DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 23, 2020

Administrator
Avera Sunrise Manor
240 Willow Street
Tyler, MN 56178

RE: CCN: 245357
Survey Start Date: April 9, 2020

Dear Administrator:

On July 8, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 18, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

The CMS Region V Office may notify you of their determination regarding any remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Electronically delivered

June 15, 2020

Administrator
Avera Sunrise Manor
240 Willow Street
Tyler, MN 56178

SUBJECT: SURVEY RESULTS
CCN: 245357
Cycle Start Date: April 9, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On May 26, 2020, the Minnesota Department of Health completed a complaint investigation at Avera Sunrise Manor to determine if your facility was in compliance with Federal requirements related to the complaint and. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the May 26, 2020 survey. Avera Sunrise Manor may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. 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. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- The date that each deficiency will be corrected.

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

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-308
Fax: 507-537-7194

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 26, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-308
Fax: 507-537-7194

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;

- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Avera Sunrise Manor may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Kamala Fiske-Downing

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

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 05/26/2020

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
F 000	INITIAL COMMENTS On 5/26/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5357008C. A deficiency was cited at F607. 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	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F 607		6/18/20

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

Electronically Signed | 06/18/2020

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 607	Continued From page 1 §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were free from neglect for 1 of 3 residents (R2) who had planned interventions for drinking with assisted devices, but were not performed as a result of 1 of 1 staff (nursing assistant (NA)-A) choosing to disregard the care plan, resulting in 2nd degree burns to R2. Findings include: Review of the 5/20/20, report filed to the State Agency (SA) identified at 3:15 p.m., R2 was given a cup of hot coffee while in her bed with the head of bed elevate. R2 spilled her coffee affecting the right side of her chest and her right hip. The spilled coffee resulted in a second degree burn to her right hip area. R2 was identified to have severe cognitive impairment with limited range of motion (ROM) in her right upper extremity and required extensive assistance with bed mobility. Review of the 5/25/20, 5-day facility investigation report submitted to the SA identified R2 had requested and received a cup of coffee while in bed with the HOB elevated. She was left unsupervised and had spilled the coffee on her chest and right side which resulted in the hot coffee pooling to right hip and thigh area. The report identified staff did not implement R2's current care plan which indicated R2 required lids on a specialized cup. The care plan further identified the resident was not to receive food or fluids while in bed related to her diagnosis of multiple sclerosis (MS). The report identified R2's care plan included fluids that were hot were to be	F 607	Charge nurse RN-A spoke with NA-A on 5/20/20 regarding coffee spill involving R2. During conversation RN-A reeducated NA-A regarding the care plan for R2 including resident cannot be provided with food or fluids in bed and must have handled covered cups. DON then spoke to NA-A regarding incident on the same afternoon giving reeducation including above information as well as educating why it is important to follow residents care plan, as not following care plan can result in injury. NA-A stated understanding of following care plan as well as needing to ensure hot liquids are given to residents safely. DON held staff meetings 5/27/20 (C.N.A.) and 5/29/20 (nurse). Education provided regarding procedure for ensuring resident safety during mealtimes and when administering food and fluids; review of vulnerable adult abuse prevention policy; review of safe distribution of food and products policy; review of residents rights and responsibilities policy and resident care planning process policy. DON and DM-D met regarding adaptive equipment and on 6/17/20 audits developed to aide in documentation of observations and compliance of adaptive equipment availability and appropriate usage. Audits will be completed 3 times per week x 1 year by DM and DON or designee. Availability by DM and appropriate usage by DON.	

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F 607	Continued From page 2 covered. The report identified NA-A had been re-educated and understood that the resident should be up in a chair for all meals and snacks. The report further identified that R2 had four areas of redness approximately 6 centimeters (cm) by 2 cm and an area where a blister had popped but the skin remained intact. Review of the facilities 5/20/20, Investigation Documentation, identified R2 had been given a hot cup of coffee in an uncovered Styrofoam cup by nursing assistant (NA-A) while in bed and NA-A then left the room. The investigation documentation identified within minutes NA-A heard yelling and re-entered R2's room. The hot coffee had spilled down the front of R2's clothing and pooled inside her brief on the right hip area. She had sustained a 2nd degree burn to her right hip. R2's 3/14/20, quarterly Minimum Data Set (MDS) identified R2 had severe cognitive impairment and severe decision-making skills. R2 required extensive assistance of two staff for transferring, bed mobility, and toileting. The MDS identified she was independent with set up for eating. R2's diagnoses included: hypertension, diabetes mellitus, MS, and depression. R2's 3/20/20, care plan identified on 9/30/19, R2 was to utilize adaptive equipment related to her decline in activities of daily living (ADLs). She was to have an adaptive cup with handles and lids, a lipped plate, built up silverware, and dycem under her plate to hold in place. This setting was to be placed on a bedside table raised to fit her height. Other interventions that had been in place since 7/31/19, included liquids were to be covered. If liquids were too hot, water was to be	F 607	Person responsible for plan of correction is Director of Nursing.	

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F 607	Continued From page 3	F 607		

added. R2 was not to have food or liquids while in bed. R2 had a history of spilling her food and liquids frequently while eating. Review of R2's undated nursing assistant (NA) care sheet identified R2 was to have cups with handles. R2 was not to eat in bed and had to be in her wheelchair (WC) in an upright position for all meals.

Observation on 5/26/20 at 9:24 a.m., identified R2 shared a room with another female resident. R2 was observed in her WC watching television seated in front of a bed table with two Styrofoam cups with lids and straws. R2's room was located at the end of a hallway and when observed staff were not present. Additional observation at 12:00 p.m., R2 was eating lunch in the dining room with a two handled covered adaptable cup with hot tea and built up silverware with a divided plate to assist her to eat independently.

Interview on 5/26/20 at 10:00 a.m., with NA-C identified at meal time room trays are distributed by NA's. Staff were to have the resident out of bed and in a chair or their WC with a table in front of them. The NA's will then call down to the kitchen to set up the meal trays for staff to deliver to resident room. NA-C identified our process is to get four people up and served at a time. NA-C identified if there is an incident or accident they are to stay with the person and call for help. The nurse would be called into the room to assess the resident. Nursing is responsible for completing a report and contacting the doctor and family.

Interview on 5/26/20 at 10:40 a.m., with registered nurse (RN)-A identified to be the charge nurse on the afternoon of 5/20/20. She had been called into R2's room around 3:00 p.m.,

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F 607	Continued From page 4	F 607		

found R2 in bed with HOB elevated and her top was wet from spilled coffee. RN-A identified R2's top was removed and the skin assessed. R2's skin on the upper half of body was intact with no redness or signs of trauma. At the time of the skin assessment staff had went to change R2's brief and a burn to the right hip and thigh area was identified. The hot liquid had pooled in the brief causing reddened areas and a blister. The blister was intact at that time and the area was left open to air. R2 was then kept off of her right side to avoid pressure to the area. RN-A identified she had been called into the room within minutes of the incident. RN-A identified NA-A reported R2 requested to stay in bed for her coffee and snacks. NA-A had elevated R2's head of bed and gave her a cup of coffee in a Styrofoam cup that did not contain a lid. NA-A left the room to finish passing snack cart and within 5 minutes heard the call for help. NA-A communicated to RN-A she had went back into room and discovered the spilled coffee. The physician was contacted as well as R2's son. RN-A identified R2 does have periods of forgetfulness, but was able to identify she had spilled the coffee on herself.

Interview on 5/26/20 at 10:58 a.m., with dietary manager (DM)-D identified the care plan will list adaptive equipment for the resident. If there is not a care plan for adaptive equipment then the resident would receive liquids in a heavy weight disposable cup with a lid. The snack cart is set up by dietary and will have the adaptive equipment placed on the cart. The cart will also have the heavy weight disposable cups for those residents who do not require adaptive equipment. The NA assigned to pass the snack cart is responsible for knowing the care plan and what

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F 607	Continued From page 5	F 607		

adaptive equipment a resident is to use. The DM-D identified she was not aware of the incident until she read the progress notes and then spoke to the charge nurse.

Observation on 5/26/20 at 12:17 p.m., with NA-B and NA-C of R2's right hip and thigh area revealed an open area approximately the size of a 50 cent piece where a blister had opened. A scant amount of yellow drainage had been noted on her brief. Approximately 1 to 2 inches below that area were 2 small intact reddened areas.

Interview on 5/26/20 at 2:06 p.m., with NA-A identified on 5/20/20, she had passed snack chart that afternoon. R2 was still in bed at snack time and requested her snack and hot beverage while in bed. NA-A identified she elevated head of bed, then gave her a hot beverage in a Styrofoam cup with no lid. NA-A then left the room to go to the next room and within minutes heard R2's roommate yell for assistance. NA re-entered room to discover R2's shirt was wet. She then got a towel that was in the room and placed it between the wet shirt and resident's skin. She then identified she left the room to get the charge nurse to come and assess her. No redness was noted on the upper part of R2's body but when they went to change the bedding the redness of the hip was discovered. NA-A identified the area was just really red and at that time there were no blisters or bubbles. NA-A identified there had not been an adaptive cup on the snack cart that day. NA-A confirmed instead of taking the time to go back into the kitchen to get the adaptive cup she used what was available on the cart, disregarding R2's care plan.

Interview on 5/26/20 at 2:21 p.m., with

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F 607	Continued From page 6	F 607		

administrative assistant (AA)-B identified it was her responsibility to update the NA care sheets. AA-B identified R2's care plan had been updated on 5/20/20. AA-B identified R2 is not new to the facility and prior to the 5/20/20 update the care plan had identified R2 was to have an adaptive cup with handles and lid. The care plan also had identified R2 needed to be out of bed related to history of spilling food. The expectation would be staff caring for the resident needed to know what is on care plan. NA's are to be carrying "care sheets" with them and be able to pull out of their pocket to review when in question.

Interview on 5/26/20 at 4:00 p.m., with director of nursing (DON) who identified at the beginning of each shift NA's are expected to obtain a care plan sheet for the area they are working. Her expectation for staff would have been to have read and understood care plan. She would expect staff to make sure they have the adaptive equipment needed for the resident and if not, residents were not to be given substitutes that may cause harm. The DON identified NA-A had been verbally counseled after incident on 5/20/20 by charge nurse. She also followed up with NA-A that day and provided some feedback on the same information the charge nurse had provided to her. DON identified that NA-A understood the policy and procedures. DON identified that everyday at 2:00 p.m. we have a conversation with the day and afternoon shift to follow up on any changes and incidents that may have happened. DON identified she will be having staff training on 5/27/20 to re-educate all staff. She was unable to provide written documentation on the re-education provided to NA-A.

Interview on 5/26/20 at 4:15 p.m., with

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F 607	Continued From page 7 Administrator identified he was aware of the incident and did not have any addition information to add. Review of the 9/2019, Vulnerable Adult Abuse Prevention Plan, identified the residents have a right to be free from neglect. Neglect was defined as a failure of the facility and it's employee's to provide services that are necessary to avoid physical harm.	F 607		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 15, 2020

Administrator
Avera Sunrise Manor
240 Willow Street
Tyler, MN 56178

Re: Event ID: XG5P11

Dear Administrator:

The above facility survey was completed on May 26, 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,

Kamala Fiske-Downing

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

Minnesota Department of Health

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	00338	A. BUILDING: _____ B. WING _____	C 05/26/2020

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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 5/26/20, 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 complaint found to be SUBSTANTIATED: H5357008C, however NO	2 000		

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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 applicable licensing orders were issued. 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		