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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3O1X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00776

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245225**
2.STATE VENDOR OR MEDICAID NO.
(L2) **685740000**

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

4. TYPE OF ACTION: **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 **10/29/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **65** (L18)
13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:
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 __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Holly Kranz, Unit Supervisor 12/12/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 12/12/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245225 October 30, 2018

Administrator
Sleepy Eye Care Center
1105 3rd Avenue Southwest
Sleepy Eye, MN 56085

Dear Administrator:

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 October 17, 2018 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 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,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 30, 2018

Administrator
Sleepy Eye Care Center
1105 3rd Avenue Southwest
Sleepy Eye, MN 56085

RE: Project Number S5225028

Dear Administrator:

On September 17, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on September 7, 2018. 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 October 29, 2018, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 7, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 17, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 7, 2018, effective October 17, 2018 and therefore remedies outlined in our letter to you dated September 17, 2018, 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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 3O1X

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

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2.STATE VENDOR OR MEDICAID NO.
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(L4) **1105 3RD AVENUE SOUTHWEST**
(L5) **SLEEPY EYE, MN** (L6) **56085**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/07/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **65** (L18)
13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II HFE NE II 10/01/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 10/12/2018 (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)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
12/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 17, 2018

Sleepy Eye Care Center
Attn: Administrator
1105 3rd Avenue Southwest
Sleepy Eye, MN 56085

RE: Project Number S5225028

Dear Administrator:

On September 7, 2018, 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

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 an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

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 October 17, 2018, 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 December 7, 2018 (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 March 7, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING _____ B. WING _____	09/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 9/4/18 - 9/7/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 9/4/18 - 9/7/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756		10/17/18

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

Electronically Signed | 09/27/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING _____ B. WING _____	09/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 1 of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the pharmacist addressed the lack of parameters for administration of as needed (PRN) pain medications for 1 of 5 resident (R48) reviewed for unnecessary medications.	F 756	It is the policy of the Sleepy Eye Care Center to ensure that the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and to ensure the pharmacist reports any irregularities to the attending physician	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING _____ B. WING _____	09/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 2 Findings include: R48's face sheet dated 9/7/18 included a diagnosis of pain. R48's current physician orders dated 9/7/18 included: acetaminophen (a pain medicine for minor aches and pains) liquid 20.3 milliliters (ml) (650 milligrams) by mouth (PO) every 4 hours as needed (PRN) for pain and oxycodone (a narcotic pain medicine for moderate to severe pain) 5 milligrams (mg) take 1-2 tablets (5-10 mg) PO every 4 hours PRN for pain. The admission Minimum Data Set (MDS) assessment dated 8/16/18, identified R48 as having a Brief Interview for Mental Status (BIMS) score of 13 indicating intact cognition. The MDS also indicated R48 had frequent pain rating it a 10 on a 1-10 pain scale (0= no pain, 1-2= mild pain, 3-4= moderate pain, 5-6= severe pain, 7-8= very severe pain, 9-10= worst possible) and required extensive assistance of staff with bed mobility, transfers, dressing, toilet use, and personal hygiene. R48's care plan last revised on 8/27/18 included a focus for pain related to recent surgery. Interventions included to administer medication per physician order, monitor pain characteristics and use of non-medicinal interventions such a humor, relaxation, distraction, imagery techniques, massage, music, heat, cold. R48's medication administration record (MAR) dated August 26-31st 2018, identified R48 received 1 dose of PRN acetaminophen for pain rated a 10 on pain scale and 12 does of the PRN	F 756	and the facility's medical director and director of nursing. Resident #48 Reviewed resident medical record. Oxycodone was discontinued on 9/6/2018. Received order on 9/8/2018 for Hydrocodone-Acetaminophen 5-325mg give 1 tablet by mouth every 4 hours as needed for low back pain. Give Tylenol for pain 1-4, give 1 tab of Hydrocodone for pain 5-8. Give 2 tabs of Hydrocodone for pain 9-10. All resident charts were reviewed to ensure that all prn pain medications were prescribed correctly and updated as necessary. The Director of Nursing and the consulting pharmacist reviewed the policies and procedures for proper monitoring of medication usage. The nursing staff will be educated on Monday October 1st on the importance of the pharmacist's review. The Director of Nursing will audit 10 residents charts weekly x4 weeks to ensure prn pain medications orders are prescribed correctly. Results to be shared with consulting pharmacist. The Director of Nursing is responsible for overall compliance along with communicating results of audits to the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245225	A. BUILDING _____ B. WING _____	09/07/2018

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

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F 756	Continued From page 3 oxycodone for pain rated 0-10 on pain scale. R48's MAR dated September 1-7th 2018, identified R48 received 8 doses of PRN acetaminophen for pain rated 3-10 and 17 doses of PRN oxycodone for pain rated 4-10 on pain scale. During interview on 9/7/18, at 12:06 p.m. R48 was sitting on edge of bed. She stated she did not know what pain medications she receives and did not ask for them by name. R48 further stated she couldn't tell the difference between them indicating she was always in some sort of pain. During interview on 9/7/18, at 3:09 p.m. registered nurse (RN)-A stated she uses "nursing judgement" to decide which pain medication to administer to R48. RN-A further explained R48 usually rated her pain a 10 (on 1-10 pain scale) so would give 2 oxycodone and acetaminophen in between to "hold her". RN-A stated usually there are parameters on orders but confirmed R48's orders lacked parameters related to administration of acetaminophen vs. oxycodone. No pharmacy recommendations for parameters related to acetaminophen and oxycodone 1-2 tabs was noted for R48. During interview on 9/7/18, at 3:17 p.m. director of nursing (DON) stated there should be a range of when to administer medication and verified the pharmacist did not address the lack of parameters for PRN pain medications. During interview on 9/7/18, at 3:49 p.m. consultant pharmacist indicated he would expect pain medications to have parameters and	F 756	The facility alleges that it will be in substantial compliance and complete all action items by October 17, 2018.	

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F 756	Continued From page 4 confirmed he had not identified this on his monthly visit. A facility policy titled, Pharmaceutical Consulting Contract Addendum 2017, dated 1/1/17, identified the consultant shall prepare a pharmaceutical care plan for each resident and shall perform a monthly drug regimen review of each resident's pharmaceutical care plan and personal record for the purpose of identifying drug problems, potential drug problems, and irregularities related to drug therapy and compliance with CMS/MN Dept of Health/Board of Pharmacy rules and regulations. The consultant shall prepare a written report discussing all problems, suggestions, and irregularities identified during the monthly review.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		10/17/18

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F 757	Continued From page 5 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to identify parameters for as needed (PRN) pain medications for 1 of 5 (R48) reviewed for unnecessary medications. Findings include: R48's face sheet dated 9/7/18 included a diagnosis of pain. R48's current physician orders dated 9/7/18 included: acetaminophen (a pain medicine for minor aches and pains) liquid 20.3 milliliters (ml) (650 milligrams) by mouth (PO) every 4 hours as needed (PRN) for pain and oxycodone (a narcotic pain medicine for moderate to severe pain) 5 milligrams (mg) take 1-2 tablets (5-10 mg) PO every 4 hours PRN for pain. The admission Minimum Data Set (MDS) assessment dated 8/16/18, identified R48 as having a Brief Interview for Mental Status (BIMS) score of 13 indicating intact cognition. The MDS also indicated R48 had frequent pain rating it a 10 on a 1-10 pain scale (0= no pain, 1-2= mild pain, 3-4= moderate pain, 5-6= severe pain, 7-8= very severe pain, 9-10= worst possible) and required extensive assistance of staff with bed mobility, transfers, dressing, toilet use, and personal hygiene. R48's care plan last revised on 8/27/18 included a focus for pain related to recent surgery.	F 757	It is the policy of the Sleepy Eye Care Center to ensure that each resident's drug regimen is free from unnecessary drugs. Resident #48 Reviewed resident medical record. Oxycodone was discontinued on 9/6/2018. Received order on 9/8/2018 for Hydrocodone-Acetaminophen 5-325mg give 1 tablet by mouth every 4 hours as needed for low back pain. Give Tylenol for pain 1-4, give 1 tab of Hydrocodone for pain 5-8. Give 2 tabs of Hydrocodone for pain 9-10. All resident charts were reviewed to ensure that all prn pain medications were prescribed correctly and updated as necessary. The Director of Nursing and the consulting pharmacist reviewed the policies and procedures for proper monitoring of medication usage. The nursing staff will be educated on Monday October 1st on the importance of the pharmacist's review and the importance of parameters with PRN medications. The Director of Nursing will audit 10	

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F 757	Continued From page 6 Interventions included to administer medication per physician order, monitor pain characteristics and use of non-medicinal interventions such a humor, relaxation, distraction, imagery techniques, massage, music, heat, cold. R48's medication administration record (MAR) dated August 26-31st 2018, identified R48 received 1 dose of PRN acetaminophen for pain rated a 10 on pain scale and 12 does of the PRN oxycodone for pain rated 0-10 on pain scale. R48's MAR dated September 1-7th 2018, identified R48 received 8 doses of PRN acetaminophen for pain rated 3-10 and 17 doses of PRN oxycodone for pain rated 4-10 on pain scale. During interview on 9/7/18, at 12:06 p.m. R48 was sitting on edge of bed. She stated she did not know what pain medications she receives and did not ask for them by name. R48 further stated she couldn't tell the difference between them indicating she was always in some sort of pain. During interview on 9/7/18, at 3:09 p.m. registered nurse (RN)-A stated she uses "nursing judgement" to decide which pain medication to administer to R48. RN-A further explained R48 usually rated her pain a 10 (on 1-10 pain scale) so would give 2 oxycodone and acetaminophen in between to "hold her". RN-A stated usually there are parameters on orders but confirmed R48's orders lacked parameters related to administration of acetaminophen vs. oxycodone. During interview on 9/7/18, at 3:17 p.m. director of nursing (DON) stated there should be a range of when to administer medication and verified the	F 757	residents' charts weekly x4 weeks to ensure prn pain medications orders are prescribed correctly. Results to be shared with consulting pharmacist. The Director of Nursing is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The facility alleges that it will be in substantial compliance and complete all action items by October 17, 2018.	

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F 757	Continued From page 7 lack of parameters for R48's PRN pain medications. The DON stated her expectation is the order be clarified to include parameters at time of receipt.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medications were dated when opened and removed from medication carts or room/refrigerator when	F 761	It is the policy of the Sleepy Eye Care Center to provide pharmaceutical services to meet the needs of each resident.	10/17/18

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F 761	Continued From page 8 expired in 1 of 2 medication carts, 1 of 1 medication room and 1 of 1 medication refrigerator. Findings include: R31's signed physician orders dated 8/29/18, included an order for Breo Ellipta aerosol powder breath activated inhaler 200-25 mcg/inh (micrograms/inhalation) (fluticasone furoate-vilanterol) 1 puff inhale orally one time a day related to chronic obstructive pulmonary disease. The order was dated 6/11/18 with a start date of 6/12/18. On 9/4/18, at 6:45 p.m. the medication cart for hall 3 was observed with licensed practical nurse (LPN)-A. The contents of the cart included one Breo Ellipta 200/25 mcg/inh inhaler and one Breo Ellipta 100-25 mcg/inh inhaler. The Breo Ellipta 100-25 mcg/inh inhaler was undated related to when the inhaler had been opened, and indicated there were 4 doses left. LPN-A checked R31's physician orders and verified the dose of the inhaler had changed. LPN-A was unable to tell if the 100-25 mcg inhaler was expired though the pharmacy label indicated it was issued in 2017. LPN-A verified the Breo Ellipta 100-25 mcg dose inhaler was both discontinued and expired though still remained on the medication cart. LPN-A was unable to verify if the inhaler had been used since discontinuation and was unaware that the dosing of the two inhalers were different stating, "I guess they (the doses) are different". On 9/7/18, at 1:56 p.m. the medication room was observed with LPN-B. Contents of the emergency kit included a package of 2 Glutose 15 oral glucose gel with an expiration date of	F 761	Resident #31 Expired medication, Breo-Ellipta inhaler was disposed of as soon as expiration was identified. Glutose gel and Pneumovax vaccination were disposed of as soon as expiration was identified. All medications in medication carts and stock and ER medications were reviewed for expiration dates. Outdated medications were removed. The Director of Nursing and the consulting pharmacist reviewed the policies and procedures for proper storage and monitoring of medication usage. The nursing staff will be educated on Monday October 1st on the importance of removing expired medications from medication carts, medication room and refrigerator. A monthly schedule of checking medication carts for expired medications was developed for nursing staff. The Director of Nursing will check medications carts for expired medications bimonthly. Results to be shared with consulting pharmacist. The Director of Nursing is responsible for overall compliance along with communicating results of audits to the QAPI Committee.	

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F 761	Continued From page 9 8/14/17. LPN-B confirmed the the glucose gel was expired. On 9/7/18, at approximately 2:20 p.m. the locked medication refrigerator located on hall one was observed with LPN-B. Contents of the medication refrigerator included one Pneumovax 23 pneumococcal vaccination with an expiration dated of 7/12/18. LPN-B confirmed the vaccine was expired. The Pharmaceutical Services Policy & Procedure Manual revised December 2005 included: 4.27 Discontinued Medications. All medications that have had their orders discontinued shall be removed from the resident storage sites and placed in a specified, secured area of the medication room until destruction. Discontinued medications shall be stored for no longer than three months after the date of discontinuance.	F 761	The facility alleges that it will be in substantial compliance and complete all action items by October 17, 2018.	

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	245225	A. BUILDING **01 - SLEEPY EYE CARE CENTER** B. WING _____	**09/07/2018**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Sleepy Eye Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Sleepy Eye Care Center is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1972 and was determined to be of Type II(000) construction. In 1985, addition was constructed and was determined to be of Type II(000) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 52 at time of the survey.	K 000		

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

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

Electronically delivered

September 17, 2018

Sleepy Eye Care Center
Attn: Administrator
1105 3rd Avenue Southwest
Sleepy Eye, MN 56085

Re: Project Number S5225028

Dear Administrator:

The above facility was surveyed on September 4, 2018 through September 7, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00776	A. BUILDING: _____ B. WING _____	09/07/2018

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SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

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

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SLEEPY EYE CARE CENTER	1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 9/4 - 9/7/18, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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	00776	A. BUILDING: _____ B. WING _____	09/07/2018

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter	21530		10/17/18

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21530	Continued From page 3 must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the pharmacist addressed the lack of parameters for administration of as needed (PRN) pain medications for 1 of 5 resident (R48) reviewed for unnecessary medications. R48's face sheet dated 9/7/18 included a diagnosis of pain. R48's current physician orders dated 9/7/18 included: acetaminophen (a pain medicine for minor aches and pains) liquid 20.3 milliliters (ml) (650 milligrams) by mouth (PO) every 4 hours as needed (PRN) for pain and oxycodone (a narcotic pain medicine for moderate to severe pain) 5 milligrams (mg) take 1-2 tablets (5-10 mg) PO every 4 hours PRN for pain. The admission Minimum Data Set (MDS) assessment dated 8/16/18, identified R48 as having a Brief Interview for Mental Status (BIMS) score of 13 indicating intact cognition. The MDS also indicated R48 had frequent pain rating it a 10 on a 1-10 pain scale (0= no pain, 1-2= mild pain, 3-4= moderate pain, 5-6= severe pain, 7-8= very severe pain, 9-10= worst possible) and required extensive assistance of staff with bed mobility, transfers, dressing, toilet use, and personal hygiene.	21530	It is the policy of the Sleepy Eye Care Center to ensure that the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and to ensure the pharmacist reports any irregularities to the attending physician and the facility□s medical director and director of nursing. Resident #48 Reviewed resident medical record. Oxycodone was discontinued on 9/6/2018. Received order on 9/8/2018 for Hydrocodone-Acetaminophen 5-325mg give 1 tablet by mouth every 4 hours as needed for low back pain. Give Tylenol for pain 1-4, give 1 tab of Hydrocodone for pain 5-8. Give 2 tabs of Hydrocodone for pain 9-10. All resident charts were reviewed to ensure that all prn pain medications were prescribed correctly and updated as necessary. The Director of Nursing and the consulting pharmacist reviewed the policies and procedures for proper monitoring of medication usage.	

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21530	Continued From page 4 R48's care plan last revised on 8/27/18 included a focus for pain related to recent surgery. Interventions included to administer medication per physician order, monitor pain characteristics and use of non-medicinal interventions such a humor, relaxation, distraction, imagery techniques, massage, music, heat, cold. R48's medication administration record (MAR) dated August 26-31st 2018, identified R48 received 1 dose of PRN acetaminophen for pain rated a 10 on pain scale and 12 does of the PRN oxycodone for pain rated 0-10 on pain scale. R48's MAR dated September 1-7th 2018, identified R48 received 8 doses of PRN acetaminophen for pain rated 3-10 and 17 doses of PRN oxycodone for pain rated 4-10 on pain scale. During interview on 9/7/18, at 12:06 p.m. R48 was sitting on edge of bed. She stated she did not know what pain medications she receives and did not ask for them by name. R48 further stated she couldn't tell the difference between them indicating she was always in some sort of pain. During interview on 9/7/18, at 3:09 p.m. registered nurse (RN)-A stated she uses "nursing judgement" to decide which pain medication to administer to R48. RN-A further explained R48 usually rated her pain a 10 (on 1-10 pain scale) so would give 2 oxycodone and acetaminophen in between to "hold her". RN-A stated usually there are parameters on orders but confirmed R48's orders lacked parameters related to administration of acetaminophen vs. oxycodone. No pharmacy recommendations for parameters	21530	The nursing staff will be educated on Monday October 1st on the importance of the pharmacist□s review. The Director of Nursing will audit 10 residents charts weekly x4 weeks to ensure prn pain medications orders are prescribed correctly. Results to be shared with consulting pharmacist. The Director of Nursing is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The facility alleges that it will be in substantial compliance and complete all action items by October 17, 2018.	

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21530	Continued From page 5 related to acetaminophen and oxycodone 1-2 tabs was noted for R48. During interview on 9/7/18, at 3:17 p.m. director of nursing (DON) stated there should be a range of when to administer medication and verified the pharmacist did not address the lack of parameters for PRN pain medications. During interview on 9/7/18, at 3:49 p.m. consultant pharmacist indicated he would expect pain medications to have parameters and confirmed he had not identified this on his monthly visit. A facility policy titled, Pharmaceutical Consulting Contract Addendum 2017, dated 1/1/17, identified the consultant shall prepare a pharmaceutical care plan for each resident and shall perform a monthly drug regimen review of each resident's pharmaceutical care plan and personal record for the purpose of identifying drug problems, potential drug problems, and irregularities related to drug therapy and compliance with CMS/MN Dept of Health/Board of Pharmacy rules and regulations. The consultant shall prepare a written report discussing all problems, suggestions, and irregularities identified during the monthly review. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance.	21530		

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21530	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to identify parameters for as needed (PRN) pain medications for 1 of 5 (R48) reviewed for unnecessary medications.	21535	It is the policy of the Sleepy Eye Care Center to ensure that each resident□s drug regimen is free from unnecessary drugs.	10/17/18

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21535	Continued From page 7 R48's face sheet dated 9/7/18 included a diagnosis of pain. R48's current physician orders dated 9/7/18 included: acetaminophen (a pain medicine for minor aches and pains) liquid 20.3 milliliters (ml) (650 milligrams) by mouth (PO) every 4 hours as needed (PRN) for pain and oxycodone (a narcotic pain medicine for moderate to severe pain) 5 milligrams (mg) take 1-2 tablets (5-10 mg) PO every 4 hours PRN for pain. The admission Minimum Data Set (MDS) assessment dated 8/16/18, identified R48 as having a Brief Interview for Mental Status (BIMS) score of 13 indicating intact cognition. The MDS also indicated R48 had frequent pain rating it a 10 on a 1-10 pain scale (0= no pain, 1-2= mild pain, 3-4= moderate pain, 5-6= severe pain, 7-8= very severe pain, 9-10= worst possible) and required extensive assistance of staff with bed mobility, transfers, dressing, toilet use, and personal hygiene. R48's care plan last revised on 8/27/18 included a focus for pain related to recent surgery. Interventions included to administer medication per physician order, monitor pain characteristics and use of non-medicinal interventions such a humor, relaxation, distraction, imagery techniques, massage, music, heat, cold. R48's medication administration record (MAR) dated August 26-31st 2018, identified R48 received 1 dose of PRN acetaminophen for pain rated a 10 on pain scale and 12 does of the PRN oxycodone for pain rated 0-10 on pain scale. R48's MAR dated September 1-7th 2018, identified R48 received 8 doses of PRN	21535	Resident #48 Reviewed resident medical record. Oxycodone was discontinued on 9/6/2018. Received order on 9/8/2018 for Hydrocodone-Acetaminophen 5-325mg give 1 tablet by mouth every 4 hours as needed for low back pain. Give Tylenol for pain 1-4, give 1 tab of Hydrocodone for pain 5-8. Give 2 tabs of Hydrocodone for pain 9-10. All resident charts were reviewed to ensure that all prn pain medications were prescribed correctly and updated as necessary. The Director of Nursing and the consulting pharmacist reviewed the policies and procedures for proper monitoring of medication usage. The nursing staff will be educated on Monday October 1st on the importance of the pharmacist□s review and the importance of parameters with PRN medications. The Director of Nursing will audit 10 residents□ charts weekly x4 weeks to ensure prn pain medications orders are prescribed correctly. Results to be shared with consulting pharmacist. The Director of Nursing is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The facility alleges that it will be in	

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21535	Continued From page 8 acetaminophen for pain rated 3-10 and 17 doses of PRN oxycodone for pain rated 4-10 on pain scale. During interview on 9/7/18, at 12:06 p.m. R48 was sitting on edge of bed. She stated she did not know what pain medications she receives and did not ask for them by name. R48 further stated she couldn't tell the difference between them indicating she was always in some sort of pain. During interview on 9/7/18, at 3:09 p.m. registered nurse (RN)-A stated she uses "nursing judgement" to decide which pain medication to administer to R48. RN-A further explained R48 usually rated her pain a 10 (on 1-10 pain scale) so would give 2 oxycodone and acetaminophen in between to "hold her". RN-A stated usually there are parameters on orders but confirmed R48's orders lacked parameters related to administration of acetaminophen vs. oxycodone. During interview on 9/7/18, at 3:17 p.m. director of nursing (DON) stated there should be a range of when to administer medication and verified the lack of parameters for R48's PRN pain medications. The DON stated her expectation is the order be clarified to include parameters at time of receipt. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could work in conjunction with the consultant pharmacist to develop policies and procedures related to monitoring of pro re nata (PRN) medication use, parameters, and monitoring of effectiveness. The DON could educate staff related to these changes in policy and procedure, and audit resident records to ensure process changes are implemented. Results of audits could be reported	21535	substantial compliance and complete all action items by October 17, 2018.	

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21535	Continued From page 9 to the quality assurance committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medications were dated when opened and removed from medication carts or room/refrigerator when expired in 1 of 2 medication carts, 1 of 1 medication room and 1 of 1 medication refrigerator. Findings include: R31's signed physician orders dated 8/29/18, included an order for Breo Ellipta aerosol powder breath activated inhaler 200-25 mcg/inh (micrograms/inhalation) (fluticasone furoate-vilanterol) 1 puff inhale orally one time a day related to chronic obstructive pulmonary disease. The order was dated 6/11/18 with a start date of 6/12/18. On 9/4/18, at 6:45 p.m. the medication cart for hall 3 was observed with licensed practical nurse (LPN)-A. The contents of the cart included one Breo Ellipta 200/25 mcg/inh inhaler and one Breo Ellipta 100-25 mcg/inh inhaler. The Breo Ellipta	21620	It is the policy of the Sleepy Eye Care Center to provide pharmaceutical services to meet the needs of each resident. Resident #31 Expired medication, Breo-Ellipta inhaler was disposed of as soon as expiration was identified. Glutose gel and Pneumovax vaccination were disposed of as soon as expiration was identified. All medications in medication carts and stock and ER medications were reviewed for expiration dates. Outdated medications were removed. The Director of Nursing and the consulting pharmacist reviewed the policies and procedures for proper storage and monitoring of medication usage.	10/17/18

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21620	Continued From page 10 100-25 mcg/inh inhaler was undated related to when the inhaler had been opened, and indicated there were 4 doses left. LPN-A checked R31's physician orders and verified the dose of the inhaler had changed. LPN-A was unable to tell if the 100-25 mcg inhaler was expired though the pharmacy label indicated it was issued in 2017. LPN-A verified the Breo Ellipta 100-25 mcg dose inhaler was both discontinued and expired though still remained on the medication cart. LPN-A was unable to verify if the inhaler had been used since discontinuation and was unaware that the dosing of the two inhalers were different stating, "I guess they (the doses) are different". On 9/7/18, at 1:56 p.m. the medication room was observed with LPN-B. Contents of the emergency kit included a package of 2 Glutose 15 oral glucose gel with an expiration date of 8/14/17. LPN-B confirmed the the glucose gel was expired. On 9/7/18, at approximately 2:20 p.m. the locked medication refrigerator located on hall one was observed with LPN-B. Contents of the medication refrigerator included one Pneumovax 23 pneumococcal vaccination with an expiration dated of 7/12/18. LPN-B confirmed the vaccine was expired. The Pharmaceutical Services Policy & Procedure Manual revised December 2005 included: 4.27 Discontinued Medications. All medications that have had their orders discontinued shall be removed from the resident storage sites and placed in a specified, secured area of the medication room until destruction. Discontinued medications shall be stored for no longer than three months after the date of discontinuance.	21620	The nursing staff will be educated on Monday October 1st on the importance of removing expired medications from medication carts, medication room and refrigerator. A monthly schedule of checking medication carts for expired medications was developed for nursing staff. The Director of Nursing will check medications carts for expired medications bimonthly. Results to be shared with consulting pharmacist. The Director of Nursing is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The facility alleges that it will be in substantial compliance and complete all action items by October 17, 2018.	

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21620	Continued From page 11 SUGGESTED METHODS OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure expired medications are no longer in use. The Director of Nursing Services or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21620		