascular accident (CVA) R9 required extensive dimobility, transfers, and	F 68	1. How corrective action will be accomplished for those residents f have been affected by the deficien practice. ¿ Therapy eval only completed with to assessment for decrease in RO Restorative nursing program put in place for ROM for resident. 2. How the facility will identify other residents having the potential to be affected by the same deficient practiced by the same deficient practiced and the complete same deficient practiced. Audit 100% of residents who are to ROM exercises included in restorations program. 3. What measures will be put into por systemic changes made, to enserted.	tesident M. to the that	
	(CAA) dated 3/17/2	ange Care Area Assessment 3, identified R9 required ce with activities of daily living		the deficient practice will not recur.		

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245597 B.	s. WING	03/06/2024
NAME OF PROVIDER OR SUPPLIER SUNNYSIDE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	BE COMPLÉTION
(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.	therapy and nursing when resident discharged form therapy. Commun tool includes if restorative program recommended. Educate all licensed nursing staff of importance of restorative nursing programming and communication to deficient practice is being corrected will not recur. ¿ Audit 10% of therapy discharges for requirement of restorative nurse programming and exercises in week prior. Weekly x4 weeks, monthly x2 mont Will have QAPI review the results a make recommendations to continuaudits as needed. Corrective action monitored by DON or designee. 5. The date that each deficiency with corrected 4/20/2024	ication is n cool. e d and r ogram Audit hs and e n will be

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	` '	TE SURVEY MPLETED	
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F 688	Continued From pa	ge 13	F6	688		
	indicated R9 had lir	on 3/6/24 at 8:20 p.m., NA-A mited ROM on his right side. as not aware of any RNP in place for R9.				
	registered nurse (Resided hemiplegia and ADL's. RN-A confirmation for ROM. RN-A verified been communicated had not been communicated had not been communicated have been communicated h	on 3/6/24 at 8:25 a.m., (N)-A indicated R9 had right and required staff assistance for med R9 had an OT or an RNP program to maintain the recommendation had not d to the staff and therefore, eleted. RN-A stated her have been the RNP would nicated to staff and started to from OT to prevent further				
	therapy director (TE discharged from O a RNP to his right a ROM. TD stated it v	on 3/6/24 at 8:59 a.m., O) verified R9 had been T on 2/20/24, and was to have Irm to prevent further loss of would have been important to for R9 to prevent a decline				
	director of nursing l R9 had not been re per therapy recomm	on 3/6/24 at 10:05 a.m., DON stated she was unaware ceiving restorative services nendations. DON indicated staff would have followed dations.				
	Nursing Programs or restorative nursing interventions that p	policy titled Restorative dated 8/1/23, identified programs referred to nursing romoted the resident's ability ently and safely as possible d on achieving and				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245597	B. WING _		03/	06/2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554	•		
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F 688	psychosocial function discharging therapis appropriate restoratives	ge 14 I physical, mental, and poing. Identified the st would communicate to the tive aide the provisions of the e nursing plan, and provide ing to carry out the plan.	F 68	38			
F 880 SS=E	S483.80 Infection Confidence on the facility must estimate infection prevention	1)(2)(4)(e)(f)	F 88	30		4/20/24	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	DING	` '	OATE SURVEY COMPLETED
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F 880	development and tridiseases and infect §483.80(a) Infection program. The facility must estand control program a minimum, the following services and communicable staff, volunteers, visproviding services arrangement based conducted accordinaccepted national services for the but are not limited to (i) A system of survices arrangement based conducted accordinaccepted national services for the but are not limited to (i) A system of survices are not limited to (ii) A system of survices are not limited to (ii) When and to who communicable diservices in the facilia (iii) When and to who communicable diservices in the facilia (iii) When and to who communicable diservices in the facilia (iii) Standard and transitional to be followed to provide the facilia (iii) Standard and transitional transitional services are not limited to be followed to provide the facilia (iii) When and the facilia (iii) Standard and transitional services are not limited to be followed to provide the facilia (iii) Standard and transitional services are not limited to the facilia (iii) When and to who communicable diservices are not limited to the facilia (iii) Standard and transitional services are not limited to the facilia (iii) When and to who communicable diservices are not limited to the facilia (iii) When and to who communicate the facilia (iii) Standard and transitional services are not limited to the facilia (iii) When and to who communicate the facilia (iii) Standard and transitional services are not limited to the facilia (iii) When and to who communicate the facilia (iii) Standard and transitional services are not limited to the facilia (iii) When and to who communicate the facilia (iii) Standard and transitional services are not limited to the facilia (iii) When and to who communicate the facilia (iii) Standard and transitional services are not limited to the facilia (iii) When and to who communicate the facilia (iii) Standard and transitional services are not limited to the facilia (iii) When and the facilia (iiii) When and the facilia	ment and to help prevent the ransmission of communicable ions. In prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements: Item for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual if upon the facility assessmenting to §483.70(e) and following standards; en standards, policies, and program, which must include, or eillance designed to identify able diseases or ey can spread to other ty; from possible incidents of ease or infections should be ansmission-based precautions event spread of infections; solation should be used for a		880		

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F 880	must prohibit employ disease or infected contact with resider contact will transmi (vi)The hand hygier by staff involved in §483.80(a)(4) A systidentified under the corrective actions to §483.80(e) Linens. Personnel must ha transport linens so infection. §483.80(f) Annual in The facility will condition. §483.80(f) Annual in The facility will condition.	ces under which the facility byees with a communicable skin lesions from direct ints or their food, if direct it the disease; and ne procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the aken by the facility. Indle, store, process, and as to prevent the spread of review. Cluct an annual review of its neir program, as necessary. NT is not met as evidenced tion, interview, and document ailed to ensure personal orted in a manner that contamination for 2 of 3 for linen transportation. In failed to complete hand in delivery and ensure safe es during dining observation. For Disease Control (CDC) of D - Linen and Laundry ted 5/4/23, identified linens	F 8	1. How corrective action w accomplished for those res have been affected by the opractice.¿ Educate team members habeverages and linens, and when handling linens and because the contraction of the contr	idents found to deficient and hygiene everages. If yother ial to be ent practice.	
		ckaged, transported, and that prevented risk of		beverages and linens, and when handling linens and b		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	\ \ \ \ \	E SURVEY PLETED	
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F 880	soiled items. In add Communities: Clea 7/18/22, identified in important thing to puring an observation the 100 hallway nuran uncovered cart down the hallway. It removed a washold uncovered cart and room. NA-C returned hands and removed the uncovered cart and room. NA-C returned to the and removed a washold uncovered cart and room. NA-C returned to the uncovered cart and room. NA-C returned hands and removed the uncovered cart R1's room. NA-C resanitized hands and towel from the uncovered cart R4's room. NA-C returned hands and removed the uncovered cart R4's room. NA-C returned hands and removed the uncovered cart R4's room. NA-C returned hands and removed the uncovered cart R4's room. NA-C returned hands and removed the uncovered cart R4's room. NA-C returned hands and removed the uncovered cart R4's room. NA-C returned hands and removed the uncovered cart R4's room. NA-C returned hands and removed the uncovered cart R4's room. NA-C returned hands and removed the uncovered cart R4's room. NA-C returned hands and removed the uncovered cart R4's room. NA-C returned hands and removed the uncovered cart R4's room. NA-C returned hands and removed the uncovered cart R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart.	ust, debris, soiled linens or lition, CDC Handwashing in In Hands Save Lives updated landwashing was the most revent food poisoning. Ion on 3/4/24 at 2:58 p.m., in ring assistant (NA)-C pushed that contained clean linen NA-C sanitized hands and the and a towel from the delivered the items to R18's ed to the hallway, sanitized a washcloth and towel from as a resident wheeled by the delivered the items to R24's room. In hallway, sanitized hands sholoth and towel from the delivered the items to R14's ed to the hallway, sanitized a washcloth and towel from and delivered the items to eturned to the hallway, diremoved a washcloth and towel from and delivered items to R25's ed to the hallway, sanitized a washcloth and towel from and delivered the items to eturned to the hallway, sanitized a washcloth and towel from and delivered the items to eturned to the hallway, and removed a washcloth and towel from and delivered the items to eturned to the hallway, and removed a washcloth and overed cart and delivered the items to eturned to the hallway, and removed a washcloth and overed cart and delivered the ands and removed a left from the uncovered cart and delivered cart and the from the uncovered cart and	F 8	3. What measures will be por systemic changes made the deficient practice will not ¿All clean linens in hallway with sheet. Instructions postart. Educate all team members control practices regarding linens and beverages. Educate all team members hygiene policy and procedu. 4. How the facility will moni corrective actions to ensure deficient practice is being owill not recur.¿ Audit 10% of linen pass and pass weekly x4 weeks, mo months. Will have QAPI reand make recommendation audits as needed. Corrective monitored by DON or designation of the process	e, to ensure that of recur. It to be covered sted on linen It on infection handling of It on handling of It or its e that the corrected and It of beverage on the corrected and It of beverage on the corrected and the correc	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	LTIPLE CONSTRUCTION DING	` '	TE SURVEY MPLETED
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F 880	R20. MDS coordinates around one of the grand over the top produced from the form of R20 who programs the MDS coordinator placed front of R20 who programs the MDS coordinator stated in place her hands are when carrying a glawas important not the resident drank from During an observat NA-D placed several an uncovered carthallway near the numembers walked by p.m., NA-D returned pushed the cart down addition, NA-C broughallway. NA-C program to the hallway with a placed it on the emuncovered linen car proceeded to remove the uncovered linen car the other water pitcher at the other water	ge 18 poured two glasses of milk for ator placed her right hand glasses and placed her left part of one glass (the area you ceeded to carry the two costs the dining room. MDS the two glasses on the table in oceeded to drink from the rdinator held in her left hand. Ton 3/5/24 at 1:46 p.m., MDS the rnormal practice was to cound the center of the glass are to prevent infections. Ton 3/5/24 at 2:46 p.m., all washcloths and towels on and placed the cart in the carses' station as two staff by the uncovered cart. At 3:11 do to the uncovered cart and with the 200 hallway. In ght an empty cart down the eeded to remove a washcloth uncovered linen cart and to R11's room. NA-C returned a dirty water pitcher and provided the cart and to R11's room. NA-C returned a dirty water pitcher and provided the returned to the hallway. NA-C we a washcloth and towel from the cart and delivered the items of the returned to the hallway with a land placed it on the cart with the cart and delivered them to R16's alked by the cart. NA-C		880		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	` '	TE SURVEY MPLETED	
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F 880	and placed it on the pitchers. At no time hygiene during the During an interview stated her normal plinen on a clean unwas important to contamination of the During an interview stated her normal phands before passi uncovered cart. NA sanitized her hands cart should have be possible cross contamination of the During an interview possible cross contamination of the During and During an interview possible cross contamination of the During an interview possible cross contamination of the During and During an interview possible cross contamination of the During and During an interview possible cross contamination of the During and During an interview possible cross contamination of the During an in	way with a dirty water pitcher cart with the other water did NA-C perform hand above observation. on 3/5/24 at 3:12 p.m., NA-D ractice was to pass clean covered cart. NA-D stated it over the linen cart to prevent e linens. on 3/5/24 at 3:16 p.m., NA-C process was to sanitize her ng linen from a clean and the sen covered to prevent	F 8	80		
	was staff would per linens during transp touching any areas drinks from. A facility policy titled Control Manual Env Services/Housekee indicated the facility linen to each reside Identified clean line covered cart with a contamination while facility. A facility policy titled and Handling dated	form hand hygiene, cover bort, and staff should not be of the glass the resident				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245597	B. WING		03	/06/2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 16561 US HIGHWAY 10 LAKE PARK, MN 56554	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	to handle utensils, o	stances. Indicated staff were cups, glasses, and dishes in avoid touching surfaces that	F 8	80			

F5597034

PRINTED: 03/25/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245597	B. WING		03/05/2024
	ROVIDER OR SUPPLIER DE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
K 000	INITIAL COMMENTS		K 00	00	
	FIRE SAFETY				
	Minnesota Department Fire Marshal Division of this survey Sunnys not in compliance with participation in Medic Subpart 483.70(a), Lit 2012 edition of Nation Association (NFPA) Strong Code (LSC), Chapter	arvey was conducted by the of Public Safety, State on 03/05/2024. At the time ide Care Center was found in the requirements for are/Medicaid at 42 CFR, fe Safety from Fire, and the hal Fire Protection standard 101, Life Safety 19 Existing Health Care, of NFPA 99, Health Care			
	ALLEGATION OF CO DEPARTMENTS ACC SIGNATURE AT THE PAGE OF THE CM'S	WILL SERVE AS YOUR MPLIANCE UPON THE CEPTANCE. YOUR BOTTOM OF THE FIRST 2567 FORM WILL BE TION OF COMPLIANCE.			
	ONSITE REVISIT OF CONDUCTED TO VAISUBSTANTIAL COMPREGULATIONS HAS	PLIANCE WITH THE			
		N THE E-POC PROCESS, A HE PLAN OF CORRECTION			
	PLEASE RETURN THE CORRECTION FOR TO DEFICIENCIES (AK	THE FIRE SAFETY			
_ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u> E	TITLE	(X6) DATE

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.

Electronically Signed

03/21/2024

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		
		245597	B. WING		03/05/2024
NAME OF PROVID			1	TREET ADDRESS, CITY, STATE, ZIP CODE 6561 US HIGHWAY 10 AKE PARK, MN 56554	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
HEASTA 445 ST. By 6 FM. THE DEI 1. A take 2. A to e 3. I perf 4. I action 5. The Mai (111 1-st add barri and divid smooth The mar	e-mail to: .HC.Inspections@ EPLAN OF CORIFICIENCY MUST LLOWING INFORM A detailed descripten or planned to of Address the measensure the deficient Indicate how the formance to ensure the deficient Indicate how the formance to ensure the actual or properties and monitoring. The actual or properties and monitoring the actual or properties, the entire faction was not separate, the entire faction was not separate, the entire faction was one ded by three smooths are compartments are facility is fully spended for the elarm systematic facility is fully spended for the	EINSPECTIONS HAL DIVISION FREET, SUITE 145 1-5145, or Petate.mn.us RECTION FOR EACH INCLUDE ALL OF THE EMATION: Ition of the corrective action Forrect the deficiency. Bures that will be put in place free solutions are sustained. Reponsible for the corrective fing of compliance. Posed date for completion of -story no basement Type II France/ dayroom was added. Type V (111). Since this Frantal by a 2-hour fire fility is considered V (111) Building. The facility is France to the corrective transport of the corrective trans	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245597	B. WING		03/05/2024
	ROVIDER OR SUPPLIER DE CARE CENTER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETION
K 000	which is monitored for notification. The facility has a cap census of 27 at the ti	or automatic fire department bacity of 30 beds and had a me of the survey. 42 CFR, Subpart 483.70(a)	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is with NFPA 96, Stand and Fire Protection of Operations, unless: * residential cooking appliances such as in toasters) are used for cooking in accordance * cooking facilities oper compartments with 3 with the conditions unlor * cooking facilities in 30 or fewer patients of 18.3.2.5.4, 19.3.2.5.4 Cooking facilities proper 9.2.3 are not requipments hazardous areas, but corridor.	s protected in accordance and for Ventilation Control f Commercial Cooking equipment (i.e., small nicrowaves, hot plates, r food warming or limited se with 18.3.2.5.2, 19.3.2.5.2 sen to the corridor in smoke 0 or fewer patients comply nder 18.3.2.5.3, 19.3.2.5.3, smoke compartments with comply with conditions under 4. tected according to NFPA 96 uired to be enclosed as t shall not be open to the 3.3.2.5.4, 19.3.2.5.1 through	K 324		4/20/24
	This REQUIREMENT	Γ is not met as evidenced			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245597	B. WING		03/05/2024	
NAME OF PROVIDER OR SUPPLIER SUNNYSIDE CARE CENTER			10	STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
K 324	documentation, and stailed to install proper equipment per NFPA Safety Code, sections This deficient finding impact on the resider Findings include: On 03/05/2024 between it was revealed by obtain Coffee Shop did not have a cooktop or range, included An interview with the	n, a review of available staff interview, the facility protection for cooking 101 (2012 edition), Life 19.3.2.5.3 (9). could have an isolated	K 324	1. How corrective action will be accomplished for those residents four have been affected by the deficient practice: The power source cords to to oven has been removed from the over 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 practic. This was the only electric oven in the Sunnyside facility. All team members be educated that the electric oven is inoperable and does not have a timer. 3. What measures will be put into pla or systemic changes made, to ensure the deficient practice will not recur: A 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 a will not recur: The maintenance supervisor will audit to ensure a power source has not been replaced weekly then monthly x6 to ensure compliance. Results will be reviewed at QAPI to determine if there is an ongoing need 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.	he n e: will ce, that sign ng nd er x3 e. to e.	

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	COMPLETED	
		00016	B. WING		03/06/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUNNYS	IDE CARE CENTER		HIGHWAY 1 RK, MN 565			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
2 000	Initial Comments		2 000			
	****ATTEN	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficit herein are not corrected shall limit with a schedule of the Minnesota Department	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Rule When a rule contain comply with any of the lack of compliance. The result in the assess					
	that may result from orders provided that the Department with	hearing on any assessments non-compliance with these ta written request is made to hin 15 days of receipt of a nt for non-compliance.				
	conducted at your facility was NOT in Licensure and the facility because indicated.	S: , a licensing survey was acility by surveyors from the ent of Health (MDH). Your compliance with the MN State ollowing correction orders are eate in your electronic plan of reviewed these orders and				

Minnesota Department of Health

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

TITLE

Electronically Signed

03/21/24

If continuation sheet 1 of 20

(X6) DATE

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00016	B. WING		03/06/2024
	PROVIDER OR SUPPLIER	16561 US	DRESS, CITY, S HIGHWAY 10 RK, MN 5655		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETE
2 000	Minnesota Department the State Licensing federal software. To assigned to Minnesota Nursing Homes. The appears in the far leading to the finding Homes. The state of the correction orders the findings which a statute after the state as evidence by." For are the Suggested Time period for Correction of State lices the Minnesota Department of Headyou electronically, is necessary for State of State lices and the state of the Winnesota Department of Headyou electronically, is necessary for State of the Winnesota Department of Headyou electronically, is necessary for State of the Winnesota Department of Headyou electronically, is necessary for State of the Winnesota Department of Headyou electronically, is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Department of Headyou electronically. It is necessary for State of the Winnesota Depa	en they will be completed. The tent of Health is documenting Correction Orders using an umbers have been to a state statutes/rules for the assigned tag number aft column entitled "ID Prefix attete/rule out of compliance is any Statement of Deficiencies" as the "To Comply" portion of an are in violation of the state are in violation of the state attement, "This Rule is not met following the surveyors findings whethous of Correction and arection. In participate in the electronic ansure orders consistent with an artment of Health in a state. The state licensing and on the attached Minnesota and the orders being submitted to a Although no plan of correction are Statutes/Rules, please arected in the box available for indicate in the electronic attached in the electronic attached be a statuted to the electronic and the statutes are the heading and the electronic and the statutes are the heading and the electronic although the electronic and the electron			

Minnesota Department of Health

STATE FORM U58P11 If continuation sheet 2 of 20

Minnesota Department of Health

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00016	B. WING		03/0	06/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUNNYS	IDE CARE CENTER		HIGHWAY 1 RK, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From page	ge 2	2 000			
	CORRECTION FOR	ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULES.				
2 550	MN Rule 4658.0400 Resident Assessme	Subp. 4 Comprehensive ent; Review	2 550			4/4/24
	home must examine quarterly and must comprehensive ass	assessments. A nursing e each resident at least revise the resident's essment to ensure the of the assessment.				
	by: Based on interview facility failed to accurate Data Set (MDS) cor	ent is not met as evidenced and document review, the urately code the Minimum rectly for 1 of 1 residents resident assessment.		Corrected		
	Findings include:					
	Long-Term Care Fa Instrument (RAI) 3.0 10/2023, identified 3 Therapy Code conti- administered via ma a resident to relieve oxygen used in Bi-le	ıs Positive Airway Pressure				
	2/26/24, Section O: Procedures, and Pr	nimum Data Set (MDS) dated Special Treatments, ograms. Question 001000 C not received oxygen in the last				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00016	B. WING		03/0	6/2024
	PROVIDER OR SUPPLIER	16561 US	DRESS, CITY, S HIGHWAY 1 RK, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 550	Continued From pa	ge 3	2 550			
	indicated R79 requicontinuous positive machine that used breathing airways of R79's signal 2/20/24, identified R	re plan updated 3/5/24, red oxygen with the use of his airway pressure (CPAP) (a mild air pressure to keep pen while sleeping). Ined physician orders dated 279 was to use two liters of				
	pointed to an oxyge and stated he used	on 3/5/24 at 9:05 a.m., R79 n concentrator in his room oxygen every night with that ed to a CPAP machine.				
		mission progress note dated R79 slept with a CPAP with				
	coordinator verified liters at night with a coordinator verified dated 2/26/24, had MDS stated her exp	on 3/5/24 at 11:06 a.m., MDS R79 utilized oxygen at two CPAP machine. MDS Section O of R79's MDS not been coded correctly. Sectation would have been the een coded correctly.				
	director of nursing (received oxygen with DON confirmed R79 not been coded acc	on 3/5/24 at 3:41 p.m., DON) verified R79 had the a CPAP machine at night. 9's MDS dated 2/26/24, had curately. DON stated her have been for staff to complete				
	Completion dated 8 were assessed, use	policy titled MDS 3.0 /1/23, identified residents ed a comprehensive s, in order to identify care				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00016	B. WING		03/0	06/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUNNYS	IDE CARE CENTER		HIGHWAY 1 RK, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 550	plan. Indicated personassessment must a section they completed. SUGGESTED MET The director of nurs review and revise personately to ensuring that each comprehensive associated. The director of nurs completed. The director of nurs accurately completed.	op an interdisciplinary care sons completing part of the accuracy of the ated by signature. HOD OF CORRECTION: sing (DON) or designee could olicies and procedures related the individual resident's essment is accurately according or designee atem to educate staff and ag system to ensure staff	2 550			
2 890	Subp. 2. Range of that is directed towarthrough positioning implemented and more comprehensive resident of nursing services development of a n	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the dent assessment, the director must coordinate the ursing care plan which ho enters the nursing home age of motion does not on in range of motion unless all condition demonstrates range of motion is	2 890			4/4/24

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		00016	B. WING		03/	06/2024
NAME OF PROVIDER OF		16561 US	DRESS, CITY, HIGHWAY RK, MN 56			
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
review, the motion set range of reviewed restorative. Findings R9's quant 12/13/23, impairment hemipleg or spinal side of the understant damage). (Stroke). assistant toileting. R9's Sign (CAA) date extensive (ADL's) with transfers. R9's current passive reangle of the comment of the comm	observative facility for ces to motion (Rowho required and to late of the cord injury and cere indicated and to late of the cord included and t	ion, interview and document failed to provide range of prevent potential decrease in OM) for 1 of 1 residents (R9) ired range of motion for exercises. mum Data Set (MDS) dated R9 had mild cognitive diagnosis which included ition caused by brain damage y that leads to paralysis on one sphasia (loss of ability to ess speech, caused by brain bral vascular accident (CVA) R9 required extensive dimobility, transfers, and ange Care Area Assessment 23, identified R9 required ce with activities of daily living ded dressing, bed mobility,	2 890	Corrected		

Minnesota Department of Health

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	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		00016	B. WING		03/0	6/2024
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
SUNNYS	SIDE CARE CENTER		RK, MN 5655			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 890	Continued From pa	ge 6	2 890			
	exercises with there daily.	aband were to be completed				
	Review of R9's prog	gress notes lacked any				
	R9 was seated in h	ion on 3/4/24 at 12:35 p.m., is recliner in his room and pick up his right arm to place the recliner.				
	indicated he had lin	on 3/4/24 at 12:39 p.m., R9 nited ROM in his right arm and staff had not been assisting exercises.				
	nursing assistant (National Romannia Ro	on 3/6/24 at 8:15 a.m., NA)-B indicated R9 had very right side and required staff L's. NA-B stated he had residents in the past however y ROM programs currently in				
	indicated R9 had lin	on 3/6/24 at 8:20 p.m., NA-A nited ROM on his right side. as not aware of any RNP in place for R9.				
	registered nurse (Rasided hemiplegia and ADL's. RN-A confirmation for ROM. RN-A verified been communicated had not been compered expectation would have been communicated have been com	on 3/6/24 at 8:25 a.m., N)-A indicated R9 had right nd required staff assistance for med R9 had an OT or an RNP program to maintain of the recommendation had not d to the staff and therefore, leted. RN-A stated her have been the RNP would nicated to staff and started e from OT to prevent further				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00016	B. WING		03/06/2024	
	PROVIDER OR SUPPLIER	16561 US	DRESS, CITY, S HIGHWAY 10 RK, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE	
2 890	therapy director (TE discharged from O a RNP to his right a ROM. TD stated it wimplement the RNP related to further loss to be a facility of the restoration was therapy recommend. Review of a facility of the live as independent and actively focused and actively	right side. on 3/6/24 at 8:59 a.m., b) verified R9 had been on 2/20/24, and was to have rm to prevent further loss of would have been important to of for R9 to prevent a decline as of ROM. on 3/6/24 at 10:05 a.m., b) Stated she was unaware ceiving restorative services mendations. DON indicated a staff would have followed dations. policy titled Restorative dated 8/1/23, identified programs referred to nursing romoted the resident's ability ently and safely as possible d on achieving and physical, mental, and physical, mental, and poning. Identified the ast would communicate to the tive aide the provisions of the enursing plan, and provide ing to carry out the plan. CHOD OF CORRECTION: sing and/or designee could e staff to provide a resident program, based on residents' assessed needs. The DON or duct audits of the restorative ensure the residents	2 890			

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l `´´	E CONSTRUCTION	COMPLETED	
		00016	B. WING		03/0	06/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUNNYS	IDE CARE CENTER		HIGHWAY 1 RK, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTION (CORRECTIVE APPROPERTION (CORRECTIVE APPROPERTION (CORRECTIVE APPROPERTION (CORRECTIVE ACTION (CORRECTIVE ACTION (CORRECTION	.D BE	(X5) COMPLETE DATE
2 890	Continued From page	ge 8	2 890			
	(21) days.					
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			4/4/24
	home must establis	n control program. A nursing h and maintain an infection signed to provide a safe and ht.				
	by: Based on observation review, the facility facility facility was transported risk of contact hallways observed facility hygiene during liner	ent is not met as evidenced on, interview, and document ailed to ensure personal orted in a manner that ontamination for 2 of 3 for linen transportation. In failed to complete hand a delivery and ensure safe es during dining observation.		Corrected		
	Findings include:					
	guidance, Appendix Management updat must be sorted, pac stored in a manner contamination by du soiled items. In add Communities: Clear 7/18/22, identified h	for Disease Control (CDC) CD - Linen and Laundry ed 5/4/23, identified linens ckaged, transported, and that prevented risk of ust, debris, soiled linens or ition, CDC Handwashing in h Hands Save Lives updated andwashing was the most revent food poisoning.				
	the 100 hallway nur an uncovered cart	on on 3/4/24 at 2:58 p.m., in sing assistant (NA)-C pushed that contained clean linen IA-C sanitized hands and				

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554 SUNNYSIDE CARE CENTER CACH CORRECTIVE ACTION SHOULD BE COMMILET BERECEDED BY FULL (EACH DEPICENCY MUST BE RECEDED BY FULL (EACH DEPICENCY MUST BE RECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) 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 lowel 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 R15'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 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 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 R25's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and delivered the items to R25's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and delivered the items to R25's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and delivered the items to R25's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and delivered the items to R25's room. NA-C returned to the hallway, sanitized hands and removed a washcloth and delivered the items to R25's room. NA-C returned to the hallway sanitized hands an		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED	
SUNNYSIDE CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES TAG (AA) ID REETIX (AA) ID RECOUNTY MUST BE PRECEDED BY FULL PREVIOUS CONFECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED DATE CROSS-REFERENCED DATE CROSS-REFERENCED DATE CROSS-REFERENCED DATE CROSS-REFERENCED DATE CRO			00016	B. WING		03/0	6/2024
CAS DISCRIPTION SUMMARY STATEMENT OF DEFICIENCIES DISCRIPTION PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CASTE	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 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 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 R14'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 the 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 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 R10'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 R10'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 R10'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 R10's room. NA-C returned to the hallway sanitized hands and removed a washcloth and towel from the uncovered cart and deliver	SUNNYS	IDE CARE CENTER					
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 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 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 ight 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	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
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 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 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 (MMDS) coordinator polaced 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	21375	Continued From pa	ge 9	21375			
glass the MDS coordinator held in her left hand. During an interview on 3/5/24 at 1:46 p.m., MDS		removed a washclouncovered cart and room. NA-C returned the uncovered cart cart. NA-C delivered NA-C returned to the and removed a was uncovered cart and room. NA-C returned the uncovered cart R1's room. NA-C resanitized hands and removed the uncovered cart. room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C resanitized hands and towel from the uncovered cart. R4's room. NA-C resanitized hands and towel from the uncovered cart. R4's room. NA-C resanitized hands and towel from the uncovered cart. R4's room. NA-C resanitized hands and towel from the uncovered cart. R4's room. NA-C resanitized hands and towel from the uncovered cart. R4's room. NA-C resanitized hands and towel from the uncovered cart. R4's room. NA-C resanitized hands and towel from the uncovered cart. R4's room. NA-C resanitized hands and removed the uncovered cart. R4's room. NA-C resanitized hands and removed the uncovered cart. R4's room. NA-C resanitized hands and removed the uncovered cart. R4's room. NA-C resanitized hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C resanitized hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and removed the uncovered cart. R4's room. NA-C returned hands and	th and a towel from the delivered the items to R18's ed to the hallway, sanitized d a washcloth and towel from as a resident wheeled by the d the items to R24's room. The hallway, sanitized hands shcloth and towel from the delivered the items to R14's ed to the hallway, sanitized d a washcloth and towel from and delivered the items to eturned to the hallway, d removed a washcloth and overed cart as a staff member NA-C delivered items to R25's ed to the hallway, sanitized d a washcloth and towel from and delivered the items to eturned to the hallway, d removed a washcloth and overed cart and delivered the n. NA-C returned to the ands and removed a el from the uncovered cart and to R15's room. The one of the delivered hand lasses and placed her left art of one glass (the area you ceeded to carry the two lasses on the table in oceeded to drink from the rdinator held in her left hand.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	00016	B. WING	_	03/0	6/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUNNYSIDE CARE CENTER		HIGHWAY 1 RK, MN 565			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21375 Continued From participation on a clean uncovered lines to the hall and placed it on the pitchers. At no time hygiene during the During an interview stated her normal linen on a clean uncovered lines to the hall and placed it on the care the other water pitchers. At no time hygiene during the condition on a clean uncovered lines to the hall and placed it on the pitchers. At no time hygiene during the condition of the condition of the can be conditioned as a condition of the can be captured to the hall and placed it on the pitchers. At no time hygiene during the condition of the condition	her normal practice was to ound the center of the glass ass. MDS coordinator stated it to touch the area of the glass and to prevent infections. Ition on 3/5/24 at 2:46 p.m., ral washcloths and towels on and placed the cart in the urses' station as two staff by the uncovered cart. At 3:11 dt to the uncovered cart and with the 200 hallway. In aght an empty cart down the ceeded to remove a washcloth uncovered linen cart and to R11's room. NA-C returned a dirty water pitcher and and placed it on the cart with the cart and delivered the items. The creturned to the hallway with a land placed it on the cart with the cher. NA-C proceeded to hand towel from the rt and delivered them to R16's alked by the cart. NA-C way with a dirty water pitcher et cart with the other water et did NA-C perform hand above observation. If on 3/5/24 at 3:12 p.m., NA-D oractice was to pass clean covered cart. NA-D stated it	21375	DEFICIENCY)		
contamination of the	over the linen cart to prevent le linens. on 3/5/24 at 3:16 p.m., NA-C				

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STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	.	E SURVEY PLETED
		00016	B. WING		03/	06/2024
NAME OF PROVID	ER OR SUPPLIER	16561 US	DRESS, CITY, S HIGHWAY 1 RK, MN 565			
	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
state hand unco sanificant possions. Duri direct was liner touch drink. A fact Configuration covers continued facility. A fact and were organized to has such food. SUC DON reviews continued to has such food.	ds before passicated cart. NA dized her hands should have be sible cross control of nursing of an interview at a from any areas as from. cility policy titled at the facility of the facility of the facility of the each reside at the facility of the each reside at the facility of the each reside at the facility of the prepared cart with a famination while the facility of the prepared cart with a famination while at the prepared cart with a famination while at the prepared cart with a famination while at the prepared of th	process was to sanitize her ing linen from a clean income. C stated she should have should have should passing linen and the een covered to prevent samination. Ton 3/5/24 at 3:38 p.m., (DON) stated her expectation form hand hygiene, cover port, and staff should not be of the glass the resident	21375			

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			COMPLETED	
		00016	B. WING		03/06/2024		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SUNNYS	IDE CARE CENTER		HIGHWAY 1 RK, MN 565				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21375	Continued From page	ge 12	21375				
	followed.						
	TIME PERIOD OF (21) days.	CORRECTION: Twenty-one					
21565	MN Rule 4658.1325 Medications Self Ad	Subp. 4 Administration of Imin	21565			4/4/24	
	self-administer med resident assessmer care as required in 4658.0405 indicate	inistration. A resident may lications if the comprehensive plan of and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.					
	by: Based on observation review, the facility fa	ent is not met as evidenced on, interview and document ailed to ensure nebulizer dministered safely for 2 of 2 who were observed to self zer and had not been a self administer medications.		Corrected			
	Findings include:						
	R26						
	12/13/23, identified and had diagnoses sclerosis (chronic dinervous system) he side of body), hemip side of body) and chairflow and breathing	nimum Data Set (MDS) dated R26 was cognitively intact which included: multiple isease that affects central miplegia (paralysis on one paresis (weakness on one parenic obstructive pulmonary onic lung disease that cause ig problems). R26's MDS dependent for self care and					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00016	B. WING		03/0	6/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUNNYS	IDE CARE CENTER		HIGHWAY 10 RK, MN 5655			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 13	21565			
	R26's care plan reversed an activity of data performance deficit R26's care plan interest dependence on star personal hygiene. It infarction (CVA/stronon-dominant side.) R26's Order Summincluded orders for Inhalation Solution milliliter (ML) 1 vial for while awake. R26's Order Summincluded orders for Inhalation Solution milliliter (ML) 1 vial for while awake. R26's Order Summing self-administer medication self-administer medication of the self-administration of the self-admin	ised 12/20/23, identified R26 ally living (ADL) self-care related to disease processes. erventions included ff for bathing, dressing, and dentified R26 had a cerebral ke) which affected R26's left, ary Report signed 3/1/24, Ipratropium-Albuterol 0.5-2.5 (3) milligram (MG)/3 inhale orally four times a day ary Report lacked an order to lication. Indicated documentation of a performance of medication (SAM) eted. Ion on 3/6/24 at 7:13 a.m., arrse (LPN)-A administered ons and topical medication. At				
	was unaware if R26	ulizer out. LPN-A stated she had an order or SAM nebulizer medication.				

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	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00016	B. WING		03/	06/2024	
	PROVIDER OR SUPPLIER	16561 US	DDRESS, CITY, STANDERSS, CITY, STANDERSS				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
21565	Continued From pa	ge 14	21565				
	registered nurse (R R26 did not have an of medication, inclu- verified no resident SAM assessment of she expected staff while any resident re- medication. R9 R9's quarterly Mining 12/13/23, indicated impairment and had impairment and had hemiplegia (a condi- or spinal cord injury side of the body), a understand or expre- damage), and cere (Stroke). Indicated	non 3/6/24 at 7:39 a.m., N)-A and LPN-A confirmed on order for self administration ding the nebulizer. RN-A is at the facility currently had a completed and RN-A indicated would remain in the room ecceived a nebulizer. The mum Data Set (MDS) dated R9 had mild cognitive id diagnoses which included ition caused by brain damage in that leads to paralysis on one phasia (loss of ability to less speech, caused by brain bral vascular accident (CVA) R9 required extensive if mobility, transfers, toileting ne.					
	revealed a SAM as	ctronic health record (EHR) sessment had not been did not have an order for self edications.					
	and signed 2/20/24 Ipratropium-albuter (medication used to airways and increase	phone Orders dated 2/12/24, directed staff to administer of inhalation solution DuoNeb relax the muscles in the se air flow to the lungs) four and every four hours as needed					
		ministration Record dated ndicated R9 had been taking					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00016	B. WING		03/06/2024	
	PROVIDER OR SUPPLIER	16561 US	DRESS, CITY, S HIGHWAY 1 RK, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE	
21565	R9's care plan date limited mobility and supervision with act During a continuous 7:20 a.m., R9 was a room with a mask or running. No staff we 7:26 a.m., trained nentered R9's room machine and remove the nebulizer material staff did not remain treatment was being nursing staff turned placed the mask or During an interview TMA-A verified she treatment on R9 and stated she was unsubseen completed for have time to sit with nebulizer so she we turned on the mach when the nebulizer indicated sometime himself and	milligrams (mg) per three				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		`	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00016	B. WING		03/06/2024	
	PROVIDER OR SUPPLIER	16561 US	DRESS, CITY, S HIGHWAY 1 RK, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
21565	did not have a SAM nebulizer treatment current residents had nebulizer's as they administer the nebulizer's as they administer the nebulizer treatment received the nebulizer treatment received the nebulizer treatment and interview director of nursing (not have SAM asseresident did not have physician's orders, with the resident duadministration. Review of a facility Self-Administration. Review of a facility Self-Administer medications may be further indicated a redications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be further indicated redocumented on the interdisciplinary teamedications may be	N)-A confirmed R9 and R26 assessment for their s. RN-A stated none of the ad a SAM assessment for were not safe to self alizers. RN-A indication her rsing staff would have stayed and R26 while they received and R26 while they received and R26 while they received and R26 are treatments appropriately. on 3/6/24 at 7:42 a.m., DON) verified R9 and R26 did assments. DON indicated if the re a SAM assessment or staff were expected to remain ring the entire nebulizer policy titled Resident of Medication dated esident may only dications after the facility's m has determined which as self-administered safely. Esident's preference would be appropriate form and placed	21565			

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· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00016	B. WING		03/0	6/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUNNYS	SUNNYSIDE CARE CENTER 16561 US HIGHWAY 10 LAKE PARK, MN 56554					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
21565	Continued From page	ge 17	21565			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144. Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			4/4/24
	residents have the courtesy and respec	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observation review, the facility fa	ent is not met as evidenced on, interview and document ailed to provide a dignified or 1 of 1 residents (R16) who with eating in the dining		Corrected.		
	Findings Include:					
	1/12/24, identified Filimpairment and had anxiety, depression (CVA/stroke) hemip	imum Data Set (MDS) dated R16 had severe cognitive diagnoses which included: , cerebral vascular accident legia (paralysis on one side of esis (weakness on one side of				
	self-care performant hemiplegia and hen non-dominant side. assistance with hyg R16's care plan ideal altered nutritional st	ised 3/4/24, identified R16 had nce deficit related to niparesis affecting left R16's interventions included iene, bathing and dressing. ntified R16 had potential for tatus related to CVA and assistance at times with				

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· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
		00016	B. WING		03/	06/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
SUNNYS	SIDE CARE CENTER		HIGHWAY 10 RK, MN 5655				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
21805	During an observation R16 sat in a high baroom at a table. Nur near R16's right side eggs while he remaiside. NA-B went to on a stool next to at the other resident. Walked over to R16 and provided R16 and onto the plate. NA-soda in a can with a standing with left har R16's wheelchair with full of eggs and dring R16 if done, removed R16 if done, removed R16 if done, removed R16 transported R16 out the usual provided R16 out the usual pr	ge 18 clan identified R16 received donor 3/5/24 at 8:56 a.m., ack wheelchair in the dining rsing assistant (NA)-B stood e, and provided 2 spoonful of ined standing on R16's right the other side of the table, sat nother resident and assisted At 9:00 a.m., NA-B stood up, and stood at R16's right side a spoonful of eggs. NA-B R16's bacon, asked R16 if he and placed the bacon back B provided R16 a drink of a straw. NA-B remained and resting on the back of hile providing R16 with spoons aks. At 9:05 a.m. NA-B asked ed R16's dishes from the b's clothing protector and t of the dining room. on 3/5/24 at 10:16 a.m., NA-B becess was to be seated while with eating. NA-B indicated it o stand while assisting g and indicated NA-B should sting R16 in order to pay		DEFICIENCY			
	During an interview registered nurse (Respected to be sear with eating and have RN-A indicated it was residents their full a RN-A verified it was	. ,					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 16561 US HIGHWAY 10 LAKE PARK, MN 56554 CA4 ID SUMMARY STATEMENT OF DEFICENCES	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
SUNNYSIDE CARE CENTER 16561 US HIGHWAY 10 LAKE PARK, MN 56554 (X4) ID			00016	B. WING		03/06/2024
(X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (AS) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	NAME OF I	PROVIDER OR SUPPLIER				
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