Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 18, 2023

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

RE: CCN: 245045
Cycle Start Date: January 20, 2023

Dear Administrator:

On February 28, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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April 18, 2023

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

Re: Reinspection Results
Event ID: BE7R12

Dear Administrator:

On February 28, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 20, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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February 8, 2023

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

RE: CCN: 245045
Cycle Start Date: January 20, 2023

Dear Administrator:

On January 20, 2023, 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 April 20, 2023, (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 July 20, 2023, (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

Please contact me with any questions.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@state.mn.us

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 _____	C 01/20/2023

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 1/17/23 to 1/20/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/17/23 to 1/20/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be unsubstantiated: H50457603C (MN00090241). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 validate substantial compliance with the regulations has been attained.	F 000		
F 567	Protection/Management of Personal Funds	F 567		2/17/23

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

Electronically Signed | 02/16/2023

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

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F 567 SS=C	Continued From page 1 CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do	F 567		

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F 567	Continued From page 2 not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to divide monthly trust fund interest between all residents that had money in the interest-bearing trust fund account. This had the ability to affect all 38 residents in the facility. Findings included: During an interview on 1/19/23 at 1:16 p.m., the director of financial services (DFS) stated there were forty-eight (48) resident names on the resident interest-bearing trust fund account. Every month when the interest would come in, it would not be divided between all residents based on the amount of money each resident had in the account, but between the top five (5) residents that had the most money in the account at that time. The DFS stated she was not aware interest had to be divided between all resident on the interest-bearing account. During an interview on 1/19/23 at 1:50 p.m., the administrator stated all residents who had money in the interest-bearing trust fund account would have the money divided between all of them based on the amount of money each resident had in the account. If there were more than 5 residents in the trust fund account, then more than 5 residents would be getting interest at the end of each month. Facility policy Long Term Care Resident's Trust Accounts last reviewed/revised 12/8/22, indicated the facility would maintain an interest-bearing checking account for the resident funds and	F 567	Long Term Care Resident's Trust Accounts policy was reviewed and does not require changes at this time. A spreadsheet has been created with all residents; calculating the interest for each month and end-of-month balance for each resident. The Director of Patient Financial Services will review, and complete monthly loading onto the spreadsheet to ensure trust fund interest is divided amongst all residents that had money in the interest-bearing trust fund account.	

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F 567	Continued From page 3 disburse in the accounts monthly.	F 567		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ordered and assessed interventions to prevent the development and/or worsening of pressure ulcers for 1 of 2 residents (R38) reviewed for pressure ulcers. Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/19, defined pressure ulcers as "A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, because of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful. The	F 686	Sunnyside Health Care Center does provide ordered and assessed interventions to prevent the development and/or worsening of pressure ulcers. R38's care sheet and care plan was reviewed and updated on 1/19/23. We added a wedge cushion to R38's plan of care to aid in a more comfortable position while in bed. Wound care was providing guidance; however, we have since changed our process, and all residents who require wound care management and follow-up, will be going down to the clinic for continued assessment and evaluation.	2/17/23

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F 686	Continued From page 4 RAI defined the following pressure ulcer stages as follows: - Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ ruptured blister. - Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling - Deep Tissue Injury (DTI) is a purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. R38's quarterly Minimum Data Set (MDS) dated 12/13/22, identified R38 had moderate cognitive impairment. R38 had extensive to total assistance required for repositioning, transferring, and showering. Diagnoses included depression. The MDS indicated R38 had a DTI. R38's undated care plan identified R38 required extensive assistance with repositioning, transferring, and bathing. R38 had impaired skin integrity related to DTI to the left buttock with interventions that included complete wound assessment weekly on wound rounds, dressing changes, and every two (2) hour repositioning side to side. R38's tissue tolerance test dated 11/17/22,	F 686	All residents who are dependent on staff for turning and repositioning; care sheets and care plans were reviewed on 2/15/23. Pressure Ulcer and Skin Injury Prevention policy and procedure was reviewed and updated on 2/16/23. Repositioning policy and procedure was reviewed and updated on 2/16/23. All staff educated on the importance of repositioning per each resident's individualized plan of care on 2/15/23 & 2/16/23. Daily audits x2 weeks for R38, and then weekly x8 randomly for residents who require full dependence of staff for bed repositioning. Audit findings will be discussed at weekly QI and quarterly QAA meetings. The Assistant Director of Nursing is responsible for monitoring, and ensuring compliance.	

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F 686	Continued From page 5 indicated every two-hour repositioning. R38's undated care sheet indicated R38 was every two hour turn and reposition. The care sheet lacked information about side-to-side repositioning. R38's nursing wound care note(s) identified the following: - 11/26/22, there was a "moisture vs pressure" area to the left (L) outer buttocks that measured 2.5 centimeters (cm) long (L) x 2.2 cm wide (W) x 0 cm deep (D) with a soft scab and defined edges. The notes indicated this wound presented 11/16/22 - 12/13/22, the "moisture vs pressure" area had changed to a dark purple DTI that measured 1.6cm L x 1.8 cm W x 1.5 cm D. The wound had undermining, significant erosion underneath the outwardly visible wound margins that resulted in more extensive damage beneath the skin surface, from the nine o'clock to the 12'oclock (on a clock face) Wound care clinic was consulted - 12/26/22, the DTI had changed to an unstageable pressure ulcer (PU) that measured 1.7cm L x 2cm W x 1.1cm D. There was undermining from the 12 o'clock to the 5 o'clock position. There was tunnelling, a complex wound that extends from the surface to various underlying tissues as it forms passageways into the various tissue layers, at the two o'clock that was 1.8 cm deep, and at the 4 o'clock that was 1.3cm deep. During an interview on 1/18/23, at 2:58 p.m. registered nurse (RN)-A acknowledged R38 had	F 686		

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F 686	Continued From page 6 a stage three PU to the left buttocks. The wound had changed from a DTI to a stage three PU. RN-A stated R38 was supposed to be turned every two hours and side to side repositioning to assist in wound healing. During continuous observation on 1/19/23, at 8:31 a.m. to 10:55 a.m. R38 was laying flat on her back with a pillow slightly under her right upper shoulder. The head of her bed was at approximately the 35-degree angle upwards. There were no pillows or other items to under either side of her hips to keep pressure off her buttocks or to promote wound healing. On 1/19/23, at 10:55 a.m. nurse assistant (NA)-A entered room. She performed a partial bed bath on the upper body. While turned to the right side a border dressing was observed over the left buttocks dated 1/19/22. After finishing the bath R38 was positioned on her right side and a pillow was placed under her left back to support her. Wound care Clinic provider notes were requested but not provided. During interview on 1/19/23 at 11:17 a.m., nurse assistant (NA)-A verified R38 was laying on her back when she entered to room at 10:55 a.m. NA-A statted R38 was supposed to be repositioned every 2 hours but it was okay for R38 to be flat on her back as part of the repositioning schedule. NA-A stated her repositioning information was located on the resident care sheet. She reviewed the care sheet and noted every two-hour repositioning, but the care sheet lacked the side-to-side positioning. NA-A could not recall the last time R38 had been repositioned. NA-A confirmed R38 had a	F 686		

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F 686	Continued From page 7 pressure ulcer on her left buttocks. During interview on 1/19/23 at 1:56 p.m., RN-B stated R38 had a pressure ulcer on her left buttocks. RN-B stated R38 was supposed to be turned every two hours but it was okay for R38 to be on her back as part of the repositioning schedule. RN-B stated turning at least every two hours was important to take pressure off the left buttocks and the wound to promote comfort and wound healing. During interview on 1/20/23, at 10:59 a.m. the director of nursing (DON) stated staff were expected to follow the care plan and reposition as documented in the care plan to promote wound healing. Facility policy Pressure Ulcer and Skin Injury Prevention last reviewed/revised 11/22/22, indicated dependent residents would be turned and repositioned every two hours.	F 686		
F 948 SS=E	Training for Feeding Assistants CFR(s): 483.95(h) §483.95(h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a state approved training program for paid feeding assistants was provided for the director of	F 948	Sunnyside Health Care Center does not use any individuals working in the facility as a paid feeding assistant.	2/17/23

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F 948	Continued From page 8 spiritual care (DSC-A) who completed job duties of a paid feeding assistant. This had the potential to affect 6 of 9 residents (R28, R12, R4, R36, R29, R10) who required feeding assistance. Findings include: On 01/17/23 at 12:10 p.m., during the entrance conference for the recertification survey the director of nursing (DON) stated the facility did not use paid feeding assistants. R28's quarterly Minimum Data Set (MDS) dated 11/16/22, indicated R28 had severe cognitive impairment and had a diagnosis of Alzheimer's disease. The electronic medical record (EMR) noted a diagnosis of dysphagia (difficulty swallowing) on 11/8/22. R28's MDS further indicated R28 required extensive assistance of one with dining. R12's comprehensive MDS dated 11/22/22, indicated R12 had severe cognitive impairment and had diagnoses of dysphagia and Alzheimer's disease. R12's MDS further indicated R12 required extensive assistance of one with dining. R4's quarterly MDS dated 11/29/22, indicated R4 had severe cognitive impairment and had a diagnosis of Alzheimer's disease. The EMR noted a diagnosis of dysphagia on 11/23/22. R4's MDS further indicated R4 required extensive assistance of one with dining. R36's significant change MDS on 11/16/22, indicated R36 had severe cognitive impairment and had a diagnosis of dysphagia. R36's MDS further indicated R36 required supervision during dining.	F 948	DSC-A was helping with passing trays; however, she should not have been assisting with eating per our policy- nursing personnel only. All residents who require feeding assist, their care plans were reviewed with the IDT on 2/16/23. Our Assisted Dining policy and procedure was reviewed and updated on 2/16/23. Education was provided to all staff on 2/15/23 and 2/16/23 to review the facility's policy "resident's will be assisted with feeding as needed by nursing personnel or "family members". Audits will be done 3x/week, rotating meals x2 months to ensure compliance. Audit findings will be discussed at weekly QI and quarterly QAA meetings. The Assistant Director of Nursing is responsible for corrective actions and monitoring of compliance.	

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	245045	A. BUILDING _____ B. WING _____	C 01/20/2023

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F 948	Continued From page 9 R29's quarterly MDS dated 12/20/22, indicated R29 has severe cognitive impairment and had diagnoses of dysphagia and dementia. R29's MDS further indicated R29 required supervision during dining. R10's significant change MDS dated 10/26/22, indicated R10 had severe cognitive impairment and had diagnoses of dysphagia and Alzheimer's disease. R10's MDS further indicated R10 was independent with dining. An undated document titled Cart 2 provided by the director of nursing, indicated R10 needed occasional assistance with dining. During an observation on 1/18/23, at 1:04 p.m. R12 and DSC-A were seated at a table in the dining room. DSC-A was observed assisting R12 with eating. During an interview on 1/18/23, at 1:09 p.m. DSC-A stated she had been provided with training on how to encourage swallowing, what size of bite to give, and what to watch for such as runny nose and coughing by the nurses and nursing assistants that worked at the facility. DSC-A stated she could not remember how long the course was or when it had taken place. DSC-A stated she was assisting R12 with dining. DSC-A stated she did not have a list of residents she was able to help and she was able to assist them all. During an interview on 1/19/23, at 8:32 a.m. nursing assistant (NA)-A stated DSC-A went through a program and was educated on assisting residents with dining. During an interview on 1/19/23, at 8:40 a.m.	F 948		

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F 948	Continued From page 10 licensed practical nurse (LPN)-A stated DSC-A had been trained and could assist residents with dining. During an interview on 1/19/23 at 9:40 a.m., the DON verified DSC-A, unlicensed personnel, did not have state approved training to assist residents with dining. The DON explained DSC-A received the same training families would receive, which would have been provided by speech therapy. The DON was unable to recall the date or length of the training provided to DSC-A. Documentation of a state-approved program for feeding assistants for DSC-A was requested and not provided. A facility policy titled Assisted Dining revised 11/22/22, stated, "Residents will be assisted with feeding as needed by nursing personnel or family member." A facility policy on Paid Feeding Assistants was requested by not provided.	F 948		

Electronically delivered

February 8, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: BE7R11

Dear Administrator:

The above facility was surveyed on January 17, 2023, through January 20, 2023, 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

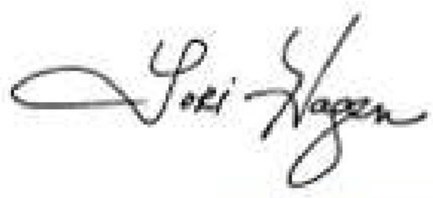
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 contact me with any questions.



Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00048	A. BUILDING: _____ B. WING _____	C 01/20/2023

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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: On 1/17/23 to 1/20/23, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. The following licensing orders were issued: St 0905 and St 1920. Please indicate in your electronic	2 000		

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2 000	Continued From page 1 plan of correction that you have reviewed these orders, and identify the date when they will be completed. The following complaint was found to be unsubstantiated: H50457603C (MN00090241). 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 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. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. 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		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ordered and assessed interventions to prevent the development and/or worsening of pressure ulcers for 1 of 2 residents (R38) reviewed for pressure ulcers. Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/19, defined pressure ulcers as "A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, because of intense and/or prolonged	2 905	Corrected.	2/17/23

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2 905	Continued From page 3 pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful. The RAI defined the following pressure ulcer stages as follows: - Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ ruptured blister. - Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling - Deep Tissue Injury (DTI) is a purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. R38's quarterly Minimum Data Set (MDS) dated 12/13/22, identified R38 had moderate cognitive impairment. R38 had extensive to total assistance required for repositioning, transferring, and showering. Diagnoses included depression. The MDS indicated R38 had a DTI. R38's undated care plan identified R38 required extensive assistance with repositioning, transferring, and bathing. R38 had impaired skin integrity related to DTI to the left buttock with interventions that included complete wound assessment weekly on wound rounds, dressing changes, and every two (2) hour repositioning side to side.	2 905		

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2 905	Continued From page 4 R38's tissue tolerance test dated 11/17/22, indicated every two-hour repositioning. R38's undated care sheet indicated R38 was every two hour turn and reposition. The care sheet lacked information about side-to-side repositioning. R38's nursing wound care note(s) identified the following: - 11/26/22, there was a "moisture vs pressure" area to the left (L) outer buttocks that measured 2.5 centimeters (cm) long (L) x 2.2 cm wide (W) x 0 cm deep (D) with a soft scab and defined edges. The notes indicated this wound presented 11/16/22 - 12/13/22, the "moisture vs pressure" area had changed to a dark purple DTI that measured 1.6cm L x 1.8 cm W x 1.5 cm D. The wound had undermining, significant erosion underneath the outwardly visible wound margins that resulted in more extensive damage beneath the skin surface, from the nine o'clock to the 12'oclock (on a clock face) Wound care clinic was consulted - 12/26/22, the DTI had changed to an unstageable pressure ulcer (PU) that measured 1.7cm L x 2cm W x 1.1cm D. There was undermining from the 12 o'clock to the 5 o'clock position. There was tunnelling, a complex wound that extends from the surface to various underlying tissues as it forms passageways into the various tissue layers, at the two o'clock that was 1.8 cm deep, and at the 4 o'clock that was 1.3cm deep. During an interview on 1/18/23, at 2:58 p.m.	2 905		

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2 905	Continued From page 5 registered nurse (RN)-A acknowledged R38 had a stage three PU to the left buttocks. The wound had changed from a DTI to a stage three PU. RN-A stated R38 was supposed to be turned every two hours and side to side repositioning to assist in wound healing. During continuous observation on 1/19/23, at 8:31 a.m. to 10:55 a.m. R38 was laying flat on her back with a pillow slightly under her right upper shoulder. The head of her bed was at approximately the 35-degree angle upwards. There were no pillows or other items to under either side of her hips to keep pressure off her buttocks or to promote wound healing. On 1/19/23, at 10:55 a.m. nurse assistant (NA)-A entered room. She performed a partial bed bath on the upper body. While turned to the right side a border dressing was observed over the left buttocks dated 1/19/22. After finishing the bath R38 was positioned on her right side and a pillow was placed under her left back to support her. Wound care Clinic provider notes were requested but not provided. During interview on 1/19/23 at 11:17 a.m., nurse assistant (NA)-A verified R38 was laying on her back when she entered to room at 10:55 a.m. NA-A statted R38 was supposed to be repositioned every 2 hours but it was okay for R38 to be flat on her back as part of the repositioning schedule. NA-A stated her repositioning information was located on the resident care sheet. She reviewed the care sheet and noted every two-hour repositioning, but the care sheet lacked the side-to-side positioning. NA-A could not recall the last time R38 had been repositioned. NA-A confirmed R38 had a	2 905		

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2 905	Continued From page 6 pressure ulcer on her left buttocks. During interview on 1/19/23 at 1:56 p.m., RN-B stated R38 had a pressure ulcer on her left buttocks. RN-B stated R38 was supposed to be turned every two hours but it was okay for R38 to be on her back as part of the repositioning schedule. RN-B stated turning at least every two hours was important to take pressure off the left buttocks and the wound to promote comfort and wound healing. During interview on 1/20/23, at 10:59 a.m. the director of nursing (DON) stated staff were expected to follow the care plan and reposition as documented in the care plan to promote wound healing. Facility policy Pressure Ulcer and Skin Injury Prevention last reviewed/revised 11/22/22, indicated dependent residents would be turned and repositioned every two hours. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure wheelchair positioning in assessed and corrected in a timely manner to help prevent pressure ulcers and other complications, then inservice staff on any applicable changes and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
21910	MN St. Statute 144.651 Subd. 25 Patients & Residents of HC Fac.Bill of Rights	21910		2/17/23

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21910	Continued From page 7 Subd. 25. Financial affairs. Competent residents may manage their personal financial affairs, or shall be given at least a quarterly accounting of financial transactions on their behalf if they delegate this responsibility in accordance with the laws of Minnesota to the facility for any period of time. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to divide monthly trust fund interest between all residents that had money in the interest-bearing trust fund account. This had the ability to affect all 38 residents in the facility. Findings included: During an interview on 1/19/23 at 1:16 p.m., the director of financial services (DFS) stated there were forty-eight (48) resident names on the resident interest-bearing trust fund account. Every month when the interest would come in, it would not be divided between all residents based on the amount of money each resident had in the account, but between the top five (5) residents that had the most money in the account at that time. The DFS stated she was not aware interest had to be divided between all resident on the interest-bearing account. During an interview on 1/19/23 at 1:50 p.m., the administrator stated all residents who had money in the interest-bearing trust fund account would have the money divided between all of them based on the amount of money each resident had in the account. If there were more than 5 residents in the trust fund account, then more than 5 residents would be getting interest at the	21910	Corrected.	

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21910	Continued From page 8 end of each month. Facility policy Long Term Care Resident's Trust Accounts last reviewed/revised 12/8/22, indicated the facility would maintain an interest-bearing checking account for the resident funds and disburse in the accounts monthly. SUGGESTED METHOD OF CORRECTION: The Administrator could assure that funds that are maintained by the facility in an interest bearing account are disbursed to all residents based on the amount they have in their individual accounts. The QAA could randomly audit accounts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21910		

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	245045	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**01/19/2023**

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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/19/2023. 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 02/16/2023

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
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email 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 3 story building with a full basement, Type I (332) construction was added. Because the original building and its additions meet the construction type allowed for existing buildings,	K 000		

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K 000	Continued From page 2 this facility was surveyed as a single building. This skilled nursing home is not 2 hour fire rated separated from the attached hospital, and the hospital was also inspected. The nursing home beds are all located on the 2 story of the building. The facility has a capacity of 42 beds and had a census of 38 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not enclose stairways used for exits and smoke proof enclosures per NFPA 101 (2012), Life Safety Code, section 7.1.3.2.1. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 01/19/2023 between 09:00 am and 11:30am, it was revealed by observation that storage materials had been placed in the emergency exit vestibule in the emergency exit in the physical therapy area.	K 225	1) The storage materials placed in the emergency exit vestibule in the emergency exit stairwell of the Therapy Area were removed on January 19, 2023. 2) All staff were instructed that storage materials cannot be placed in the emergency exit vestibule or stairwells on January 19,2023. 3) The Director of Building and Grounds will make monthly walk throughs of the stairwells to ensure all stairwells are clear of any storage materials. 4) The Director of Building and Grounds is responsible for the corrective actions	2/17/23

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K 225	Continued From page 3 An interview with the Director of Building and Grounds and Facility Administrator verified these deficient findings at the time of discovery.	K 225	and monitoring of compliance. 5) The actual or proposed date of completion of the remedy is February 17, 2023.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		2/17/23

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K 363	Continued From page 4 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 01/19/2023 between 09:00am and 11:30am, it was revealed by observation that the resident room door 264 and door 270 would not latch. An interview with the Director of Building and Grounds and Facility Administrator verified these deficient findings at the time of discovery.	K 363	1) The resident room doors 264 and 270 that would not latch were repaired on January 19, 2023. 2) All resident room doors in Sunnyside Health Care Center will be tested by maintenance staff for proper latching on a quarterly basis beginning January 19, 2023. 3) The Director of Building and Grounds will inspect all resident room doors to ensure proper latching on a quarterly basis beginning January 19, 2023. 4) The Director of Building and Grounds is responsible for the corrective actions and monitoring of compliance. 5) The actual or proposed date of completion of the remedy is February 17, 2023.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		2/17/23

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K 511	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/19/2023, between 09:00 am and 11:30 am, it was revealed by observation that three (3) electrical panels one (1) panel located in each wing were not locked. An interview with the Director of Building and Grounds and Facility Administrator verified this deficient finding at the time of discovery.	K 511	1) The unsecured electrical panels were secured on January 19, 2023. 2) Facility maintenance staff were instructed on January 19, 2023, to secure all electrical panels that were unsecured while gaining access to electrical breakers. 3) The Director of Building and Grounds will inspect all electrical panels to ensure they are properly secured on a quarterly basis beginning January 19, 2023. 4) The Director of Building and Rounds is responsible for the corrective actions and monitoring of compliance. 5) The actual and proposed date of completions of the remedy is February 17, 2023.	