STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245597	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Care Center	16561 US Highway 10 Lake Park, MN 56554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to obtain informed consent and provide education to the resident or resident representative on the risks and benefits regarding the use of opioid medication for 1 of 5 residents (R22) reviewed for unnecessary medications. Findings include: Review of R22's quarterly Minimum Data Set (MDS) dated [DATE], identified R22 had intact cognition and had diagnosis which included anemia (A condition in which the body does not have enough red blood cells), hemiparesis (a medical condition characterized by weakness on one side of the body, often affecting the arm, leg, and potentially the face), and multiple sclerosis (MS) (A chronic autoimmune disease that affects the central nervous system brain and spinal cord). Identified R22 had pain and was on a pain regimen. R22's significant change Care Area Assessment (CAA) dated 3/26/25, identified R22 reported pain as always present. Identified R22's pain made it difficult for R22 to sleep and that pain medication was available. R22's care plan revised 4/5/25, identified R22 had pain related to MS and received pain medication. Care plan directed staff to administer medications as ordered and monitor and document side effects. R22's Order Summary Report dated 5/19/25, identified orders for the opioid medication Oxycodone 5 milligrams (mg) every four hours as needed for pain with a start date of 5/16/25. R22's medication administration record (MAR) identified R22 received Oxycodone 5 mg two times on 5/16/25, and two times on 5/17/25. R22's medical record lacked evidence of education to R22 or R22's representative regarding the risks and benefits of the opioid medication. During an interview on 6/9/25 at 1:30 p.m., R22 stated she has used oxycodone a few times in the past month. R22 stated she did not recall anyone talking with her regarding the risks and the benefits of oxycodone use. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/25 at 10:33 a.m., registered nurse (RN)-A verified R22 had a new order for oxycodone since 5/16/25, and R22 had received four dosed of the opioid medication in the past month. RN-A confirmed education regarding risk and benefits regarding the opioid medication had not been done with R22 or her representative. RN-A stated the current process is to only provide education regarding risk versus benefits with psychotropic medication use. During an interview on 6/10/25 at 10:43 a.m., acting director of nursing (DON) stated she did not think anyone had completed education with R22 regarding the benefits and risk of the opioid medication. DON stated her expectation was that education regarding the risks and benefits of the opioid medication should have been completed with R22 prior to starting the opioid medication. During an interview on 6/10/25 at 11:39 a.m., pharmacist consultant (PC) stated it was important to educate residents regarding the risks and benefits of using an opioid medication. CP stated her expectation was the facility would have provided R22 with education regarding the risks and benefits of the opioid prior to starting the opioid medication. Review of a facility policy titled High Risk Medication revised 2/19/25, identified the facility recognized some medications were associated with greater risk of adverse consequences than other medications. Identified high risk medications could include: antidiabetic's, psychotropics, cardiac medications, opioids, diuretics and antibiotics. Identified residents and/ or representatives would have been educated on the use and risks/benefits of high risk medications including, adverse effects.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess the use of a restrictive device as a potential restraint for 1 of 1 resident (R22) reviewed for restraints. Findings include: Review of R22's quarterly Minimum Data Set (MDS) dated [DATE], identified R22 had intact cognition and had diagnosis which included anemia (A condition in which the body does not have enough red blood cells), hemiparesis (a medical condition characterized by weakness on one side of the body, often affecting the arm, leg, and potentially the face), and multiple sclerosis (MS) (A chronic autoimmune disease that affects the central nervous system (brain and spinal cord). Indicated R22 required extensive assistance for activities of daily living (ADL's) which included bed mobility, transfers, and toileting. Identified R22 had not had any falls since the last assessment and required a wheelchair for mobility. Indicated R22 did not use any restraints. Review of R22's significant change Care Area Assessment (CAA) dated 11/15/24, identified R22 had intact cognition, was a high risk for falls related to medication use. CAA identified R22 did not use any restraints. Review of R22's quarterly fall assessment dated [DATE], identified R22 was at high risk for falls related to history of falls and current diagnosis. Review of R22's current physician orders signed 5/19/25, did not identify an order for a restraint. R22's medical record lacked any evidence a restraint assessment had been completed. Review of R22's care plan revised 6/1/25, identified R22 had a self care deficit related to hemiparesis of the left side. Identified R22 required staff assistance and a non mechanical lift for transfers. Identified R22 required a wheelchair for mobility. Care plan lacked any evidence of a seat belt being used in R22's wheelchair. During an observation on 6/9/25 at 11:35 a.m., R22 was seated in a motorized wheelchair in her room with a seatbelt fastened around her waist. During an interview on 6/9/25 at 11:40 a.m., R22 stated she was not able to remove the seatbelt from her waist. R22 stated she was only able to use her right hand to operate her motorized wheelchair but was not strong enough to remove the seatbelt. R22 stated the seatbelt did make it difficult to move while in the wheelchair. R22 further stated staff told her the seatbelt was for her safety so she did not fall out of the wheelchair. During an observation on 6/9/25 at 5:30 p.m., R22 was seated in a motorized wheelchair in the dining room with a seatbelt fastened around her waist. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/10/25 at 8:05 a.m., R22 was seated in a motorized wheelchair in her room with a seatbelt fastened around her waist. During an interview on 6/10/25 at 8:10 a.m., nursing assistant (NA)-B stated R22 had the seatbelt in her motorized wheelchair fastened around her waist for a while. NA-B stated staff removed the seatbelt from R22's waist for her since R22 was not able to remove it herself. NA-B further stated she was told R22 needed the seatbelt around her waist to keep R22 from sliding out of the motorized wheelchair. During an interview on 6/10/25 at 8:15 a.m., licensed practical nurse (LPN)-B verified R22 was seated in her room in a motorized wheelchair with a seatbelt fastened around her waist. LPN-B stated the seatbelt was to prevent R22 from falling out of the wheelchair. LPN-B confirmed R22 was unable to remove the seatbelt. During an observation on 6/10/25 at 8:20 a.m., licensed practical nurse (LPN)-B asked R22 to remove the seatbelt from her waist. R22 used her right hand and attempted to remove the seatbelt and stated she was not able to remove the seatbelt. During an interview on 6/10/25 at 10:49 a.m., registered nurse (RN)-A stated she was aware that R22 used a seatbelt around her waist while in her motorized wheelchair to prevent R22 from sliding out of the wheelchair. RN-A stated she was aware R22 was not able to remove the seatbelt but did not consider the seatbelt a potential restraint since R22 was able to ask staff to remove the seatbelt. During an interview on 6/10/25 at 10:57 a.m., acting director of nursing (DON) stated she just noticed the seatbelt fastened around R22 waist in her wheelchair yesterday and prior to that she was not aware that R22 used a seatbelt around her waist while in the motorized wheelchair. DON stated the seatbelt would be considered a potential restraint since R22 was not able to remove the seatbelt and it restricted her movement. DON stated her expectation was that staff would have assessed the seatbelt to determine if it was being used as a restraint. Review of a facility policy titled Restraint Free Environment revised 2/19/25, identified a physical restraint referred to any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Physical restraints may include, but were not limited to: using devices in conjunction with a chair, such as trays, tables, cushions, or belts that the resident could not remove and prevented the resident from rising.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) correctly for 1 of 1 residents (R12) reviewed for resident assessment. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2023, identified Section J 1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.) Code 1, yes: if the resident has fallen since the last assessment. Continue to Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) item (J1900), whichever is more recent. J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent code the number of falls since last assessment and if there were any injuries. R12's quarterly Minimum Data Set (MDS) dated [DATE], Section J1800 identified R12 had a fall since last assessment. Section J1900 identified R12 had one fall without an injury since last assessment. Review of R12's falls progress notes from 12/30/24 to 2/18/25, revealed the following: -on 12/30/24 at 4:20 p.m., R12 had an unwitnessed fall with no injuries. -on 2/18/25 at 8:30 p.m., R12 had an unwitnessed fall with no injuries. During an interview on 6/10/25 at 9:45 a.m., acting director of nursing (DON) verified R12 had two falls between 12/30/24 and 2/18/25. DON stated her expectation was that the MDS should have been coded accurately. Review of a facility policy titled MDS 3.0 Completion revised 2/19/25, identified residents were assessed, used a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Indicated persons completing part of the assessment must attest to the accuracy of the section they completed by signature.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** R3 R3's significant change of status MDS dated [DATE], identified R3 was cognitively intact and had diagnoses which included: heart failure, arthritis and chronic obstructive pulmonary disease (lung condition that restricts breathing). Identified R3 used a walker for mobility and required supervision or touching assistance for dressing, transfers and walking. R3's activity of daily living (ADL) Function/Rehabilitation Potential CAA dated 5/22/25, identified R3 required assistance in ADLs, had impaired balance and transition during transfers and functional impairment in activity. R3's contributing factors included generalized weakness and decreased safety awareness. R3's Skilled Nursing Facility (SNF) Morse Fall Scale assessment dated [DATE], identified R3 had a history of falling, and had a score of 65, which indicated R3 was at high risk for falls. R3's comprehensive care plan revised 5/15/25, identified R3 had an ADL self-care performance deficit related to muscle weakness, and required maximum assistance with bathing, and supervision touching assistance with tub/shower transfer. R3's care plan also identified R3 was at risk for falls related to past history of falls. During an observation on 6/10/25 at 2:17 p.m., NA-A and R3 left the tub room. R3 was seated on her four wheeled walker dressed in a gown and housecoat. NA-A pushed R3 down the hall backward while R3 sat on the four wheeled walker seat, then they entered R3's room. During an interview on 6/10/25 at 2:33 p.m., NA-A stated she had given R3 a shower then transported R3 to her room. NA-A indicated R3 sometimes got overheated after her shower and needed help getting back to her room. NA-A stated she had R3 sit on the walker seat, then pushed her backwards down the hall to her room. NA-A stated this was her usual practice, and had done this for years. At 2:37 p.m. NA-A and surveyor knocked then entered R3's room and looked at R3's walker. On the rear left leg of the walker was a warning sticker that indicated this is a walking aide only. Do not use as transportation device. NA-A indicated she was unaware that walkers were not to be used to transport residents. During an interview on 6/10/25 at 10:00am., acting (DON) stated R12 had falls in the facility and was at high risk for further falls. DON stated one of R12's fall interventions was to have the wheelchair within reach of R12. DON stated her expectation was staff would have followed care planned interventions to prevent falls. During a follow-up interview on 6/10/25 at 2:53 p.m., DON stated the four wheeled walkers were not to be used to transport residents because of a tipping hazard. DON indicated she would expect staff to obtain a wheelchair to transport a resident if they were unable to walk with their walker. DON also indicated in the past R3 had transported herself while sitting on the seat of the walker, and had been educated on proper use of the walker. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Fall Prevention Program revised 2/19/25 identified, each resident would be assessed for fall risk and receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Identified the nurse would initiate interventions on the resident's care plan in accordance to the resident's level of risk. The facility policy titled Safe Resident Handling/Transfers revised 2/19/25, identified the facility ensured that residents were handled and transferred safety to prevent or minimize risks for injury and provide and promote a safe and secure and comfortable experience. The policy identified the interdisciplinary team or designee would evaluate and assess each resident's individual needs, on admission and reviewed quarterly, after a significant change in condition or based on direct care staff observations or recommendations. Based on observation, interview and document review, the facility failed to implement interventions for 1 of 1 residents (R12) who had several falls in the facility and remained at high risk for falls. Further, the facility failed to ensure safe transportation of a resident (R3) who was at risk for falls. Findings include: R12's significant change Minimum Data Set (MDS) dated [DATE], identified R12 had severe cognitive impairment and diagnosis which included cancer, hypertension (elevated blood pressure) and dementia. Identified R12 required extensive assistance with activities of daily living (ADLs), which included: bed mobility, transfers, and toileting. R12's significant change Care Area Assessment (CAA) dated 3/26/25, identified R12 was at risk for falls related to previous falls, cognitive and visual impairment. R12's care plan revised 12/30/24, identified R12 was high risk for falls related to confusion, gait/balance problems and lack of safety awareness. Identified R1 required maximum assistance of 1 to 2 staff to move between surfaces. Identified various interventions for falls which included: ensure wearing non skid socks at night, call light within reach and walker within reach at all times. Review of R12's fall assessment dated [DATE], identified R12 had an impaired gait, weakness, and required a walker. Identified R12 was at high risk for falls. Review of R12's falls progress notes from 12/30/24 to 5/31/25, revealed the following: -on 12/30/24 at 4:20 p.m., R12 had an unwitnessed fall and was found in his room lying on the floor in front of the recliner. No injuries noted, R12 was unable to say what happened. Root cause: R12 was attempting to self transfer. Intervention added to the care plan: ensure walker was within reach. -on 2/18/25 at 8:30 p.m., R12 had an unwitnessed fall and was found lying on the floor in his room with regular socks on his feet with soft touch call light on. No injuries noted, R12 was unable to say what happened. Root cause -self transferring. Intervention: wear non skid socks at night. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-on 4/23/25 at 5:00 p.m., staff heard R12's wife yell for help and found R12 on the floor in his room next to the bed, no injuries noted. Root cause wife was attempting to transfer R12 out of his recliner when R12 lost his balance. Intervention: wife to not transfer R12. -on 5/31/25 at 5:13 p.m., staff was walking with R12 when wife started walking with R12 and R12 fell landing on his wife, no injuries to R12 or wife. Root cause: R12 lost balance as wife began walking with R12. Intervention: Remind wife to not walk with R12. During an observation on 6/9/25 at 1:48 p.m., R12 was seated in his recliner in his room, walker was turned around and pushed up against the wall approximately five feet from R12. During an observation on 6/9/25 at 2:58 pm., R12 was seated in his recliner in his room, walker continued to be turned around and pushed up against the wall approximately five feet from R12. During an observation on 6/10/25 at 9:34 a.m., R12 was seated in his recliner in his room, walker was turned around and pushed up against the bed approximately six feet from R12. Nursing assistant (NA)-B and registered nurse (RN) acting director of nursing (DON) verified R12's wheelchair was pushed up against the bed approximately six feet from R12. During an interview on 6/10/25 at 9:38 NA-B stated R12 required staff assistance for transfers. NA-B stated R12 had previous falls and was at risk for further falls. NA-B stated R12's walker should have been within reach of R12.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess and attempt alternatives prior to use of bed rails for 2 of 2 residents (R5, R26) reviewed who were observed to have bed rails. Findings include: R5's quarterly Minimum Data Set (MDS) dated [DATE], identified R5 was cognitively intact and had diagnoses which included: heart failure, arthritis, and dementia. R5's MDS identified R5 was independent with dressing, hygiene, rolling left to right, transfers and walking, and required substantial/maximal assistance with putting on/taking off footwear. R5's care plan revised 6/5/25, identified R5 had an activities of daily living (ADL) self-care performance deficit related to pain and forgetfulness. R5 had the ability to roll from lying on back to left and right side and return to lying on back on the bed independently. R5 was independent lying to sitting on side of bed and transfers. R5's care plan lacked identification of a grab bar on R5's bed. R5's Bed Rail Consent form dated 3/7/25, identified R5 had a grab bar on bed to aid in positioning. The form included potential benefits and risks of bed rail use. R5's medical record lacked a comprehensive assessment of R5's bed rail including: appropriate use of bed rail, measurements to assure safety and attempted alternatives prior to the use of the bed rail. During an observation on 6/9/25 at 12:43 p.m., R5 had a double sized standard bed with a black grab bar on the right side of bed, measuring approximately 1.5 feet tall and 1 foot wide. The grab bar sat approximately two inches from the mattress, then went under the mattress. R5 indicated her daughter had brought the rail in to be used, and was not aware if any staff member had assessed it. During an observation on 6/10/25 at 10:35 a.m., R5 was dressed in street clothes sitting at her computer in her room. R5's bed continued to have a grab bar attached to bed. During an interview on 6/11/25 at 9:26 a.m., nursing assistant (NA)-A indicated R5 was independent with most cares however, required assistance with her compression stockings. NA-A stated R5 had her own personal bed, and had witnessed R5 use the grab bar a few times, to help her swing her body up and out of bed. During an interview on 6/11/25 at 10:40 a.m., licensed practical nurse (LPN)-A stated R5 was mostly independent, however, staff assisted her to put her socks on. LPN-A confirmed R5 had a grab bar on her bed, and had witnessed R5 use it to get in and out of bed. LPN-A stated their usual practice was to obtain a consent form when bed rails were used, then review them annually. LPN-A indicated R5's family had brought the grab bar to the facility. LPN-A was not aware if R5 had tried anything prior to having the grab bar installed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 10:44 a.m., R5 indicated she used the grab bar when getting out of bed. R5 stated she would be able to get out of the bed without it however, it was handy. R5 stated her family member attached it to her bed. R26's quarterly MDS dated [DATE], identified R26 was cognitively intact and had diagnoses which included: asthma, anxiety disorder and Guillain barre syndrome (a rare neurological disorder where the immune system attacks the peripheral nervous system, causing muscle weakness and sometimes paralysis). Identified R26 was independent with dressing, hygiene, transfers and walking, and required substantial/maximal assistance with rolling side to side. R26's care plan revised 2/20/25, identified R26 had an activities of daily living (ADL) self-care performance deficit related to Guillain barre syndrome. R26 required partial/moderate assistance of one staff in bed to turn and reposition as necessary. At times of increased pain or weakness the resident need extensive assistance of one. R26's care plan lacked identification of a grab bar on R26's bed. R26's Bed Rail Consent form dated 2/5/25, identified R 26 had a grab bar on bed to aid in positioning. The form included potential benefits and risks of bed rail use. R26's medical record lacked a comprehensive assessment of R26's bed rail including: appropriate use of bed rail, measurements to assure safety and attempted alternatives prior to the use of the bed rail. During an observation on 6/9/25 at 1:40 p.m., R26 had a double sized standard bed with a black grab bar on the right side of bed, measuring approximately 1.5 feet tall and 1 foot wide. The grab bar sat approximately two inches from the mattress, then went under the mattress. R26 indicated her bed had the grab bar on it when she came to the facility and was not aware if any staff member had assessed it. R26 stated she used the grab bar to turn herself in bed and to transfer out of the bed. During an observation on 6/11/25 at 7:29 a.m., R26 was lying in bed and used the grab bar to stand up and transfer independently into her wheelchair. R26 stated she liked having the grab bar to use when getting out of bed. During an interview on 6/10/25 at 7:45 a.m., NA-B stated R26 was pretty independent with her mobility during the day. NA-B stated she had observed R26 use the grab bar on her bed to roll herself in bed and to transfer out of bed. During an interview on 6/11/25 at 08:10 a.m., LPN-B stated R26 was mostly independent, but staff assisted her during the night. LPN-B confirmed R26 had a grab bar on her bed, and had witnessed R26 use it to get in and out of bed. LPN-B stated their usual practice was to obtain a consent form when bed rails were used, then review them annually. LPN-B was not aware if R26 had tried anything prior to having the grab bar installed. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 10:57 a.m., acting director of nursing (DON) stated the facility's usual process was to obtain consents prior to using grab bars (bed rails) on resident's beds. DON stated some of the residents had their own beds, and had grab bars on them. DON confirmed the facility had not completed assessments of grab bars. DON confirmed they did not have the manufacturer's instructions for R5 and R26's grab bars. DON indicated it was important to do an assessment of grab bars because they could be a restraint, and to ensure resident safety. Review of the facility policy titled Proper Use Of Bed Rails, revised 2/9/25, identified the facility utilized a person-centered approach when determining the use of bed rails. Appropriate alternative approaches were attempted prior to installing or using bed rails. If bed rails were used, the facility ensured correct installation, use, and maintenance of the rails. The policy identified examples of bed rails included, but was not limited to side rails, bed side rails, safety rails, grab bars and assist bars. As part of the resident's comprehensive assessment, staff were to determine whether or not the use of bed rails met those needs. The evaluation must include an evaluation of the alternatives that were attempted prior the installation or use of bed rails and how those alternatives failed to meet the resident's assessed needs. The resident assessment should assess the resident's risk of entrapment between the mattress and the bed rail or in the bed rail itself. Informed consent from the resident or resident representative must be obtained after appropriate alternatives had been attempted prior to the installation and use of bed rails. The facility would assure correct installation and maintenance of bed rails prior to use, which included: checking with the manufacture to make sure the bed rails, mattress and bed frame were compatible, and assure a proper fit. Ongoing monitoring and supervision would be completed, including documentation in the residents records, including care plan.