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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8FI0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00048

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245045**
2.STATE VENDOR OR MEDICAID NO.
(L2) **695045102**

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

4. TYPE OF ACTION: **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 **09/09/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Colleen Johnson HFE - NE II 10/26/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/29/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 30, 2021

Administrator
Sunnyside Health Care Center
512 Skyline Boulevard
Cloquet, MN 55720

RE: CCN: 245045
Cycle Start Date: September 9, 2021

Dear Administrator:

On September 9, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 9, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 9, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@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
	245045	A. BUILDING _____ B. WING _____	09/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/7/21, through 9/9/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		10/29/21

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

Electronically Signed | 10/08/2021

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E 041	Continued From page 1	E 041		

must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):]
The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the

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E 041	Continued From page 2 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2012	E 041	1. Facilities staff conduct and document emergency generator testing, maintenance and inspection weekly on Mondays.	

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E 041	Continued From page 3 edition (LSC) sections, 9.1.3 and NFPA 110 "Standard for Emergency and Standby Power Systems 6-4, 6-4.1, and 6-4.2.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 9/08/2021, at 12:33 p.m., during the review of all available emergency generator maintenance documentation and an interview with the maintenance supervisor (MS) it was revealed that the facility could not provide documentation for 16 of 52 weekly inspections of the emergency generator. This deficient condition was verified by the MS. policy.	E 041	2. The Director of Building and Grounds assigns facilities staff to conduct weekly emergency generator testing, maintenance and inspection with the appropriate documentation each Monday. 3. The Building and Grounds Director will audit emergency generator testing, maintenance, and inspections along with the documentation on a weekly basis. 4. The Director of Buildings and Grounds is the responsible for the corrective actions and monitoring and compliance. The Building and Grounds Director will also present the weekly audit findings at our quarterly QAA committee meetings. 5. The proposed date of completion is October 29, 2021.	
F 000	INITIAL COMMENTS On 9/7/21, through 9/9/21, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to	F 000		

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F 000	Continued From page 4 validate substantial compliance with the regulations has been attained.	F 000		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		10/29/21

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F 758	Continued From page 5 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure identification and monitoring of mood and behavior symptoms to determine efficacy of psychotropic medications and to monitor side effects and effectiveness of psychotropic medications for 1 of 5 residents (R21) reviewed for unnecessary medications. Findings include: R21's diagnoses list printed 9/9/21, indicated R21's diagnoses included dementia, hallucinations, insomnia, depression, anxiety, and post traumatic stress disorder (PTSD). R21's quarterly Minimum Data Set (MDS) dated 8/4/21, indicated R21 had moderate impaired cognition, exhibited no behaviors or rejection of care, and was prescribed antipsychotic, antidepressant, and opioid medications. R21's medication orders printed 9/9/21, indicated R21 was prescribed duloxetine (antidepressant) 90 milligrams (mg), mortazapine	F 758	Sunnyside Health Care Center does ensure identification and monitoring of mood and behavior symptoms to determine efficacy of psychotropic medications and to monitor side effects and effectiveness of psychotropic medications for unnecessary medications. R21□s electronic medication administration record was reviewed and updated to reflect side effects for prescribed psychotropic medications. An intervention with targeted behaviors and mood was added and it will be monitored by a licensed nurse every shift. R21□s care plan already had a psychotropic problem; however, we have individualized it more comprehensively to include identification, mood monitoring, and behaviors. Nursing assistant documentation was enhanced to include targeted behaviors and monitoring for side effects every shift.	

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F 758	Continued From page 6 (antidepressant) 7.5 mg, and quetiapine (antipsychotic used to treat schizophrenia, bipolar disorder, and depression) 37.5 mg. R21's care plan dated 8/11/21, indicated R21 was at risk for side effects related to the use of psychotropic medications, and directed to monitor antipsychotic drug use, and review monthly for effectiveness and side effects. R21's care plan lacked identification of the side effects to monitor for the use of duloxetine, mortazapine and quetiapine medications. R21's care plan further lacked identification of target behaviors and mood symptoms related to R21's use of duloxetine, mortazapine, and quetiapine medications. R21's medication administration record (eMAR) and electronic treatment administration record (eTAR) lacked side effect or behavior monitoring for prescribed duloxetine, mortazapine and quetiapine medications. R21's eMAR and eTAR further lacked identification of target behaviors and mood symptoms for duloxetine, mortazapine, and quetiapine. On 9/09/21, at 8:44 a.m. licensed practical nurse (LPN)-B verified R21's eMAR and eTAR lacked side effect and behavior monitoring for prescribed duloxetine, mortazapine and quetiapine. LNP-B stated she was unsure what target behaviors or side effects to monitor and would have to look up the medication. On 9/09/21, at 10:35 a.m. LPN-C stated R21's eMAR did not include psychotropic or antipsychotic medication side effects or include specific behaviors to monitor. On 9/09/21, at 10:49 a.m. the director of nursing	F 758	All residents on a psychotropic medication were identified for the presence of target behaviors and mood symptoms. Each resident□s care plan, intervention, eMAR, and nursing assistant documentation has been updated to reflect the changes to our procedure. New admissions coming into the facility will have a comprehensive review of psychotropic medications, side effects, targeted behaviors and mood monitoring by a registered nurse. We have reviewed and updated our Psychotropic Drug Use policy and procedure on 10/5/21. Education will be provided to all employees. Nursing will review the use of psychotropic medication with the physician and interdisciplinary team on a quarterly basis to determine continued presence of target behaviors and/or the presence of any side effects, assists/develops behavior care plans with the interdisciplinary team. Audits will be conducted weekly for 2 months, and then monthly for all residents who are prescribed or who are currently on psychotropic medication to ensure on-going compliance with monitoring and documentation. This correction will be monitored by the Director of Nursing.	

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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 758	Continued From page 7 (DON) verified R21's electronic medical record (EMR) and care plan lacked identification and monitoring of mood and behaviors along with monitoring of side effects for psychotripic and antipsychotic medications. The DON further stated monitoring for potential adverse consequences for signs and symptoms of side effects for psychotropic and antipsychotic medications were not being monitored on a daily basis, and were monitored quarterly. On 9/09/21, at 12:30 p.m. the assistant director of nursing (ADON) verified R21's EMR lacked identification and monitoring of mood and behaviors along with monitoring of side effects for psychotropic and antipsychotic medications. The ADON further stated the benefits of monitoring would be to determine the effectiveness of the medications and what adjustments may need to be made--taper off, change meds, or to capture a better picture. On 9/09/21, at 1:13 p.m. the ADON stated the aides are looking at general monitoring of mood, nothing specific to an individual resident. The facility policy on side effect and target behavior monitoring for antipsychotropic medications was requested and was provided. The facility policy Medication Administration, Ordering, and Monitoring revised 3/23/21, lacked direction on identification and monitoring of mood and behavior symptoms for psychotropic and antipsychotic medications and monitoring of side effects and effectiveness.	F 758	The results of the audits will be discussed at our weekly IDT meetings, as well as our quarterly QAPI meetings.	
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3)	F 838		10/29/21

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	245045	A. BUILDING _____ B. WING _____	09/09/2021

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F 838	Continued From page 8 §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures	F 838		

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F 838	Continued From page 9 and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the facility-wide assessment was updated on an annual basis to ensure necessary resources for the care of their residents. This had then potential to affect all 36 residents residing in the facility. Findings include: The facility-wide assessment was requested during the entrance conference on 9/7/201. On 9/8/2021, the administrator provided the facility-wide assessment dated November 2019. On 9/09/21, at 12:21 p.m. the administrator stated that the facility assessment only needed to	F 838	1.SHCC has conducted, documented and updated its facility-wide assessment and will continue to do so annually and/or when there is a substantial modification to any part of this assessment per federal regulation and facility policy. 2.All residents have the potential to be affected by this deficient practice. 3.Our QAA/QAPI committee will address any needed modifications to the facility-wide assessment at each of our quarterly committee meetings. Annual updates will be facilitated through our QAA/QAPI committee. 4.The Administrator is responsible for the corrective actions, monitoring and	

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F 838	Continued From page 10 be updated every two years and he was in the process of updating the facility assessment as it was due in November 2021. On 9/09/21, at 1:12 p.m. the administrator was interviewed, and the Sunnyside facility policy was reviewed. The facility policy indicated that the facility assessment needed to be updated every year. The administer verified the facility-wide assessment had not been updated annually and they were not in compliance with the facility-wide assessment requirements. The facility Assessment Policy dated 3/23/2021, indicated the facility must conduct and document a facility wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The policy further indicated the facility must review and update that assessment, as necessary, at least annually. Finally, the policy indicated the facility must also review and update this assessment whenever there was, or the facilityed planned for, any change that would require a substantial modification to any part of this assessment.	F 838	compliance. 5.The proposed date of completion is October 29,2021.	

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	245045	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**09/08/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Sunnyside Health Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS	K 000		

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

Electronically Signed | 10/08/2021

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 STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Sunnyside Care Center is a 3-story building with no basement. The original building was constructed in 1962 and was determined to be of Type II(111) construction. In 1968 the second floor was added, also Type II(111) construction. In 2000 dining rooms were constructed on floors one and two of Type II(111) construction. In 2012/2013, a three-story building with a full basement, Type I (332) construction, was added. Because the original building and its additions meet the construction type allowed for existing	K 000		

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K 000	Continued From page 2 buildings, this facility was surveyed as a single building. This skilled nursing home is not a 2-hour fire rated separated from the attached hospital, and the hospital was also inspected. The nursing home beds are all located on the second story of the building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 42 beds and had a census of 36 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain the fire alarm per NFPA 101 (2012	K 345	1. The annual inspection will continue to be done by an outside contractor and is scheduled for October 25, 2021. Six	10/29/21

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K 345	Continued From page 3 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition) National Fire Alarm Code, sections 14.5.3. and 14.6.2.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/08/2021 at 12:20 PM, during a review of all available fire alarm tests and inspection documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed. This deficient condition was verified by a Maintenance Supervisor.	K 345	months after the date of completion the facilities staff will do a visual inspection of all initiating devices. Findings will be documented on the annual inspection report. 2. The Director of Buildings and Grounds will participate in the inspection to ensure it is completed. 3. The Director of Buildings and Grounds will set up a reminder in Outlook for six months after the annual inspection is completed to complete the semiannual inspection. which will be April 25, 2022. 4. The Director of Buildings and Grounds is responsible for the corrective actions and monitoring of compliance. The Director of Buildings and Grounds will present the findings of the annual and semiannual inspections at our quarterly QAA meetings. 5. The proposed date of completion is October 29, 2021.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		10/29/21

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K 353	Continued From page 4 c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available fire sprinkler test and inspection documentation, the automatic sprinkler system is not maintained in accordance with NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 2011 edition section 5.2.5 and 5.3.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/08/2021, at 1:30 PM, the gauge that is on the sprinkler riser serving the care center that is located in the lower level mechanical room within the dialysis storage room did not have a date of replacement or re-calibration listed on it. The date of manufacture for the gauge of 2011 was found on the gauge, which is outside of the five-year gauge replacement or re-calibration time frame. This deficient condition was verified by a Maintenance Supervisor.	K 353	1. The fire sprinkler gauge in question was replaced on 10/5/2021 by an outside contractor. 2. The sprinkler tester/inspecting contractor was instructed to ensure all gauges are calibrated or replaced every five years. This will be documented in the inspection report. 3. The Director of Buildings and Grounds will check the dates on all sprinkler system gauges after inspections to ensure all gauges fall inside the 5 year-window. 4. The Director of Buildings and Grounds is responsible for the corrective actions and monitoring of compliance. The Director of Buildings and Grounds will present the findings of the gauge calibration/replacement at our quarterly QAA meetings. 5. The proposed date of completion is October 29, 2021.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills	K 712		10/29/21

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K 712	Continued From page 5 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 19.7.1.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 09/08/2021, at 11:43 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct two fire drills for the 2nd shift. 2. On 09/08/2021, at 11:43 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct three fire drills for the 1st shift. 3. On 09/08/2021, at 11:43 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not verify the DACT	K 712	1. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. A Night shift fire drill was held on September 25, 2021 in SHCC resident room 250 on West Hall at 4:30 a.m., with coded announcement and DACT. 2. Fire Drill Report Form recommended by Minnesota State Fire Marshal□s Office is now used to document all necessary fire drill information for each of the 12 annual fire drills. 3.SHCC Administrator will monitor each fire drill for one year to ensure solutions are sustained. 4.SHCC Administrator with assistance of the Building and Grounds Director will be responsible for monitoring and compliance, as well as reporting quarterly to the QAA Committee. 5.The proposed date of completion is October 29, 2021.	

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K 712	Continued From page 6 for 5 of 12 fire drills. This deficient condition was verified by a Maintenance Supervisor.	K 712		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the fire door inspections per NFPA 101 (2012 edition), Life Safety Code, sections 8.3.3.1, 19.7.6, and NFPA 80 (2010 edition) Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/08/2021, at 12:24 PM, during the review of	K 761	1.Facilities staff will maintain, inspect and test fire doors annually and as needed. 2.The Director of Buildings and Grounds will develop an inspection form and map identifying all fire doors needing inspection. 3.The Director of Buildings and Grounds will conduct random fire door inspection audits to ensure completion. 4.The Director of Buildings and Grounds is responsible for the corrective actions and monitoring and compliance, as well as reporting quarterly to the QAA	10/29/21

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K 761	Continued From page 7 all available fire door tests and inspection documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that the fire door inspection had been completed. The last date that the fire doors were inspected was 12/22/2019. This deficient condition was verified by a Maintenance Supervisor.	K 761	Committee. 5. The proposed date of completion is October 29, 2021.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of all available documentation, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient condition could have a widespread impact on the residents within the facility.	K 901	1. The Director of Buildings and Grounds will do an initial utility risk assessment of electrical and gas patient care equipment. 2. Director of Buildings and Grounds will then set up a schedule for annual risk assessments to be carried out by Facilities staff. 3. Director of Buildings and Grounds will do annual audits to ensure risk assessments are being completed.	10/29/21

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K 901	Continued From page 8 Findings include: 1. On 09/08/2021, at 10:45 AM, during the documentation review and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. The utility risk assessment that was provided at the time of the inspection did not cover patient care equipment as detailed in NFPA 99 "Health Care Facilities Code" 2012 edition Chapter 10 - Electrical Equipment, and Chapter 11 - Gas Equipment. 2. On 09/08/2021, at 10:45 AM, during the documentation review and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. The utility risk assessment that was provided at the time of the inspection did not cover all rooms that are located within the care center. This deficient condition was verified by a Maintenance Supervisor.	K 901	Director of Building and Grounds will present findings of risk assessments at the quarterly QAA committee meetings. 4. Director of Buildings and Grounds will be responsible for monitoring and compliance. 5. The proposed date of completion is October 29, 2021.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.	K 918		10/29/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245045	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**09/08/2021**

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

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K 918	Continued From page 9 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections, 9.1.3 and NFPA 110 "Standard for Emergency and Standby Power Systems 6-4, 6-4.1, and 6-4.2.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include:	K 918	1. Facilities staff conduct and document emergency generator testing, maintenance and inspection weekly on Mondays. 2. The Director of Building and Grounds assigns facilities staff to conduct weekly emergency generator testing, maintenance and inspection with the appropriate documentation each Monday. 3. The Building and Grounds Director will audit emergency generator testing,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245045	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**09/08/2021**

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K 918	Continued From page 10 On 09/08/2021, at 12:33 PM, during the review of all available emergency generator maintenance documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide documentation for 16 of 52 weekly inspections of the emergency generator. This deficient condition was verified by a Maintenance Supervisor.	K 918	maintenance, and inspections along with the documentation on a weekly basis. 4. The Director of Buildings and Grounds is the responsible for the corrective actions and monitoring and compliance. The Building and Grounds Director will also present the weekly audit findings at our quarterly QAA committee meetings. 5. The proposed date of completion is October 29, 2021.	