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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VKRP

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00048

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245045**

2.STATE VENDOR OR MEDICAID NO.
(L2) **695045102**

3. NAME AND ADDRESS OF FACILITY
(L3) **SUNNYSIDE HEALTH CARE CENTER**
(L4) **512 SKYLINE BOULEVARD**
(L5) **CLOQUET, MN** (L6) **55720**

4. TYPE OF ACTION: **7** (L8)

| | |
|---|---|
| **1. Initial** | **2. Recertification** |
| **3. Termination** | **4. CHOW** |
| **5. Validation** | **6. Complaint** |
| **7. On-Site Visit** | **9. Other** |
| **8. Full Survey After Complaint** | |

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/20/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
**09/30**

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

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:

**X** A. In Compliance With Program Requirements Compliance Based On:

___1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 44 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE-NE II 07/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 09/05/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**01/01/1967**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**06/26/2017**
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

**PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS**

CMS Certification Number (CCN): 245045 July 6, 2017

Mr. Jeffrey Brown, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, MN 55720

Dear Mr. Brown:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 13, 2017 the above facility is recommended for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697
cc: Licensing and Certification File

MDH
Minnesota
Department
*of* Health

**PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS**

Electronically delivered July 6, 2017

Mr. Jeffrey Brown, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, MN 55720

RE: Project Number S5045027

Dear Mr. Brown:

On May 17, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 4, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 20, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 15, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 4, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 13, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 4, 2017, effective June 13, 2017 and therefore remedies outlined in our letter to you dated May 17, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697
cc: Licensing and Certification File

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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VKRP

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Facility ID: 00048

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(L3) **SUNNYSIDE HEALTH CARE CENTER**
(L4) **512 SKYLINE BOULEVARD**
(L5) **CLOQUET, MN** (L6) **55720**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/04/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
**09/30**

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From (a) :
To (b) :

12.Total Facility Beds **44** (L18)
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10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
**X** B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 44 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 05/24/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/26/2017 (L20)

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

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

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

22. ORIGINAL DATE OF PARTICIPATION
**01/01/1967**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 17, 2017

Mr. Jeffrey Brown, Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, MN 55720

RE: Project Number S5045027

Dear Mr. Brown:

On May 4, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

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

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

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

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

## DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

## OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 13, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 13, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 4, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 4, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

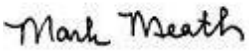
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118  Fax: (651) 215-9697

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245045 | A. BUILDING _____ B. WING _____ | 05/04/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNNYSIDE HEALTH CARE CENTER | 512 SKYLINE BOULEVARD CLOQUET, MN 55720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 282 SS=D | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 1 residents (R24) in the sample who required assistance with incontinence cares and repositioning.<br><br>Findings include:<br><br>R24's care plan dated 2/8/17, identified R24 as | F 282 | Sunnyside Health Care Center does provide services by qualified persons in accordance with each resident□s written plan of care. This deficiency was noted on 1 of 1 resident in the sample who required assistance with incontinence cares and repositioning.<br><br>R24's care plan has been reviewed and updated. | 6/13/17 |

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

Electronically Signed | 05/23/2017

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245045 | A. BUILDING _____ B. WING _____ | 05/04/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNNYSIDE HEALTH CARE CENTER | 512 SKYLINE BOULEVARD CLOQUET, MN 55720 |

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|---|---|---|---|---|
| F 282 | Continued From page 1<br>incontinent of bladder and directed the staff to assist with incontinence cares at night and to assist to the toilet every two hours while awake. The care plan also identified R24 at risk for the development of pressure ulcers, and directed the staff to assist with repositioning every two hours.<br><br>During continuous observation on 5/3/17, from 7:10 a.m. to 9:40 a.m. R24 did not received assistance with incontinence cares. At 7:10 a.m. R24 was observed seated in a wheelchair in the dining room. At 7:40 a.m. R24 was served breakfast and nursing assistant (NA)-A was observed to assist R24 with the meal. At 8:20 a.m. R24 was wheeled from the dining room to the living room area next to the nurse's station. R24 remained in the living room until 9:26 a.m. at which time registered nurse (RN)-A brought R24 to her room. At 9:32 a.m. NA-B entered R24's room and assisted her to the rest room via a mechanical standing lift. R24's pants and incontinent product were observed to be saturated with urine. R24's buttocks were observed to be red and intact.<br><br>On 5/3/17, at 9:40 a.m. NA-B stated R24 had last been assisted with incontinence cares by the night staff. NA-B stated R24 had been assisted out of bed between 6:00 a.m. to 6:30 a.m. by the night shift. NA-B stated the night shift had not reported the exact time they had assisted R24 with cares. NA-B confirmed R24 had not been assisted with incontinence cares and repositioning for three hours.<br><br>On 5/3/17, at 12:50 p.m. RN-A stated R24 was to | F 282 | Resident Care Managers will identify and review all residents who are dependent upon staff for repositioning and toileting to ensure their care plans are being followed.<br><br>A coaching was conducted for NA-B in regards to not following R24'□s care plan with repositioning, toileting, and incontinence cares.<br><br>A Care Plan policy will be developed.<br><br>Measures to correct the deficient practices are as follows: All Nursing staff (RNs, LPNs, NA/Rs) will be educated on the importance of following each resident□s plan of care.<br><br>Monitoring will be completed by a QA tool and done by an RN to ensure all NARs are in compliance with each resident□s plan of care. QA audits will be conducted daily x1 week, weekly x1 month, monthly x1 and random as needed to ensure ongoing compliance.<br><br>The correction will be monitored by the Resident Care Managers and the Director of Nursing to ensure compliance.<br><br>Any issues and/or concerns will be brought to the weekly IDT meeting as well as the NA/R monthly meetings in order to discuss/review the results of the audits by the Director of Nursing.<br><br>Results will be discussed at our quarterly QAA meeting and action will be taken as | |

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|---|---|---|---|
| | 245045 | A. BUILDING _____ B. WING _____ | 05/04/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SUNNYSIDE HEALTH CARE CENTER | 512 SKYLINE BOULEVARD CLOQUET, MN 55720 |

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| F 282 | Continued From page 2<br>receive assistance with incontinence cares and repositioning every two hours as directed by the care plan.<br><br>On 5/3/17, at 2:00 p.m. the director of nurses (DON) stated R24 was to receive incontinence and repositioning cares every two hours as directed by the care plan. The DON stated the communication between shifts could be improved to ensure timely care could be provided on a continuous basis.<br><br>On 5/4/17, at 10:51 a.m. the DON stated the facility did not have a care plan policy but would expect the staff to provide care according to the care plan. | F 282 | necessary.<br><br>The Director of Nursing will be responsible. | |
| F 312 SS=D | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure that 1 of 1 resident (R24) who required assistance with incontinence care received timely assistance according to the comprehensive assessment.<br><br>Findings include:<br><br>R24's quarterly Minimum Data Set (MDS) dated 3/8/17, indicated R24 was diagnosed with dementia and displayed moderate cognitive impairment. R24 required extensive assistance of | F 312 | Sunnyside Health Care Center does provide ADL care for dependent residents. This deficiency was noted on 1 of 1 resident who required assistance with incontinence care received timely assistance in according to the comprehensive assessment.<br><br>R24's Bladder and Bowel Assessment has been reviewed.<br><br>Resident Care Managers will identify and | 6/13/17 |

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| F 312 | Continued From page 3<br>two staff with transferring, bed mobility and toileting use. R24 was frequently incontinent of bladder and always incontinent of bowel.<br><br>R24's Urinary Care Area Assessment (CAA) dated 12/15/16, indicated R24 was frequently incontinent of bladder and always incontinent of bowels. The CAA indicated R24 was able to void on the toilet but required the use of incontinent products at all times.<br><br>R24's Bowel and Bladder assessment dated 3/6/17, indicated R24 was incontinent of bowel and bladder, and directed the staff to provide assistance with incontinence care every two hours.<br><br>R24's care plan dated 2/8/17, directed the staff to assist R24 every two hours with incontinence cares at night, and to assist to the toilet every two hours while awake.<br><br>During continuous observation on 5/3/17, from 7:10 a.m. to 9:40 a.m. R24 did not received assistance with incontinence cares. At 7:10 a.m. R24 was observed seated in a wheelchair in the dining room. At 7:40 a.m. R24 was served breakfast and nursing assistant (NA)-A was observed to assist R24 with the meal. At 8:20 a.m. R24 was wheeled from the dining room to the living room area next to the nurse's station. R24 remained in the living room until 9:26 a.m. at which time registered nurse (RN)-A brought R24 to her room. At 9:32 a.m. NA-B entered R24's room and assisted her to the rest room via a mechanical standing lift. R24's pants and incontinent product were observed to be saturated with urine. | F 312 | review all residents who are dependent upon staff for toileting to ensure their care plans are being followed.<br><br>A coaching was conducted for NA-B in regards to not following R24'□s care plan with repositioning, toileting, and incontinence cares.<br><br>A communication board will be developed in order to enhance communication between the night and day shift to ensure timely care will be provided on a continual basis. This communication tool will be kept at the Nurses station. The night staff will be expected to document the last times, and day staff will be expected to review and follow per resident□s plan of care. QA audits will be conducted daily x1 week, and randomly to ensure the times are being documented correctly.<br><br>The Incontinent Care Program policy will be reviewed and updated.<br><br>Measures to correct the deficient practices are as follows: All Nursing staff (RNs, LPNs, NA/Rs) will be educated on the importance of toileting plans as well as the new process and expectation with the communication board.<br><br>Monitoring will be completed by a QA tool and done by an RN to ensure all staff are in compliance with each resident□s plan of care related to their personalized toileting plans. QA audits will be conducted on R24 daily x1 week, weekly x1 month, and then monthly x1 and | |

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| F 312 | Continued From page 4<br>On 5/3/17, at 9:40 a.m. NA-B stated R24 had last been assisted with incontinence cares by the night staff. NA-B stated R24 had been assisted out of bed between 6:00 a.m. to 6:30 a.m. by the night shift. NA-B stated the night shift had not reported the exact time they had assisted R24 with incontinence cares. NA-B confirmed R24 had not been assisted with incontinence cares for three hours.<br><br>On 5/3/17, at 12:50 p.m. RN-A stated R24 was to receive assistance with incontinence cares every two hours as directed by the care plan.<br><br>On 5/3/17, at 2:00 p.m. the director of nurses (DON) stated R24 was to receive incontinence cares every two hours as directed by the care plan. The DON stated the communication between shifts could be improved to ensure timely care could be provided on a continuous basis.<br><br>The Incontinent Care Program policy dated 9/2016, directed the staff to provide bladder care according to the individualized toileting program for each resident. | F 312 | random as needed to ensure ongoing compliance.<br><br>The correction will be monitored by the Resident Care Managers and the Director of Nursing to ensure compliance.<br><br>Any issues and/or concerns will be brought to the weekly IDT meeting as well as the NA/R monthly meetings in order to discuss/review the results of the audits by the Director of Nursing.<br><br>Results will be discussed at our quarterly QAA meeting and action will be taken as necessary.<br><br>The Director of Nursing will be responsible. | |
| F 314 SS=D | 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>(b) Skin Integrity -<br><br>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure | F 314 | | 6/13/17 |

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| F 314 | Continued From page 5<br>ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br><br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure a resident identified at risk for pressure ulcers received the necessary care and treatment to prevent the development of pressure ulcers for 1 of 3 residents (R24) in the sample identified at risk for pressure ulcers.<br><br>Findings include:<br><br>R24's quarterly Minimum Data Set (MDS) dated 3/8/17, indicated R24 was diagnosed with dementia and displayed moderate cognitive impairment. R24 required extensive assistance of two staff with transferring, bed mobility and R24 was unable to ambulate. The MDS indicated R24 was at risk for the development of pressure ulcers.<br><br>R24's Pressure Ulcer Care Area Assessment (CAA) dated 12/15/16, indicated R24 was at risk for the development of skin breakdown due to mobility concerns and bladder incontinence. R24 required extensive assistance of two staff for repositioning and utilized pressure redistribution cushions on her bed and wheelchair.<br><br>R24's Braden Scale (assessment used for the predication of pressure ulcers) dated 3/6/17, | F 314 | Sunnyside Health Care Center does provide treatment/services to prevent/heal pressure sores. This deficiency was noted on 1 of 3 residents in the sample identified at risk for pressure ulcers.<br><br>R24's Braden Scale and Tissue Tolerance has been reviewed.<br><br>R24 has been moved to the am care list in order to keep better track of toileting times due to her potential risk for skin breakdown. Upon admission, R24 presented with a callous area on her coccyx that we continue to monitor. R24 has had no pressure related sores.<br><br>Resident Care Managers will identify and review all residents who are dependent upon staff for repositioning to ensure their care plans are being followed.<br><br>A coaching was conducted for NA-B in regards to not following R24'□s care plan with repositioning, toileting, and incontinence cares.<br><br>The Repositioning policy will be reviewed and updated. | |

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| F 314 | Continued From page 6<br>indicated R24 was at high risk for the development of pressure ulcers.<br><br>The Tissue Tolerance Check Summary (tool used to determine tissue perfusion) dated 4/3/17, indicated R24 was able to tolerate every two hour repositioning while in a chair or bed.<br><br>R24's care plan dated 5/1/17, indicated R24 had a history of callous area on her coccyx, fragile skin and being dependent upon staff for repositioning. The care plan directed the staff to assist with repositioning every two hours.<br><br>During continuous observation on 5/3/17, from 7:10 a.m. to 9:40 a.m. R24 did not received assistance with repositioning. At 7:10 a.m. R24 was observed seated in a wheelchair in the dining room. At 7:40 a.m. R24 was served breakfast and nursing assistant (NA)-A was observed to assist R24 with the meal. At 8:20 a.m. R24 was wheeled from the dining room to the living room area next to the nurse's station. R24 remained in the living room until 9:26 a.m. at which time registered nurse (RN)-A brought R24 to her room. At 9:32 a.m. NA-B entered R24's room and assisted her to the rest room via a mechanical standing lift. R24's wheelchair was equipped with a pressure redistribution cushion. R24's skin was observed to be reddened without open areas and she was incontinent of urine.<br><br>On 5/3/17, at 9:40 a.m. NA-B stated R24 had last been repositioned by the night staff. NA-B stated R24 had been assisted out of bed between 6:00 a.m. to 6:30 a.m. by the night shift. NA-B stated the night shift had not reported the exact time R24 had been repositioned. NA-B confirmed R24 had not been repositioned for three hours. | F 314 | Measures to correct the deficient practices are as follows: All Nursing staff (RNs, LPNs, NA/Rs) will be educated on the importance of preventing pressure sores by following each residents plan of care in relation to their tissue tolerance.<br><br>Monitoring will be completed by a QA tool and done by an RN to ensure all NARs are in compliance with each resident's repositioning times per tissue tolerance. QA audits will be conducted for R24 daily x1 week, weekly x1 month, monthly x1 and random as needed to ensure ongoing compliance.<br><br>The correction will be monitored by the Resident Care Managers and the Director of Nursing to ensure compliance.<br><br>Any issues and/or concerns will be brought to the weekly IDT meeting as well as the NA/R monthly meetings in order to discuss/review the results of the audits by the Director of Nursing.<br><br>Results will be discussed at our quarterly QAA meeting and action taken as necessary.<br><br>The Director of Nursing will be responsible. | |

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| F 314 | Continued From page 7<br><br>On 5/3/17, at 12:50 p.m. RN-A stated R24 was to receive assistance with repositioning every two hours as directed by the care plan.<br><br>On 5/3/17, at 2:00 p.m. the director of nurses (DON) stated R24 was to be repositioned every two hours as directed by the care plan. The DON stated the communication between shifts could be improved to ensure timely care could be provided on a continuous basis.<br><br>The Repositioning Policy dated 3/1/17, directed the staff to develop an individualized care plan for repositioning to promote comfort for all bed or chair bound resident and to prevent skin breakdown. | F 314 | | |

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| | 245045 | A. BUILDING **01 - MAIN BUILDING** B. WING _____ | **05/04/2017** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br>FIRE SAFETY<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Sunnyside Health Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:<br><br>HEALTH CARE FIRE INSPECTIONS<br>STATE FIRE MARSHAL DIVISION<br>445 MINNESOTA STREET, SUITE 145<br>ST. PAUL, MN 55101-5145, or | K 000 | EPOC | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 05/23/2017 |

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

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| K 000 | Continued From page 1<br>By e-mail to both:<br>Marian.Whitney@state.mn.us<br>and<br>Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency<br><br>Sunnyside Care Center, is a 3-story building with no basement. The original building was constructed in 1962 and was determined to be of Type II(111) construction. In 1968 the second floor was added, also Type II(111) construction. In 2000 dining rooms were constructed on floors one and two of Type II(111) construction. In 2012/2013 a 3 story building with a full basement, Type I (332) construction was added. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. This skilled nursing home is not 2 hour fire rated separated from the attached hospital, and the hospital was also inspected. The nursing home beds are all located on the 2 story of the building.<br><br>The building is fully sprinklered throughout. The facility has a fire alarm system with smoke | K 000 | | |

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| K 000 | Continued From page 2<br>detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code.<br><br>The facility has a capacity of 44 beds and had a census of 39 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by: | K 000 | | |
| K 324 SS=D | NFPA 101 Cooking Facilities<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 | K 324 | | 6/13/17 |

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| K 324 | Continued From page 3<br><br>This STANDARD is not met as evidenced by:<br>Based on a complaint received from the Minnesota Department of Health survey team and staff interview, the facility is cooking food that produces grease-laden vapors on a counter top electric grill without the proper exhaust hood equipment and extinguishing system in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.2.5 and NFPA 96(11). This deficient practice could affect 39 of 39 residents, as well as an undetermined number of staff, and visitors.<br><br>Findings Include:<br><br>At 3:30 p.m. on 05/03/17, information was received via email from a Minnesota Department of Health (MDH) Supervisor notifying me that on 05/03/17 MDH surveyors witnessed facility staff members frying eggs in portable griddles in the main resident dining room. The MDH surveyors also stated that the staff members were cooking eggs using a aerosol can of vegetable based oil as a release agent that was creating grease laden vapors in an area that is not protected by an approved commercial cooking hood equipped with a fire suppression system.<br><br>This deficient practice was verified by the Maintenance Supervisor | K 324 | Sunnyside Health Care Center does provide a safe and comfortable environment for all of the residents in our care. As well, SHCC does take seriously the requirements within NFPA 101: Cooking Facilities.<br><br>39 of 39 residents, as well as staff and visitors could have been affected from this deficient practice.<br><br>The cooking of fried eggs and/or any other food by staff on residential grade electronic griddles spayed with vegetable based (aerosol) oil in the main dining room without an approved commercial hood equipped with the appropriate fire suppression system was discontinued the date of May 3, 2017. All fried food items will be prepared in the commercial grade kitchen at ground level. The existing main resident dining room will be assessed for further to ensure other potential hazards are eliminated.<br><br>All SHCC/CMH staff and management assigned or responsible to residents during food prep and or food service including: Nursing, Activities, Nutrition Services & Housekeeping will be re-educated to the NFPA requirements relative to Cooking Facilities.<br><br>All policies related to food handling equipment and food prep policies will be reviewed and revised as necessary. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245045 | A. BUILDING **01 - MAIN BUILDING** B. WING _____ | **05/04/2017** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SUNNYSIDE HEALTH CARE CENTER** | **512 SKYLINE BOULEVARD CLOQUET, MN 55720** |

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|---|---|---|---|---|
| K 324 | Continued From page 4 | K 324 | Weekly audits will be conducted on random days of the week covering each meal to ensure compliance with NFPA 101. Audits will be done weekly times six months, and then monthly for six additional months by either the facility Administrator, DON, Nutrition Services Manager or designee.<br><br>Monitoring for compliance will be documented, reported and discussed at the quarterly quality assessment and performance improvement committee meetings for one year.<br><br>The person responsible for compliance and reporting is the Nutrition Services Manager. | |
| K 712 SS=F | NFPA 101 Fire Drills<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7<br>This STANDARD is not met as evidenced by:<br>Based on review of reports, records and staff | K 712 | Sunnyside Health Care Center has | 6/13/17 |

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| K 712 | Continued From page 5<br>interview, it was determined that the facility failed to conduct 2 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 39 of 39 residents, as well as an undetermined number of staff, and visitors.<br><br>Findings include:<br><br>On facility tour between 10:00 a.m. to 2:00 p.m. on 05/03/2017, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was found that the facility did not transmit a fire alarm signal to the alarm monitoring company for 2 of 12 fire drills<br><br>This deficient condition was verified by a Maintenance Supervisor. | K 712 | reviewed and revised our practice and policy (Fire Drill Alarm Activation).<br><br>The facilities previous fire drill alarm activation policy stated that alarms would not be activated on the Midnight Shift so resident and patient sleep was not disrupted. As a result of not activating the alarm there was not transmission of the signal.<br><br>The practice and policy now reflects that the alarms will be activated on the midnight shift to ensure that the digital alarm communication transmission (DACT) reaches the intended destination, along with the silencing of the audible alarm only on the midnight shift.<br><br>All staff will be educated to the new policy and procedure. The staff responsible for fire drill activation (Maintenance) will learn the actual procedure for activating the transmission, while silencing the audible alarm.<br><br>The Building & Grounds Director will audit the successful DACT activation monthly and will document findings and report compliance at the quarterly quality assurance and improvement committee meetings for one year. | |