Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 20, 2020

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

RE: CCN: 245225
Cycle Start Date: August 5, 2020

Dear Administrator:

On August 5, 2020, 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" tag) i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784

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 November 5, 2020 (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 February 5, 2021 (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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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
	245225	A. BUILDING ______ B. WING ______	C 08/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/4/20 - 8/5/20, an abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be unsubstantiated. #H5225019C #H5225020C #H5225024C The following complaints were found to be substantiated with no deficiency cited. #H5225021C #H5225022C #H5225023C However, as a result of the investigation a deficiency was identified at F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		9/3/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/26/2020

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 610	Continued From page 1 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 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 protect resident property and thoroughly investigate an allegation of missing $500 cash for 1 of 2 residents (R1) reviewed for financial exploitation. Findings include: R1's current diagnosis according to facesheet printed 8/5/20, indicated bilateral artificial knee replacement. R1's admission Minimum Data Set (MDS) assessment dated 6/4/20, indicated R1 had moderate cognitive impairment, adequate hearing and vision, clear speech, was understood and could understand. R1 required extensive assistance of one staff for bed mobility, transfers,	F 610	F610 It is the policy of the Sleepy Eye Care Center to thoroughly protect resident property and thoroughly investigate an allegation of missing property. Resident #1 has discharged. All incidents of allegation of financial exploitation from previous year were reviewed at IDT meeting on Monday August 24th with no concerns noted. Executive Director, Director of Nursing and Social Services reviewed/revised policy and procedure for abuse, neglect and mistreatment. Leadership team and IDT team will be educated on how to thoroughly investigate incidents of abuse, neglect and mistreatment on September 1, 2020. Checklist for Misappropriation of Property	

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F 610	Continued From page 2	F 610		

walking, dressing and toileting.

R1's care plan printed on 6/30/20, indicated R1 had cognitive loss with short-term memory deficient; does not always know the year, was new to the facility and had recent surgery.

R1's facility risk management report dated 6/30/20, indicated R1 reported missing five, $100 bills from his billfold. R1 reported having the money when he arrived to the facility on 6/18/20 and last saw the money in his billfold five or six days prior.

Following the allegation of missing money, a progress note dated 6/30/20, by social worker (SW) indicated R1 was encouraged not to have cash in his room. R1 gave consent to lock up his billfold and this was done by SW and director of nursing (DON). R1 was informed he could ask for his billfold back or access his money at any time.

R1's incident report folder included a document by SW dated 6/30/20, indicated she spoke to R1 about his allegation of missing money. R1 told SW when he came to the facility he had six $100 bills, four $20 bills, 1 $10 bill, 2 $5 bills and 4 $1 bills. R1 told SW he noticed on 6/30/20 he was missing five $100 bills, but the rest of his cash was in his billfold. R1 told SW he last looked in his billfold about five or six days ago, so knew the money was taken at the facility and not when he was in the hospital. R1 was asked if there was anyone they could call to verify the amount of cash he had in his billfold; R1 stated he managed his finances independently as he had no family. R1 was informed the police department would be contacted regarding potential theft. Further documentation indicated SW spoke to an officer

Provider's Plan of Correction (F 610):

will now be used with investigations of misappropriation of property.
All incidents will be reviewed at IDT weekly x4 and then monthly for a quarter to ensure that incidents have been thoroughly investigated and checklist has been used. Results of audits will be communicated to the QAPI committee.
The Director of Nursing and Director of Social Services are responsible for overall compliance along with communicating results to the QAPI committee.
The facility alleges that it will be in substantial compliance and complete all action items by September 3, 2020.

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about the missing money; SW also encouraged R1 not to have cash in his room. R1 gave SW permission to lock up his billfold.

A facility report titled IDT (interdisciplinary team) post investigative review dated 7/1/20, and signed by director of nursing (DON) indicated R1 had an allegation of misappropriation of property with R1 reporting $500 missing from his billfold in his room. The final outcome was R1 being educated not to keep money in his room, and the rest of his money was locked up.

The facility five-day investigative report dated 7/2/20, indicated that on 6/30/20, at approximately 10:30 a.m. R1 reported missing money out of his billfold. R1 told facility staff he had six $100 bills, four $20 bills, 1 $10 bill, 2 $5 bills and 4 $1 bills when he arrived to the facility. R1 informed staff he noticed that morning he was missing five $100 bills for a total of $500. R1 informed staff the rest of the cash was still in his billfold and staff confirmed this. The report indicated R1 managed his own finances, had no family or power of attorney. The report indicated R1 had some confusion and memory impairment. Following the discovery of missing cash, R1 was encouraged not to have any cash in his room and his billfold was locked up. The report indicated one staff person was interviewed regarding the missing cash; the nursing assistant who reported the allegation.

During an interview on 8/4/20, at 2:40 p.m. licensed practical nurse (LPN)-A stated the facility did not conduct an inventory of personal items for newly admitted residents, and did not ask a resident if they had a large sum of money or valuables with them. Furthermore, LPN-A stated

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"if a resident reported something missing, they assumed the resident was missing it, even if they don't know." LPN-A stated if a resident reported something missing, it was reported to the DON, then reviewed at IDT and followed up by the DON and SW.

During an interview on 8/4/20, at 2:45 p.m. nursing assistant (NA)-A stated if a resident reported something missing from their room, they would look for it and if couldn't find it, report it to a nurse or DON. NA-A stated "you always assume the resident is right and go through the process."

During an interview on 8/5/20, at 9:15 a.m. registered nurse (RN)-A stated R1 was discharged to home yesterday and stated his money was counted when his billfold was returned to him. According to RN-A s, R1 stated the money was all there except for the five, $100 bills. RN-A stated R1's billfold had been sitting on his bedside table at the time the money went missing. RN-A added this occurred while R1 was in quarantine due to Covid19 and limited staff were going in and out of his room. RN-A was not aware if anyone called the hospital where R1 had knee replacement surgery prior to being admitted, to ask if an inventory of his cash was done during their admission process. RN-A stated no one was able to verify the amount of cash R1 had in his billfold when he was admitted. RN-A stated their admission assessment does not require an inventory of personal items, such as contents of a billfold or purse, jewelry or clothing. RN-A stated there was not a form staff initiated when a resident reported missing property.

During a telephone interview on 8/5/20, at 9:24 a.m. friend (F)-C answered R1's phone, stating

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F 610	Continued From page 5 R1 was still in bed; F-C was there to check on him. F-C was aware R1 alleged to have missing cash when at the facility. R1 had told F-C he had $600 in cash and $500 went missing at the nursing home. F-C stated he drove R1 to the hospital for double knee surgery and suggested to R1 that he (F-C) take the billfold home for safekeeping, but R1 wanted to keep it with him. F-C did not see the money and could not verify the amount. F-C stated R1 might not be able to prove a withdrawal of the money from his bank account as he may have had the cash at home. F-C stated R1 was upset the money was missing and was positive the money was with him in his billfold at the nursing home. F-C will also ask R1 if he remembered if the hospital accounted for the money while he was there. F-C stated he was glad someone was looking into this on R1's behalf. During an interview on 8/5/20, at 9:42 a.m. the DON stated R1 reported he was missing $500 in cash, all in $100 dollar bills. DON stated "we looked around his room, asked him if he had done anything with it, and asked if he was sure he had the money." DON stated they were unable to locate the missing money and stated "they asked staff if they knew anything about it, but no one was able to verify R1 had the money." The local police were notified, but didn't come to the facility. DON stated "we always believe what the resident said is what happened." DON stated she doesn't know if staff took the money. DON stated the facility had cameras in the hallways, but had not looked at the footage and stated "we could go back and look." Unaware if anyone called the hospital to see if they accounted for the money in R1's billfold when he was a patient there. DON stated staff interviews regarding the allegation of	F 610		

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missing money were done by the SW and if documented, would be in the risk management folder.

During a telephone interview on 8/5/20, at 9:48 a.m. SW stated she had no conversation with R1 about personal processions, including money in his billfold when he was admitted. R1 informed her he managed his own finances and had no power of attorney. SW stated after the cash was reported missing, she typed up a summary, and stated she asked R1 questions such as if he had his billfold in the hospital, was his billfold ever unattended, and when did he see it last. R1 informed SW his money was present in his billfold after he arrived to the facility. SW stated the police were called, but they didn't come to facility; they talked to R1 on the phone. SW stated no one called the hospital to ask them if they inventoried R1's money at the time of his admission there. SW stated they did not look at facility camera footage; "there were so many people going in and out of his room." SW talked to the NA who reported the money missing but couldn't recall talking to other employees. SW stated "I mostly questioned R1 and asked if he saw anything suspicious." When asked how many staff she questioned during the investigation, SW stated she didn't know. When asked if it was one or two employees, she stated yes.

During an interview on 8/5/20, at 10:54 a.m. with the administrator and DON, when asked if there was a formal process for investigating an allegation of missing property, the DON referenced the facility form titled Checklist for Misappropriation of Property but stated this form/process was not used when R1 reported

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F 610	Continued From page 7 money missing. DON stated "they don't always follow the form; depends on who and what it is." When asked what role the administrator played in the investigation, he acknowledged he didn't play a part. When asked how many employees were interviewed following the report of missing cash, DON stated she didn't know and stated the social worker interviewed staff and she was pretty thorough. DON stated the documentation of interviews would be in R1's risk management folder. (No documentation of employee interviews were found in this folder nor otherwise produced by the facility). DON stated the facility could have interviewed more staff. DON stated the facility had security cameras in the hallways but footage was not looked at following the incident. The administrator added "it would only show who went in and out of R1's room." DON confirmed the facility did not do an admission inventory of a residents personal possessions, and also stated the facility did not have anything in resident rooms to safeguard personal items such a safe or lock box. DON stated they did not go through a resident's billfold or purse, stating "we would not know if they had a substantial amount of money unless they told us." DON added "if we do see a resident has a large amount of money, it would go in the residents trust with their permission." DON stated she did not know if R1 had the five $100 bills in his billfold; "I'm not sure," adding that his cognition was very poor. DON stated "could staff have taken it? I can't prove it one way or another." Stated she felt under the circumstances, they did a "full and through investigation." The administrator verbalized agreement. DON stated R1 was indifferent about the missing money; "he was not like oh my gosh, where's my money?" DON stated they did not call the hospital to ask if they could verify whether or	F 610		

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not R1 had this amount of cash when he was an inpatient there; "I didn't think of that."

Facility Checklist for Misappropriation of Property, revised 11/2016 indicated:
The checklist outlined seven steps in process of investigating missing property and listed a examples of report of stolen property, item, or money of any value, with the alleged perpetrator possibly being staff, resident representative, visitors, other residents,improper use of resident funds.
1. Included in the various steps were:
--Attempt to interview staff prior to leaving.
--Have written statements from staff on duty prior to leaving facility.
--Contact potential witness via telephone for statements.
--Contact laundry, dietary, housekeeping for items search.
--Utilize credit report, photos of property, bank statements, insurance documents to assist with investigation.
--Report to ombudsman.
--Utilize all collected data to complete all sections of the form.

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
August 20, 2020

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

Re: Event ID: DU5D11

Dear Administrator:

The above facility survey was completed on August 5, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

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	00776	A. BUILDING: ______ B. WING ______	C 08/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	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 8/4/20 - 8/5/20,, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be in compliance with the MN State Licensure.

The following complaints were found to be unsubstantiated.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/26/20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00776	A. BUILDING: ______ B. WING ______	C **08/05/2020**

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

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2 000	Continued From page 1 #H5225019C #H5225020C #H5225024C The following complaints were found to be substantiated however no licensing orders were issued. #H5225021C #H5225022C #H5225023C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		