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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WHV6
Facility ID: 00016

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245597**

2. STATE VENDOR OR MEDICAID NO. (L2) **863840300**

3. NAME AND ADDRESS OF FACILITY
(L3) **SUNNYSIDE CARE CENTER**
(L4) **16561 US HIGHWAY 10**
(L5) **LAKE PARK, MN** (L6) **56554**

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 **09/08/2015** (L34)

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	

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

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

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

12.Total Facility Beds **34** (L18)

13.Total Certified Beds **34** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	34			
(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 :
Gail Anderson, Unit Supervisor — 10/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 10/23/2015 (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 **02/01/1992** (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. **00660** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **09/10/2015** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245597

October 23, 2015

Ms. Danielle Olson, Administrator
Sunnyside Care Center
16561 US Highway 10
Lake Park, Minnesota 56554-9302

Dear Ms. Olson:

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 August 14, 2015 the above facility is certified for:

34 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 34 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.

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

Sincerely,

Mark Meath

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 30, 2015

Ms. Carol Kvidt, Administrator
Sunnyside Care Center
16561 US Highway 10
Lake Park, Minnesota 56554-9302

RE: Project Number S5597024

Dear Ms. Kvidt:

On August 5, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 22, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 8, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 14, 2015 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 July 22, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 14, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 22, 2015, effective August 14, 2015 and therefore remedies outlined in our letter to you dated August 5, 2015, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245597	A. Building B. Wing	9/8/2015

Name of Facility	Street Address, City, State, Zip Code
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	08/14/2015	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	08/14/2015	ID Prefix F0314 Reg. # 483.25(c) LSC	08/14/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/kfd	09/30/2015	28034	09/08/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/22/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245597	01 - MAIN BUILDING 01	9/14/2015

Name of Facility	Street Address, City, State, Zip Code
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0052	07/23/2015	ID Prefix Reg. # NFPA 101 LSC K0073	08/12/2015	ID Prefix Reg. # NFPA 101 LSC K0130	08/13/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/kfd	09/30/2015	27200	09/14/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/22/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245597	A. Building B. Wing 02 - ADMINISTRATION ADDITION	9/14/2015

Name of Facility	Street Address, City, State, Zip Code
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 LAKE PARK, MN 56554

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0052	07/23/2015	ID Prefix Reg. # NFPA 101 LSC K0070	08/12/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/kfd	09/30/2015	27200	09/14/2015
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/22/2015			

DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WHV6
Facility ID: 00016

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245597**

2. STATE VENDOR OR MEDICAID NO.
(L2) **863840300**

3. NAME AND ADDRESS OF FACILITY
(L3) **SUNNYSIDE CARE CENTER**
(L4) **16561 US HIGHWAY 10**
(L5) **LAKE PARK, MN** (L6) **56554**

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 **07/22/2015** (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 **34** (L18)

13.Total Certified Beds **34** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	34			
(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 :
Christina Martinson, HFE NEII 08/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1992
(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.
00660
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 5, 2015

Ms. Carol Kvidt, Administrator
Sunnyside Care Center
16561 Us Highway 10
Lake Park, Minnesota 56554-9302

RE: Project Number S5597024

Dear Ms. Kvidt:

On July 22, 2015, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140
Fax: (218) 332-5196

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 August 31, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 22, 2015 (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 January 22, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath, Enforcement Specialist
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING ______ B. WING ______	07/22/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the written plan of care for 1 of 3 residents (R25) reviewed for activities of daily living (ADL) who required assistance with toileting and 1 of 1 resident (R25) at risk for the development of pressure ulcers. Findings include: R25's current care plan dated 4/9/15, identified R25 had alteration in musculoskeletal status related to Parkinson disease and dementia. The care plan directed staff to change R25's position	F 282	Corrective Action: The Plan of Care for Resident # 25 was reviewed and found to be correct. The nursing assistants were educated as soon as it was revealed the plan of care was not followed. Corrective Action as it applies to other residents: #1. The plans of care were reviewed by the RN team for all resident¿s in regard to repositioning needs as well as incontinent care and found to be correct or were updated as needed after reassessment. #2. The CNA Kardex¿ s in Point of Care	8/14/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/13/2015

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

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F 282	Continued From page 1 every two hours and as needed with extensive assist of two staff to reposition. The care plan further directed staff to observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. The care plan also identified R25 had functional bowel/ bladder incontinence related to dementia, paralysis agitans and traumatic brain injury. The care plan indicated R25 was totally dependent on 2 staff for toilet use and directed staff to check/change every two hours as required for incontinence, assist with toileting as needed and provide pericare after each incontinent episode, apply ointment as per protocol. Review of Sunnyside Care Center Task List Report for the nursing assistance (NA) directed staff to turn and reposition R25 every two hours and to totally assist R25 with two staff to check and change every two hours. Continual observations was conducted on 7/21/15, from 12:57 p.m. to 4:10 p.m. At 12:57 p.m. R25 was observed lying on his back in bed with a white cloth pad underneath R25. R25 was alone in the room with the head of the bed elevated approximately 30 degrees, bed in low position and covered with a blanket which came up to his mid chest area. R25 remained alone, in the same position in bed, with the head of the bed elevated approximately 30 degrees until 2:44 p.m. -At 2:44 p.m. NA-A entered R25 room and offered R25 a snack. NA-A reached out and raised the head of the bed slightly and sat on the edge of the bed to assist R25 to eat raspberry yogurt. At 2:49 p.m. NA-A left the room and R25 remained on his back in bed, with the head of the bed raised and bed in low position. NA-A did not offer	F 282	(Point Click Care) were reviewed for clarity and found to be clear and concise. #3. All CNAs were educated on the importance of following the individual plans of care either at meetings held on August 13, 2015 or in person with a nurse. #4. An audit of the flow sheets as well as random observation audits is currently ongoing. Monitoring will continue daily until compliance is achieved then weekly x 4 weeks then biweekly x 4 weeks then monthly until review by the QAPI committee. The DON will report a summary of the monitoring to the QA committee. Date of Completion: August 14, 2015 Reoccurrence will be prevented by: Staff education and ongoing monitoring with results presented to the QAPI committee. Person responsible: DON or designee.	

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toileting or repositioning to R25.
-At 3:23 p.m. a nursing assistant entered the room, sat down in the chair, visited with R25 briefly, then immediately left the room at 3:25 p.m. The facility staff member had not offered to reposition or toileting to R25 and R25 remained in the same position with head of the bed in a semi sitting position watching TV.
-At 3:52 p.m. licensed practical nurse (LPN)-A entered R25's room, proceeded to obtain a blood sample for blood sugar testing, returned briefly to her medication cart, returned and assisted R25 to take the medication, and immediately left the room at 3:54 p.m. LPN-A had not offered to reposition or check/change R25 and R25 remained in the same sitting position on his back with bed in low position.

During interview on 7/21/15 at 4:01 p.m. NA-C confirmed R25 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. NA-C indicated she was unaware when R25 had last been repositioned or checked or changed.

-At 4:03 p.m. R25 remained in the same positron in bed. NA-B and NA-C entered R25's room, elevated the height of the bed, and lowered the head of the bed. At 4:04 NA-C confirmed R25 had been incontinent and both NA-B and NA-C proceeded to remove R25's pants and change the incontinent product. During the observation R25's buttocks was noted to be bright red around the rectal area which extended to the outer edges of his buttock crease with no open areas noted. NA-B and NA-C proceeded to assist R25 from his bed to wheelchair via total mechanical lift. R25 had not been repositioned from 12:57 p.m. until 4:03 p.m., a total of 3 hours and 6 minutes. R25

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was unable to reposition himself independently and was not assisted by staff to be checked or changed for incontinence every two hours per his current care plan.

During interview on 7/21/15 at 4:20 p.m. registered nurse (RN)-A confirmed R25 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. RN-A confirmed R25 was at risk for pressure ulcers, confirmed R25's current care plan and stated she would expect staff to reposition R25 every 2 hours and check and change R25 every 2 hours for incontinence.

During interview on 7/22/15 at 7:29 a.m. NA-A confirmed she had not repositioned R25 , had only removed the pillow from the left side of R25's back, while he remained on his back, then left him in a upright sitting/reclining position when she left R25's room.

During interview on 7/22/15 at 8:10 a.m. director of nursing (DON) confirmed R25 was at risk for the development of pressure ulcers, confirmed R25's current care plan and indicated she would expect staff to reposition R25 and check and change R25 as directed on the care plan. The DON stated she did not consider sitting R25 in a upright position in bed or removing a pillow behind his back would not be adequate repositioning for R25.

During observation on 7/22/15 at 8:28 a.m. NA-D and NA-E entered R25's room with a total mechanical lift device and proceeded to assist R25 from the wheelchair to his bed via total

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mechanical lift. At 8:33 a.m. NA-D checked R25 to see if he was incontinent of bowel and bladder and NA-D stated "he was dry." NA-D and NA-E repositioned R25 on his left side, placed a pillow behind the right side of his back and between his legs and exited the room.
-At 8:58 a.m. R25 remained in the same position, on his left side with a pillow behind his back in bed.
-At 10:23 a.m. R25 remained in the same position in bed.
-At 11:14 a.m. R25 remained in the same position on his left side in bed. NA-D and NA-E entered R25's room, and proceeded to R25 from the bed to the wheelchair via the total mechanical lift. NA-D stated "R25 was incontinent of bowel and bladder."
R25 remained in bed laying on his left side from 8:31 a.m. until 11:14 a.m. (2 hours and 43 minutes). R25 was unable to preposition himself independently and was not assisted by staff to be checked or changed for incontinence every two hours per his current care plan.

During interview on 7/22/15 at 11:25 a.m. NA-D confirmed R25 had been incontinent of bowel and bladder and verified he was not repositioned or checked and changed since 8:33 a.m. NA-D denied repositioning or checking and changing R25 since he had been laid in bed after breakfast. NA-D confirmed R25's care plan directed to reposition and check and change R25 every 2 hours.

Review of facility policy titled, Care Plans Comprehensive, revised on 9/12 indicated the facilities care planning/interdisciplinary team, in coordination with the resident, his/her family or

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F 282	Continued From page 5 representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely services to maintain good personal hygiene for 1 of 3 residents (R25) reviewed for activities of daily living. Findings include: R25's quarterly Minimum Data Set (MDS) dated 7/1/15, indicated R25 had diagnoses which included cerebrovascular accident (CVA), peripheral vascular disease, diabetes and dementia. The MDS identified R25 had severe cognitive impairment, required extensive assist of two staff for bed mobility and was totally dependent on staff for transfers. Further, the MDS identified R25 was always incontinent of bowel and bladder, and was not on a toileting or bowel toileting program. R25's bowel and bladder assessment dated	F 312	Corrective Action: The nursing assistants involved were educated on 7/23/15 as soon as it was revealed that Resident # 25 did not receive incontinent care on 7/22/15. Resident #25 plan of care was reviewed and revealed it is accurate and will remain as written; resident is to receive incontinent care every 2 hours and prn. Corrective Action as it applies to other residents: #1. The policy and procedure was reviewed and found to be adequate. #2. All CNA¿s were educated on the importance of following the individual plan of care and providing the resident incontinent care as written. This was completed on 8-14-15 either via meetings held on 8-13, 2015 or individually with a nurse.	8/14/15

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F 312	Continued From page 6 7/1/15, indicated R25 had functional bladder/bladder incontinence, was always incontinent of bowel and bladder, was not on a toileting program and was on dignity program to check and change every two hours. R25's current care plan dated 4/9/15, identified R25 had alteration in musculoskeletal status related to Parkinson disease and dementia. The care plan directed staff to change R25's position every two hours and as needed with extensive assist of two staff to reposition. The care plan further directed staff to observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. The care plan also identified R25 had functional bowel/ bladder incontinence related to dementia, paralysis agitans and traumatic brain injury. The care plan indicated R25 was totally dependent on 2 staff for toilet use and directed staff to check/change every two hours as required for incontinence, assist with toileting as needed and provide pericare after each incontinent episode, apply ointment as per protocol. Continual observations was conducted on 7/21/15, from 12:57 p.m. to 4:10 p.m. At 12:57 p.m. R25 was observed lying on his back in bed with a white cloth pad underneath R25. R25 was alone in the room with the head of the bed elevated approximately 30 degrees, bed in low position and covered with a blanket which came up to his mid chest area. R25 remained alone, in the same position in bed, with the head of the bed elevated approximately 30 degrees until 2:44 p.m. -At 2:44 p.m. NA-A entered R25 room and offered R25 a snack. NA-A reached out and raised the head of the bed slightly and sat on the edge of	F 312	#3. An audit of the flow sheets as well as random observation audits is currently ongoing. Monitoring will continue daily until compliance is achieved then weekly x 4 weeks then biweekly x 4 weeks then monthly until review by the QAPI committee. Date of Completion: August 14, 2015 Reoccurrence will be prevented by: Staff education and ongoing monitoring with results presented to the QAPI committee. Person responsible: DON or designee.	

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F 312	Continued From page 7 the bed to assist R25 to eat raspberry yogurt. At 2:49 p.m. NA-A left the room and R25 remained on his back in bed, with the head of the bed raised and bed in low position. NA-A did not offer to reposition or toilet R25. -At 3:23 p.m. a nursing assistant entered the room, sat down in the chair, visited with R25 briefly, then immediately left the room at 3:25 p.m. The facility staff member had not offered to reposition or toileting to R25 and R25 remained in the same position with head of the bed in a semi sitting position watching TV. -At 3:52 p.m. licensed practical nurse (LPN)-A entered R25's room, proceeded to obtain a blood sample for blood sugar testing, returned briefly to her medication cart, returned and assisted R25 to take the medication, and immediately left the room at 3:54 p.m. LPN-A had not offered to reposition or check/change R25 and R25 remained in the same sitting position on his back with bed in low position. During interview on 7/21/15 at 4:01 p.m. NA-C confirmed R25 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. NA-C indicated she was unaware when R25 had last been repositioned or checked or changed. -At 4:03 p.m. R25 remained in the same positron in bed. NA-B and NA-C entered R25's room, elevated the height of the bed, and lowered the head of the bed. At 4:04 NA-C confirmed R25 had been incontinent and both NA-B and NA-C proceeded to remove R25's pants and change the incontinent product. During the observation R25's buttocks was noted to be bright red around the rectal area which extended to the outer edges of his buttock crease with no open areas noted.	F 312		

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NA-B and NA-C proceeded to assist R25 from his bed to wheelchair via total mechanical lift. R25 had not been repositioned from 12:57 p.m. until 4:03 p.m., a total of 3 hours and 6 minutes. R25 was unable to preposition himself independently and was not assisted by staff to be checked or changed for incontinence every two hours per his current care plan.

During interview on 7/21/15 at 4:20 p.m. registered nurse (RN)-A confirmed R25 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. RN-A confirmed R25's current care plan and stated she would expect staff to reposition R25 every 2 hours and check and change R25 every 2 hours for incontinence.

During interview on 7/22/15 at 8:10 a.m. director of nursing (DON) confirmed R25 was at risk for the development of pressure ulcers, confirmed R25's current care plan and indicated she would expect staff to reposition R25 and check and change R25 as directed on the care plan. The DON stated she did not consider sitting R25 in a upright position in bed or removing a pillow behind his back would not be adequate repositioning for R25.

During observation on 7/22/15 at 8:28 a.m. NA-D and NA-E entered R25's room with a total mechanical lift device and proceeded to assist R25 from the wheelchair to his bed via total mechanical lift. At 8:33 a.m. NA-D checked R25 to see if he was incontinent of bowel and bladder and NA-D stated "he was dry." NA-D and NA-E repositioned R25 on his left side, placed a pillow behind the right side of his back and between his

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F 312	Continued From page 9 legs and exited the room. -At 8:58 a.m. R25 remained in the same position, on his left side with a pillow behind his back in bed. -At 10:23 a.m. R25 remained in the same position in bed. -At 11:14 a.m. R25 remained in the same position on his left side in bed. NA-D and NA-E entered R25's room, and proceeded to R25 from the bed to the wheelchair via the total mechanical lift. NA-D stated R25 was incontinent of bowel and bladder. R25 remained in bed laying on his left side from 8:31 a.m. until 11:14 a.m. (2 hours and 43 minutes). R25 was unable to preposition himself independently and was not assisted by staff to be checked or changed for incontinence every two hours per his current care plan. During interview on 7/22/15 at 11:25 a.m. NA-D confirmed R25 had been incontinent of bowel and bladder and verified he was not repositioned or checked and changed since 8:33 a.m. NA-D denied repositioning or checking and changing R25 since he had been laid in bed after breakfast. NA-D confirmed R25's care plan directed to reposition and check and change R25 every 2 hours. A facility policy was requested and one was not provided.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		8/14/15

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F 314	Continued From page 10 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely repositioning for 1 of 1 resident (R25) identified at risk for pressure ulcers. Findings include: R25's annual Minimum Data Set (MDS), dated 4/6/15, identified R25 had diagnoses which included dementia, cerebrovascular accident (CVA), peripheral vascular disease, and diabetes mellitus. The MDS identified R25 was at risk for the development of pressure ulcers and listed various treatments which included turning and repositioning. R25's care area assessment (CAA) dated 4/8/15, indicated R25 did not reposition himself, was repositioned by staff. The CAA identified R25 had the potential for skin break down, was at risk for development of pressure ulcers and required extensive assistance of two staff for bed mobility. R25's quarterly MDS, dated 7/1/15, identified R25 had severe cognitive impairment, required extensive assist of two staff for bed mobility and was totally dependent on staff for transferring. In addition, the MDS identified R25 was at risk for development of pressure ulcers, required a turning and repositioning program and utilized a	F 314	Corrective Action: The nursing assistants were educated on 7/23/15 as soon as it was revealed that Resident # 25 did not receive full repositioning on 7/22/15. Resident #25 was assessed via tissue tolerance testing completed on 8-1-15. Tissue tolerance testing showed resident was able to tolerate up to 3 hours while in bed without S/S of pressure however given his past history of ulcers and amputation he will remain on an every 2 hour repositioning schedule. Corrective Action as it applies to other residents: #1. The policy was reviewed and is adequate however the procedure was changed to include a written flow sheet used by all shifts which contains the following: Time resident was positioned and the position each resident was placed in. All residents on a repositioning schedule were assessed by the RN team to determine if there was a need to repeat tissue tolerance testing. Not all residents were reassessed due to various reasons. Of those reassessed 2 plans were changed to reflect a longer tolerance time than previous. Care plans were updated and staff alerted to the changes.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 11 pressure reducing device on the bed. R25's Braden Scale for Predicting Pressure Sore Risk form, dated 7/1/15, identified R25 was at moderate risk for the development of pressure ulcers, skin was often moist, was chairfast, had limited mobility and had a problem of friction and shearing. The form indicated R25 should be repositioned frequently, utilize a pressure relieving wheelchair cushion, and protective ointment to coccyx. R25's current care plan dated 4/9/15, identified R25 had alteration in musculoskeletal status related to Parkinson disease and dementia. The care plan directed staff to change R25's position every two hours and as needed with extensive assist of two staff to reposition. The care plan further directed staff to observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. Review of Sunnyside Care Center Task List Report for the nursing assistance (NA) directed staff to turn and reposition R25 every two hours. Continual observations was conducted on 7/21/15, from 12:57 p.m.to 4:10 p.m. At 12:57 p.m. R25 was observed lying on his back in bed with a white cloth pad underneath R25. R25 was alone in the room with the head of the bed elevated approximately 30 degrees, bed in low position and covered with a blanket which came up to his mid chest area. R25 remained alone, in the same position in bed, with the head of the bed elevated approximately 30 degrees until 2:44 p.m. -At 2:44 p.m. NA-A entered R25 room and offered	F 314	#2. All CNA¿s were reeducated on what constitutes full repositioning, proper procedure in repositioning as well as demonstration back to a nurse. The education was done either at a meeting held on 8-13-15 or 1:1 as necessary to reach all staff. #3. An audit of the flow sheets as well as random observation audits is currently ongoing. Monitoring will continue daily until compliance is achieved then weekly x 4 weeks then biweekly x 4 weeks then monthly until review by the QAPI committee. Date of Completion: August 14, 2015 Reoccurrence will be prevented by: Staff education and ongoing monitoring with results presented to the QAPI committee. Person responsible: DON or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING ______ B. WING ______	07/22/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 R25 a snack. NA-A reached out and raised the head of the bed slightly and sat on the edge of the bed to assist R25 to eat raspberry yogurt. At 2:49 p.m. NA-A left the room and R25 remained on his back in bed, with the head of the bed raised and bed in low position. NA-A did not offer to reposition or assist with toileting for R25. -At 3:23 p.m. a nursing assistant entered the room, sat down in the chair, visited with R25 briefly, then immediately left the room at 3:25 p.m. The facility staff member had not offered to reposition or toileting to R25 and R25 remained in the same position with head of the bed in a semi sitting position watching TV. -At 3:52 p.m. licensed practical nurse (LPN)-A entered R25's room, proceeded to obtain a blood sample for blood sugar testing, returned briefly to her medication cart, returned to R25's room, assisted R25 to take the medication, and left the room at 3:54 p.m. R25 remained in the same sitting position on his back with bed in low position. During interview on 7/21/15 at 4:01 p.m. NA-C confirmed R25 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. NA-C indicated she was unaware when R25 had last been repositioned or checked or changed. -At 4:03 p.m. R25 remained in the same positron in bed. NA-B and NA-C entered R25's room, raised the position of the bed up, and lowered the head of the bed. At 4:04 NA-C confirmed R25 was incontinent and both NA-B and NA-C proceeded to remove R25's pants and change the incontinent product. During the observation R25's buttocks was noted to be bright red around the rectal area which extended to the outer edges	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING ______ B. WING ______	07/22/2015

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F 314	Continued From page 13 of his buttock crease with no open areas noted. NA-B and NA-C proceeded to assist R25 from his bed to wheelchair via total mechanical lift. R25 had not been repositioned from 12:57 p.m. until 4:03 p.m., a total of 3 hours and 6 minutes. R25 was unable to preposition himself independently and was not assisted by staff to be checked or changed for incontinence every two hours per his current care plan. During interview on 7/21/15 at 4:20 p.m. registered nurse (RN)-A confirmed R25 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. RN-A confirmed R25 was at risk for pressure ulcers, confirmed R25's current care plan and stated she would expect staff to reposition R25 every 2 hours and check and change R25 every 2 hours for incontinence. During interview on 7/22/15 at 8:10 a.m. director of nursing (DON) confirmed R25 was at risk for the development of pressure ulcers, confirmed R25's current care plan and indicated she would expect staff to reposition R25 and check and change R25 as directed on the core plan. The DON stated she did not consider sitting R25 in a upright position in bed or removing a pillow behind his back would not be adequate repositioning for R25. During observation on 7/22/15 at 8:28 a.m. NA-D and NA-E entered R25's room with a total mechanical lift device and proceeded to assist R25 from the wheelchair to his bed via total mechanical lift. At 8:33 a.m. NA-D checked R25 to see if he was incontinent of bowel and bladder	F 314		

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F 314	Continued From page 14	F 314		

and NA-D stated "he was dry." NA-D and NA-E repositioned R25 on his left side, placed a pillow behind the right side of his back and between his legs and exited the room.
-At 8:58 a.m. R25 remained in the same position, on his left side with a pillow behind his back in bed.
-At 10:23 a.m. R25 remained in the same position in bed.
-At 11:14 a.m. R25 remained in the same position on his left side in bed. NA-D and NA-E entered R25's room, and proceeded to R25 from the bed to the wheelchair via the total mechanical lift. NA-D stated R25 was incontinent of bowel and bladder.
R25 remained in bed laying on his left side from 8:31 a.m. until 11:14 a.m. (2 hours and 43 minutes). R25 was unable to preposition himself independently and was not assisted by staff to be checked or changed for incontinence every two hours per his current care plan.

During interview on 7/22/15 at 11:25 a.m. NA-D confirmed R25 had been incontinent of bowel and bladder and verified he was not repositioned or checked and changed since 8:33 a.m. NA-D denied repositioning or checking and changing R25 since he had been laid in bed after breakfast. NA-D confirmed R25's care plan directed to reposition and check and change R25 every 2 hours.

7/22/15 requested facility policy and one was not provided.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	07/22/2015

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K 000	INITIAL COMMENTS FIRE SAFETY BUILDING 01 - ORIGINAL THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Sunnyside Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 08/13/2015

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245597	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 07/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or Or by email to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as two building: The Sunnyside Care Center is a 1-story building without a basement built at two different time. The original building was constructed in 1975 and is of Type II(00) construction. In 2004 an entrance and dayroom additions were constructed to the north and south sides of the 1975 building and were determined to be of Type V (111) construction. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification.	K 000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**07/22/2015**

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K 000	Continued From page 2 The facility has a capacity of 43 beds and had a census of 31 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility.	K 052	Nardini Fire Inspection Company returned on 7/23/15 to retest the 6th smoke detector as well as the other 5 detectors. As stated in the report all 6 detectors are in compliance. Completed date 7/23/15. Person responsible: Environmental Director.	7/23/15

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	245597	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**07/22/2015**

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K 052	Continued From page 3 Findings include: On facility tour between 10:30 AM to 2:30 PM on 07/22/2015, observations reveled during a documentation review of all available fire alarm documentation for the last 3 years that the fire alarm testing company did not test 1 of 6 duct smoke detector during the current 04/27/2015 annual fire alarm testing. It was found that there were 6 heat detectors inventoried and tested on the fire alarm test documentation for the 2013 and 2014 annual fire alarm test cycles; and there were only 5 noted as being tested on the 2015 fire alarm test documentation. It was also verified during an interview with the Environmental Director (GZ) that there were no devices added or removed during the past 3 years . This deficient condition was verified by the Environmental Director (GZ).	K 052		
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain combustible decoration in accordance with NFPA Life Safety Code 101 (00) section 19.7.5.4. The failure to treat and maintain the combustible decorations throughout the facility in accordance with NFPA Life Safety Code 101 (00) could allow smoke and fire to rapidly migrate through the corridors and	K 073	On 8/12/15 a mailing was sent to all families and guardians informing them of the following: any decorations hung on the exterior room doors must be treated, Sunnyside has treated and tagged all existing decorations, and any future decorations may not be hung until treated and tagged by the maintenance	8/12/15

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	245597	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**07/22/2015**

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K 073	Continued From page 4 negatively affect the egress capability in the event of an emergency for residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 07/22/2015, observations revealed that the facility could not verify if the numerous wreath style decoration located on resident room doors in the 100 and 300 wings have been treated with any type of approved flame retardant treatment. This deficient condition was verified by the Environmental Director (GZ).	K 073	department. This information was presented to the residents on 8/12/15 at a special meeting held to address the Life Safety Code. The staff was also informed via the total quality management system in place at Sunnyside. The maintenance department will also conduct periodic walk-throughs to check decorations. Completion date 8/12/15. Person responsible: Environmental Director.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility had deficient practice that are in violation of the Minnesota State Fire Code (07) sections 312, 2703.9.3, and 3003.5.2. This deficient conditions could affect residents, visitors, and staff in the event of a fire. Findings include: On facility tour between 10:30 AM to 2:30 PM on 07/22/2015, observations reveled that the natural gas supply lines and meter that are located outside the building behind the kitchen are not protected from vehicle impact as required by the	K 130	The gas line is protected from vehicle impact. On 8/13/15 a project to comply was completed. The gas line is protected per code. Date of completion 8/13/15. Person responsible: Environmental Director.	8/13/15

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	245597	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**07/22/2015**

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K 130	Continued From page 5 Minnesota State Fire Code (07) sections 312, 2703.9.3, and 3003.5.2 This deficient condition was verified by the Environmental Director (GZ).	K 130		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 08/27/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING **02 - ADMINISTRATION ADDITION** B. WING ______	**07/22/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY BUILDING 02 - 2004 ADDITIONS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Sunnyside Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/13/2015

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 1 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or Or by email to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as two building: The Sunnyside Care Center is a 1-story building without a basement built at two different time. The original building was constructed in 1975 and is of Type II(00) construction. In 2004 an entrance and dayroom additions were constructed to the north and south sides of the 1975 building and were determined to be of Type V (111) construction. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification.	K 000		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	Continued From page 2 The facility has a capacity of 43 beds and had a census of 31 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on	K 052	Repeated from above. Nardini Fire Inspection Company returned on 7/23/15 to retest the 6th smoke detector as well as the other 5 detectors. As stated in the report all 6 detectors are in compliance. Completed date 7/23/15. Person responsible: Environmental Director.	7/23/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. BUILDING **02 - ADMINISTRATION ADDITION** B. WING ____	**07/22/2015**

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

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K 052	Continued From page 3 07/22/2015, observations reveled during a documentation review of all available fire alarm documentation for the last 3 years that the fire alarm testing company did not test 1 of 6 duct smoke detector during the current 04/27/2015 annual fire alarm testing. It was found that there were 6 heat detectors inventoried and tested on the fire alarm test documentation for the 2013 and 2014 annual fire alarm test cycles; and there were only 5 noted as being tested on the 2015 fire alarm test documentation. It was also verified during an interview with the Environmental Director (GZ) that there were no devices added or removed during the past 3 years . This deficient condition was verified by the Environmental Director (GZ).	K 052		
K 070 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 18.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility used portable space heaters in non-resident care areas and failed to provide a policy on the use of portable space heaters in the facility that meets the requirements of NFPA 101 Life Safety Code (00), Section 18.7.8. This deficient practice could affect residents, visitors and staff.	K 070	Space heater was removed on 7/22/15. A policy was developed on 8/12/15. Staff was informed via the total quality management system in place at Sunnyside on 8/12/15. Date of completion 8/12/15. Person responsible: Environmental Director.	8/12/15

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	245597	A. BUILDING **02 - ADMINISTRATION ADDITION** B. WING ______	**07/22/2015**

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K 070	Continued From page 4 Findings include: On facility tour between 10:30 AM to 2:30 PM on 07/22/2015, it was observed that there is a portable space heating device being used at the receptionist desk which is located such that it is open to the residents. It was also asked if the facility has a portable space heater use policy and the facility Environmental Director (GZ) stated that he did not believe that the facility has a policy for the use of space heating devices. At the time of the inspection the facility could not provide any documentation or policy regulating the use of portable space heating devices within the facility. This deficient condition was verified by the Environmental Director (GZ).	K 070		