DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 10, 2022

CMS Certification Number (CCN): 245357

Administrator
Avera Sunrise Manor
240 Willow Street
Tyler, MN 56178

Dear Administrator:

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

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

Effective June 6, 2022 the above facility is certified for:

30 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 30 skilled nursing facility beds.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 10, 2022

Administrator
Avera Sunrise Manor
240 Willow Street
Tyler, MN 56178

RE: CCN: 245357
Cycle Start Date: May 6, 2022

Dear Administrator:

On June 9, 2022, the Minnesota Department of Health 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
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Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 25, 2022

Administrator
Avera Sunrise Manor
240 Willow Street
Tyler, MN 56178

RE: CCN: 245357
Cycle Start Date: May 6, 2022

Dear Administrator:

On May 6, 2022, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 August 6, 2022 (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 November 6, 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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING _____ B. WING _____	C 05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA SUNRISE MANOR	240 WILLOW STREET TYLER, MN 56178

(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 5/2/22 through 5/6/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/2/22 through 5/6/22, 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 complaints were found to be SUBSTANTIATED H5357016C (MN68820), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5357018C (MN73767), however, a related deficiency was cited at F609. The following complaints were found to be UNSUBSTANTIATED: H5357017C (MN70872), H5377024C (MN79419), and H5377026C (MN82797). The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/03/2022

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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F 000	Continued From page 1 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		6/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 2 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure timely reporting of an allegation of potential neglect for 1 of 1 resident (R133) to the administrator and State Agency (SA) occurred immediately but no later than 2 hours after an unwitnessed fall. Findings include: Review of the 6/10/21 at 3:27 p.m., report to the SA identified R133 had an unwitnessed fall on 6/5/21 at approximately 10:25 a.m. in the facility solarium. R133 had been found on laying on her left side with blood on her head and in her hair. R133 was identified as a resident in end stages of dementia and did not communicate efficiently. Staff were unable to complete a full range of motion assessment as R133 complained of pain. R133 was sent to the emergency department (ED) for evaluation. The report noted it was possible the care plan had not been followed. Review of the 6/15/21 at 12:21 p.m., 5 day report to the SA identified R133's care plan was updated to identify R133 was not to be left alone in the solarium after a root cause analysis was performed by the interdisciplinary team. Staff were updated to changes on the care plan. Interventions on the care plan at the time of the fall were deemed appropriate. There was no mention the facility investigation identified reporting to the administrator and the SA was delayed by 5 days and was not within 2 hours for potential neglect of care.	F 609	On 6/10/2021, VA was reported to MDH for resident with injury from unwitnessed fall that occurred in the facility solarium on 6/5/2021. R133 had been found laying on her left side with blood on her head and in her hair. R133 was sent to the emergency department for evaluation as resident was not able to effectively communicate due to diagnosis with end stage dementia and ROM was unable to be completed. R133's care plan updated. DON verified that all licensed staff had a login and password for the VA reporting site. Policies were updated to reflect: 2 hour reporting: if the alleged allegation involves abuse or seriously bodily harm there is a two hour reporting time frame; 24 hour reporting: if the alleged violation does not involve abuse or seriously bodily harm. Education was provided to staff on 5/19/2022 during nursing meeting on how to report a VA and the steps necessary to file report, including the Policy on Vulnerable Adult Reporting and Mandatory Reporting. A binder was created to be kept at the nurses station to provide staff with the steps necessary and instructions on how to file a VA report. Staff were re-educated on 6/2/2022 with in-service on when to file a VA and to immediately notify DON, including a review of the types of abuse and appropriate time frames with each event. Review of Who is a Mandated	

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F 609	Continued From page 3 R133's 5/17/21, quarterly Minimum Data Set (MDS) identified R133 had severely impaired cognition. R133 displayed continuous behaviors of inattention and disorganized thinking. R133 required extensive assist of 2 staff for bed mobility and toileting, extensive assistance of 1 staff for transfers and locomotion. R133 had diagnosis of neurocognitive disorder with Lewy bodies, Parkinson's disease, and anxiety. Interview on 5/5/22 at 11:33 a.m., with nursing assistant (NA)-C identified R133 normally was kept close to the nurses station in order to give her things to do to keep her busy and for staff to keep an eye on her. NA-C revealed R133 did not have a lot of falls and had been on hospice for a long time. Interview on 5/6/22 at 10:12 a.m., with licensed practical nurse (LPN)-A identified R133 was unable to ambulate and used a wheelchair. R133 had a tendency to bend over while in her wheelchair and attempt to pick things up off of the floor. R133 was on hospice and had been for about a year. Interview on 5/6/22 at 10:46 a.m., with registered nurse (RN)-A identified R133 had fallen in the solarium and suffered a laceration to her head. R133 had been sent over to the emergency room for evaluation. RN-A identified that the director of nursing normally does the SA reporting but all nurses are trained to file a SA report. Interview on 5/6/22 at 1:59 p.m., with the facility administrator identified he agreed the facility had not followed policy and procedure and immediately inform him of R133's unwitnessed	F 609	Reporter and review of Vulnerable Adult and Mandatory Reporting Policy. Compliance Requirements initiated 5/25/2022. Resident audits x 4 weeks, quality of life survey questions and then once monthly on-going. Education to be provided at Resident Council meeting Resident Rights Staff Audits x 4 weeks with different departments regarding Mandated reporting and Definitions. Monthly x 3 months and then quarterly on-going. It is the policy of this facility to assist those who, because of physical and mental disability or dependence on institutional services, are vulnerable to abuse or neglect: to provide safe services and living environments; and to require the reporting or suspected abuse or neglect of those we serve. Vulnerable Adult Report to be discussed at next QAPI on 6/8/2022 with Quality/Infection Control Nurse, DON, MDS Nurse, Social Services Designee, Administrator, Environmental Services and Medical Director.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA SUNRISE MANOR	240 WILLOW STREET TYLER, MN 56178

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F 609	Continued From page 4 fall resulting in an ED visit. He had reviewed the fall information and made the decision to file a SA report on 6/7/21, 2 days after the fall, but the report to the SA report was delayed further and not reported until 6/10/21, 5 days after the fall. His expectation was staff were to inform him immediately and a report to the SA was to be filed immediately but no later than 2 hours for any allegation of potential neglect or abuse. He agreed that there had been a potential for neglect as there were initial questions as to the care plan being followed. It was later discovered the care plan had been followed, but he agreed the investigation did not discover reporting had been delayed for the allegation. He noted staff needed further training on reporting to the administrator and SA timely. Review of the 3/22, Vulnerable Adult Abuse Prevention Plan policy identified all allegations of potential neglect were to be reported immediately, but no later than 2 hours to the administrator and SA.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00338	A. BUILDING: _____ B. WING _____	C 05/06/2022

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AVERA SUNRISE MANOR	240 WILLOW STREET TYLER, MN 56178

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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 5/2/22 through 5/6/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Complaints were also investigated. Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that	2 000		

Electronically delivered
May 25, 2022

Administrator
Avera Sunrise Manor
240 Willow Street
Tyler, MN 56178

Re: State Nursing Home Licensing Orders
Event ID: UHY311

Dear Administrator:

The above facility was surveyed on May 2, 2022 through May 6, 2022 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00338	A. BUILDING: _____ B. WING _____	C 05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA SUNRISE MANOR	240 WILLOW STREET TYLER, MN 56178

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 you have reviewed these orders, and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED: H5357016C (MN68820), however NO licensing orders were issued due to actions taken by the facility prior to survey. The following complaint was found to be UNSUBSTANTIATED: H5357018C (MN73767), however, a related licensing order was issued at 1980. The following complaints were found to be UNSUBSTANTIATED: H5357017C (MN70872), H5377024C (MN79419), and H5377026C (MN82797). 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	2 000		

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2 000	Continued From page 2 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 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		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must	21426		6/3/22

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21426	Continued From page 3 be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure a second test of the required 2-step tuberculin skin test (TST) was completed for 4 of 5 residents (R7, R13, R25 and R29). In addition, the facility also failed to ensure 1 of 5 residents (R16) had a tuberculosis (TB) symptom screening and TST following admission. Findings include: R7's face sheet identified he was admitted on 3/16/21 and received a Tuberculosis (TB) symptom screen and the first TST, but there was no documented second step completed. R13's face sheet identified he was admitted on 3/16/21 and received a TB symptom screen and the first TST on 3/16/21, but there was no documented second step completed. R25's face sheet identified she was admitted on 3/18/22 and received a TB symptom screen and the first TST on 3/18/22, but there was no documented second step completed. R29's face sheet identified he was admitted on 12/17/21 and received a TB symptom screen and the first TST on 12/17/21, but there was no documented second step completed. R16's face sheet identified she was admitted on	21426	It was found on 5/6/2022 during MDH survey that the policy for LTC Resident Health Program was not being followed with new admissions in order to protect and prevent illness in this facility. With evidence of error that resident's were not getting the second step in the 2-step tuberculin skin test, it was determined to change the policy and standing orders to the Quantiferon-TB Gold (QFT), which is a blood test that detects the bacteria that causes tuberculosis. Nursing staff to be educated on process change with in-person meeting and in-service. Weekly audits to be performed on resident admission days x 4 weeks if 100%, bi-weekly x 4 weeks if 100%, monthly x 3 months if 100%, and bi-monthly on-going. Reporting will be done to the QAPI team during next scheduled meeting on 6/8/2022 consisting of Quality/Infection Control Nurse, DON, MDS Nurse, Social Services Designee, Administrator, Environmental Services and Medical Director.	

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21426	Continued From page 4 12/9/19. There was no documentation that a TB symptom screen or TST had been completed. Interview on 5/9/22 at 10:48 a.m., with the director of nursing (DON), identified there had been a failure in the process for administration of TST's and symptom screening for residents following admission. The DON identified her expectation was staff were to follow policies and procedures to ensure safety of other residents, staff, and visitors from possible exposure to TB. She reported she would need to follow up with staff and provide education to correct the identified problem. Review of the October 2018, LTC Resident Health Program policy identified a two-step TST was to be completed for new admission to the nursing home. Symptom screening was to be completed prior to the first TST and with any resident that had symptoms or possible exposure to TB. The first TST was to be administered within 24 hours of admission and the second was to be administered 7-21 days after the first TST. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee could review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees. Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions as well as current residents records to ensure compliance. The ICN, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful	21426		

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21426	Continued From page 5 compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has	21980		6/3/22

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21980	Continued From page 6 reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure timely reporting of an allegation of potential neglect for 1 of 1 resident (R133) to the administrator and State Agency (SA) occurred immediately but no later than 2 hours after an unwitnessed fall. Findings include: Review of the 6/10/21 at 3:27 p.m., report to the SA identified R133 had an unwitnessed fall on 6/5/21 at approximately 10:25 a.m. in the facility solarium. R133 had been found on laying on her left side with blood on her head and in her hair. R133 was identified as a resident in end stages of dementia and did not communicate efficiently. Staff were unable to complete a full range of motion assessment as R133 complained of pain. R133 was sent to the emergency department (ED) for evaluation. The report noted it was	21980	Corrected.	

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21980	Continued From page 7 possible the care plan had not been followed. Review of the 6/15/21 at 12:21 p.m., 5 day report to the SA identified R133's care plan was updated to identify R133 was not to be left alone in the solarium after a root cause analysis was performed by the interdisciplinary team. Staff were updated to changes on the care plan. Interventions on the care plan at the time of the fall were deemed appropriate. There was no mention the facility investigation identified reporting to the administrator and the SA was delayed by 5 days and was not within 2 hours for potential neglect of care. R133's 5/17/21, quarterly Minimum Data Set (MDS) identified R133 had severely impaired cognition. R133 displayed continuous behaviors of inattention and disorganized thinking. R133 required extensive assist of 2 staff for bed mobility and toileting, extensive assistance of 1 staff for transfers and locomotion. R133 had diagnosis of neurocognitive disorder with Lewy bodies, Parkinson's disease, and anxiety. Interview on 5/5/22 at 11:33 a.m., with nursing assistant (NA)-C identified R133 normally was kept close to the nurses station in order to give her things to do to keep her busy and for staff to keep an eye on her. NA-C revealed R133 did not have a lot of falls and had been on hospice for a long time. Interview on 5/6/22 at 10:12 a.m., with licensed practical nurse (LPN)-A identified R133 was unable to ambulate and used a wheelchair. R133 had a tendency to bend over while in her wheelchair and attempt to pick things up off of the floor. R133 was on hospice and had been for about a year.	21980		

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21980	Continued From page 8 Interview on 5/6/22 at 10:46 a.m., with registered nurse (RN)-A identified R133 had fallen in the solarium and suffered a laceration to her head. R133 had been sent over to the emergency room for evaluation. RN-A identified that the director of nursing normally does the SA reporting but all nurses are trained to file a SA report. Interview on 5/6/22 at 1:59 p.m., with the facility administrator identified he agreed the facility had not followed policy and procedure and immediately inform him of R133's unwitnessed fall resulting in an ED visit. He had reviewed the fall information and made the decision to file a SA report on 6/7/21, 2 days after the fall, but the report to the SA report was delayed further and not reported until 6/10/21, 5 days after the fall. His expectation was staff were to inform him immediately and a report to the SA was to be filed immediately but no later than 2 hours for any allegation of potential neglect or abuse. He agreed that there had been a potential for neglect as there were initial questions as to the care plan being followed. It was later discovered the care plan had been followed, but he agreed the investigation did not discover reporting had been delayed for the allegation. He noted staff needed further training on reporting to the administrator and SA timely. Review of the 3/22, Vulnerable Adult Abuse Prevention Plan policy identified all allegations of potential neglect were to be reported immediately, but no later than 2 hours to the administrator and SA. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise policies or procedures to ensure timely	21980		

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21980	Continued From page 9 reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245357	A. BUILDING **01 - TYLER HEALTHCARE CENTER** B. WING _____	**05/03/2022**

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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 05/03/2022. At the time of this survey, Avera Sunrise Manor was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Avera Sunrise Manor is a one-story with partial basement facility that was constructed at two different times. The original building was constructed in 1957 and determined to be of Type II(111) construction. The 1976 addition was determined to be of Type V(111) construction. This addition is fully sprinklered and was determined to be of Type V(111) construction. The facility has smoke detection at smoke barrier doors and in spaces open to the corridor, which are monitored for automatic fire department notification. The facility is fully fire sprinkler protected. The requirement at 42 CFR, Subpart 483.70(a), is MET.	K 000		

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

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