DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 26, 2026

Administrator
Divine Providence Community Home
700 THIRD AVENUE NORTHWEST
SLEEPY EYE, MN 56085

RE: CCN: 245599
Cycle Start Date: April 15, 2026

Dear Administrator:

On June 15, 2026, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

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Electronically delivered

April 22, 2026

Administrator
Divine Providence Community Home
700 THIRD AVENUE NORTHWEST
SLEEPY EYE, MN 56085

RE: CCN:245599
Cycle Start Date: April 15, 2026

Dear Administrator:

On April 15, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility’s Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230

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 July 15, 2026 (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 October 15, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us

Web: www.sfm.dps.mn.gov

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245599	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Providence Community Home	**700 THIRD AVENUE NORTHWEST , SLEEPY EYE, Minnesota, 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
E0000	Initial Comments On 4/13/26 through 4/15/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements 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.	E0000		04/28/2026
F0000	INITIAL COMMENTS On 4/13/26 through 4/15/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. 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.	F0000		04/28/2026
F0865 SS = F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:	F0865	Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; Maintaining documentation and demonstrating evidence of our on-going QAPI (Quality Assurance and Performance Improvement) program which will include systems and reports demonstrating systematic identification, reporting, investigation analysis, and prevention of adverse events. Goals and outcomes to be reviewed, to analyze if the facility is obtaining goals. Pharmacy concerns to be documented in the meeting minutes. Residents falls and interventions to be reviewed to ensure what has been put in place is preventing further occurrences. Evidence analysis and oversight of QAPI to be documented regarding infections,	05/13/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245599	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

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F0865 SS = F	Continued from page 1 §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.	F0865	Continued from page 1 medication errors, skin tears, bruises, elopements, admissions and discharges, and employee surveillance. The documentation of minutes will also include the development, implementation, and evaluation of corrective actions or performance improvement activities. Minutes recorded to be more detailed in explanation, and expand to all aspects needed to meet the requirements set forth by state guidelines. The facility will identify other residents having the potential to be affected by the same deficient practice by; All current residents were affected by the deficient practice. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Staff education to be provided on all areas of discussion to be added to our QA (Quality Assurance) meeting. Documentation of minutes to be more precise and detailed. QAPI plan to be reviewed and revised. Policies to be reviewed and revised as needed; Quality Assurance and Performance Improvement, Quality Assurance Committee. The facility will monitor its performance to make sure that solutions are effective by; An audit will be conducted by the administrator, or designated licensed staff member, to ensure documentation of meeting minutes include all aspects needed, provide interventions and outcomes, and is detailed, covering all addressed at quality insurance meeting. Audit will be conducted quarterly for one year. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting.	05/13/2026

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F0865 SS = F	Continued from page 2 §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility	F0865		05/13/2026

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F0865 SS = F	Continued from page 3 failed to ensure data submitted to the QAPI committee for 4 of 4 quarters submitted and reviewed, was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 47 residents. Refer to F657 and F880. Findings include: Review of the QAPI meeting minutes submitted for review identified for review of the past 4 Quarters of QAPI meeting minutes identified review of each quarter is as follows: Quarter 1 (April 2025): Attendees included the medical director, DON, RN staff development coordinator (RN-A), the pharmacist, dietary manager, facility director, vice president, maintenance supervisor, the administrator, and social services attended. Data submitted included: Falls: 4 with minor injury, none with major injury. Infections: 18. 15 were urinary tract infections (UTI), and 3 were skin. Medication errors: 3 Elopements: 0 Skin tears: 3 Bruises: 12 Abrasions/scrapes/lacerations: 1 Admissions 13 Discharges: 12. 8 residents went home and 4 were deaths. Social services: to review VA reports Ethics committee was to review any ethical concerns Pharmacy was to review pharmacy/trends or concerns Performance Improvement projects were to be discussed.	F0865		05/13/2026

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F0865 SS = F	Continued from page 4 Social services documented 5 VA reports submitted to MDH and law enforcement. 2 residents had missing money. Residents were encouraged to use a lock drawer. There was no evidence of what was investigated, if the investigations were completed timely, or all staff/residents pertinent had been interviewed. 1 residents' money was found but details were not included. 2 residents were noted to have slapped one another. 1 resident's (unknown) care plan was updated, and medication was reviewed. A 2nd resident identified an (unknown) male resident touched a female resident (unknown) over their clothes inappropriately. QAPI documented there was a medication review to prevent similar incidents, and the resident was discharged to another facility. Neither resident was reported to be affected emotionally or physically. There was no indication QAPI reviewed if all the elements had been investigated thoroughly or if other residents with similar behaviors were reviewed. Bowel incontinence and medication error reductions were the PIP projects reviewed during that meeting. Analysis was occurring on PIP projects. The DON reviewed fall and infection statistics. QAPI noted the IDT team would continue to review falls weekly and interventions, however there was no indication of a comprehensive review by QAPI occurred of any benchmarks, goals or analysis of IDT data. There was also no indication employee surveillance was being reviewed or discussed. Survey results and updated policies were noted to have been reviewed and shared with the medical director. There was no indication what policies were reviewed, who reviewed the policies, or if the QAPI committee as a whole ensured those policies were appropriate and based on current standards of practice. The Pharmacist was noted to not have any trends to review at that time, however, there was no evidence the 3 medication errors noted above were discussed to identify what the benchmarks and goals were, if there were commonalities with the errors, or if they were significant to resident health. Although dietary, maintenance, and the RN staff development coordinator had attended, there was no	F0865		05/13/2026

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F0865 SS = F	Continued from page 5 indication that those departments nor others such as activities had data brought forth for review and analysis, to ensure all areas affecting patient care were being monitored. Quarter 2 (July 2025): Attendees included the medical director, DON, RN staff development coordinator (RN-A), the pharmacist, facility director, the administrator, the vice president, and social services attended. Those areas included: Social services documented no VA reported were submitted. Administration discusses PIP projects which included benchmarks, goals and analysis. Falls were again submitted by the DON. There were 46 falls (8 minor injuries and no major injuries were noted). The IDT once again was to continue to review falls weekly and discuss strategies at that time. There was no evidence QAPI had ensured a comprehensive review of each resident's fall had occurred, what the benchmarks and goals were, or that analysis of IDT team findings and interventions had occurred. There was also no evidence QAPI had discussed or recognized the dramatic spike from the previous quarter as an area of high concern. Resident infection data was documented as reviewed. There were 18 total infections, with 9being UTI, 3 skin infections, and 6 respiratory infections. Staff were encouraged to utilize McGeer's criteria and follow antibiotic stewardship, however no benchmarks or goals were discussed, and no analysis of data was documented to have occurred to identify trends, or if tracking was occurring appropriately, if transmission-based precautions were needed or implemented timely etc. There was also no employee surveillance reviewed. Skin tears, bruises medication errors, elopements and discharges were documented as reviewed, however there was no documentation to support QAPI had provided appropriate oversight and monitoring. Pharmacy had no trends to review at that time, however, there were concerns brought forth of no open or expiration dates on insulin, expired medications, and missing signatures were noted in the narcotic book in her review. There was no indication QAPI had discussed these events reported to determine what were the underlying causes or had recommended actions to correct deficient practice.	F0865		05/13/2026

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F0865 SS = F	Continued from page 6 Quarter 3 (October 2025): Attendees included the medical director, DON, RN staff development coordinator (RN-A), the pharmacist, facility director, the vice president, the administrator and social services attended. Those areas included: Social services documented 2 VA reports were submitted, 1 for an unwitnessed fall resulting in fracture, and another involving transferring a resident with an EZ stand. In that instance, QAPI documented the resident's (unknown) knees gave out resulting in bruising. No fracture was noted, and it was reported that resident was switched to a total body lift to prevent similar incidents. There was no indication QAPI had reviewed data surrounding the incidents to ensure appropriate monitoring occurred. Administration discusses PIP projects which included benchmarks, goals and analysis. Falls were again submitted by the DON. There were 20 falls (5 with minor injuries and 1 with major injuries). The IDT once again was reported to be reviewing falls weekly. There was no evidence QAPI had ensured a comprehensive review of each resident's fall had occurred, what the benchmarks and goals were, or that analysis of IDT team findings and interventions had occurred. Resident infection data was reviewed. 13 in total with 7 UTI, 4 were skin, and 2 respiratory. Again, McGeer's and antibiotic stewardship were encouraged, however there remained no evidence analysis or oversight by QAPI was occurring. Skin tears, bruises medication errors, elopements and discharges were documented as reviewed, however there was no documentation to support QAPI had provided appropriate oversight and monitoring. There were no concerns brought forth from pharmacy, however in the medication room review document submitted from pharmacy, there was a notation a cart was observed unlocked, the last shift of controlled drug count with dual signatures was on 8/11/25. This was not discussed or brought forth by pharmacy as a concern staff were not reconciling controlled meds appropriately. Open dates were still noted to be a continued concern. Quarter 4 (January 2026): Attendees included the medical director, director of nursing (DON), social services, the administrator, the Minimum Data Set (MDS) nurse, and pharmacist. No other departments	F0865		05/13/2026

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F0865 SS = F	Continued from page 7 were noted to have attended. Topics discussed were: UTI (urinary tract infections) (PIP): started on 7/1/25, which was noted to be in the implementation phase, whose purpose was to reduce UTI. Measures were Q1 9 UTI. Status was listed as increased testing. Changes initiated for actions identified were staff education, to improve resident hydration, add cranberry supplements, and ensure staff perform a "clean catch" (urinary collection to ensure no contamination occurred giving false results). A root cause analysis was completed, barrier identified, and specific education noted. Estimated completion dates were given. Other members weighed in such as pharmacist and infection preventionist, etc. Walking (PIP): a thorough analysis was completed and was similar to the above UTI section. VA (vulnerable adult) reports: staff noted they had no submissions for the previous quarter. Falls were notes as discussed. 38 for last quarter (9 with minor injuries and 0 major injuries). The interdisciplinary team (IDT) was noted to review falls weekly and discussed interventions and strategies. However, in the QAPI review, no residents were specifically discussed to ensure IDT was doing analysis of data behind falls. It was also not clear if this is a continued concern, th numbers were better or worse, what goals were, or if there was any analysis of data by QAPI to ensure IDT was reviewing their data appropriately. Resident infections were discussed in numbers but no there was no data documented as being reviewed, there were no benchmarks or goals, and no analysis identified. There was also no mention employee surveillance having been discussed. 6. Medication errors were noted as reviewed. 4 errors occurred. There was no documentation to support what the errors were, what the facility's benchmarks and goals were, or analysis of data. The QAPI committee notes documented "There were no pharmacy trends to review at this time". There was no evidence to suggest the facility addressed and included all systems of care, such as dietary or maintenance, actual and/or potential staffing issues, or that other areas that would impact resident care were reviewed. There was also no evidence of a thorough review of data if the area was not part of a performance improvement project	F0865		05/13/2026

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F0865 SS = F	Continued from page 8 (PIP). Interview and document review on 4/15/26 at 3:45 p.m., with the administrator identified she was in charge of PIP and the director of nursing (DON) was in charge of the rest of discussion and documentation of QAPI. The administrator noted that whatever the DON documented in the QAPI meeting minutes “was all they had”. In review of the QAPI minutes provided, it was discussed with the administrator there was no evidence of oversight of analysis evident as only data brought forward with a brief overview of areas that weren’t a PIP project. The administrator agreed there was a need for all data to have benchmarks, goals, actions, interventions and analysis of how well the plans worked and to ensure oversight was provided. The administrator agreed the QAPI committee needed more information to show those topics discussed were monitored appropriately to identify compliance or the need for further monitoring. Survey findings were discussed, specifically that one resident (R4) who was reviewed for falls failed to have their care plan revised after new interventions were identified to be implemented and would have been identified had the QAPI committee reviewed specifics around IDT review for falls and appropriate oversight would have occurred. The administrator agreed with that discussion and understood need for documenting the oversight. Review of the February 2026, Quality Assurance/Assessment and Performance Improvement Plan identified QAPI would make quality improvement decisions based on data analysis with input from residents, families, staff and the community. QAPI was to set goals for performance and measures progress toward those goals. The committee was to include representatives from all departments including nursing, food and nutrition, laundry, housekeeping, maintenance, health information technology, therapeutic recreation, therapy, business office and administration.	F0865		05/13/2026
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of	F0880	Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; Evaluation and revision of our current process of employee surveillance based on national standards and identify specific criteria used to determine staff return to work date. The facility will identify other residents having the potential to be affected by the same deficient	05/13/2026

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F0880 SS = F	Continued from page 9 communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880	Continued from page 9 practice by; All current residents were affected by the deficient practice. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Staff education to be provided on the completed staff surveillance process, documentation needed and determining return to work (RTW) criteria. Staff who call in due to illness will notify the charge nurse per policy. Depending on the illness, a pop-up box will appear in the staff attendance record notifying the charge nurse of the criteria to RTW to relay to staff member. Administrator and DON receive internal messages of staff illness and call-ins, and will monitor that staff are aware of RTW date, and is adhered to. Policies to be reviewed and revised as needed; Staff with Signs and Symptoms of Infectious Disease. Policy to be created; Staff Surveillance The facility will monitor its performance to make sure that solutions are effective by; An audit will be conducted by the administrator, or designated licensed staff member, to ensure proper documentation of staff surveillance, including appropriate RTW date and criteria. Audit will be conducted one time per week for one month, every other week for two months, monthly for two months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting.	05/13/2026

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F0880 SS = F	Continued from page 10 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to have a system for employee surveillance based on national standards or identify specific criteria used in determining staff return to work (RTW) for 3 of 5 sampled staff (nurse aide (NA)-A, NA-B, and trained medication aide (TMA)-A). Findings include: Interview, employee surveillance review, and staff timecard punch review on 4/15/26 at 12:18 p.m., with registered nurse (RN)-A identified she is the interim infection preventionist (IP) while the IP was on vacation. When staff called in sick, facility process only dictated a return to work that was 3 days or longer required a physician Return to Work (RTW) note. They used no criteria to identify when staff would be able to safely RTW using national and State guidelines to ensure the safety of all residents and other staff in transmission prevention of potentially infectious disease. With the 3 sampled staff: Nurse aide (NA)-B called in ill on 2/8/26, 2/9/26, 2/13/26, 2/23/26 and 2/26/26. RN-A was allowed to return to work as soon as the next day. It was later discovered after 2/26/26 NA-B was pregnant and that was the cause of her vomiting, however it was unknown at the time of illness. NA-A called in on 3/31/26 with a sore throat and runny nose. It was not documented with a presence or absence of fever. NA-A RTW on 4/1/26. NA-A was known to call-in multiple times for illness. RN-A was unaware if NA-A had tested for COVID and was not cleared for potential respiratory infectious disease following CDC guidance of	F0880		05/13/2026

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F0880 SS = F	Continued from page 11 symptoms improving and fever free for at least 24 hours prior to RTW. Trained medication aide (TMA)-A left her shift on 4/2/26. TMA-A was seen by a physician and had a RTW clearance date of 4/6/26. The documented reason was RSV. On 4/6/26, TMA-A called in with continued symptoms of RSV. Timecards identified she had RTW on 4/7/26. There was no evidence that staff had ensured TMA-A was fever free or had improved symptoms for 24 hours before her return. RN-A stated she agreed there should be a system to vet staff prior to returning based off national guidelines and was unaware staff with unknown gastro-intestinal (GI) illness were to be kept off work for 48 hours after cessation of all symptoms per CDC and minimum 72 hours per State standards of the MDH to prevent highly potentially contagious GI illness such as Norovirus. Interview on 4/15/26 at 2:50 p.m. with the administrator identified the lack of employee surveillance was discussed. The administrator was unaware of staff needing to be vetted prior to returning to work to show national and/or state standards were followed, and employees were deemed appropriate to RTW as not to potentially expose other residents and/or staff to infectious disease. The documentation above showed no evidence of that occurring. Although she thought the DON may have screened employees prior to RTW, she agreed there was no evidence appropriate employee surveillance that had occurred. The administrator agreed with the findings and on the need to improve the surveillance and RTW vetting process and ensure documentation occurred. The administrator was unaware employee surveillance was not being discussed in QAPI. Review of the January 2026, Staff with Signs and Symptoms of Infectious Disease policy identified staff assessment protocols were to have been established in order for the facility to be notified if a staff member had symptoms of an infectious disease and must stay out of the facility. The goal was to prevent residents from contracting communicable disease and prevent an outbreak. Staff exhibiting any of the symptoms below need to call into DPCH and report the symptoms they are having. The staff member receiving the call were to document the employee’s signs and symptoms such as: Vomiting	F0880		05/13/2026

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F0880 SS = F	Continued from page 12 Diarrhea Generalized body aches Cough Runny and or stuffy nose Headaches Chills Fatigue Temperature Sore Throat Once a staff's temperature had been normal for 24 hours without taking fever reducing drugs and other symptoms were absent, the employee was allowed to return to work, depending on the infection (testing may be requested). There was no indication the policy followed national standards of practice and/ or State guidelines, depending upon the symptoms. There was also no mention of how the process was to occur or that staff who were taking the call-ins had been appropriately trained per national and state standards for vetting employees in order to safely RTW. The policy did note staff were to be trained upon hire and annually on signs and symptoms of infectious disease.	F0880		05/13/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F0605	Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; Notifying physician and consulting pharmacist of deficient practice. The following fax sent to PCP (primary care provider) for R3: FAX TO: Physician, REGARDING: Request for medication change, or symptoms/rationale to continue/no reduction AND why clinically contradicted to do so regarding the following; Drug: Sertraline HCl 50MG Tablet Dose Ordered: (1.5 tablet / 75mg) by mouth daily Breakfast, FOR: TXI:F32.A Drug: [SEROquel]QUEtiapine Fumarate 25MG Tablet Dose Ordered: (0.5 tablet / 12.5mg) by mouth daily Breakfast, FOR: TXI:F03.90, Agitation Date of order: 12/01/2025 FOR: TXI:R45.1 Please provide specific behaviors or symptoms when providing rationale to continue the above medications if not implementing GDR (gradual dose reduction), and why it would be clinically contraindicated (if not implementing GDR). The following fax sent to PCP for R8; FAX TO:	05/13/2026

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F0605 SS = D	Continued from page 13 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which	F0605	Continued from page 13 Physician, REGARDING: Request for med change, or symptoms/rationale to continue/no reduction AND why clinically contradicted to do so regarding the following; Drug: [Zoloft]Sertraline HCl 25MG Tablet Dose Ordered: (1 tablet / 25mg) by mouth daily HS, FOR: Date of order: 06/06/2023 FOR: TXI:F32.A Drug: [Lyrica]Pregabalin 75MG Capsule Dose Ordered: (1 capsule / 75mg) by mouth b.i.d. Breakfast, HS, Date of order: 06/03/2025 FOR: TXI:G90.09 Drug: [Ativan]LORazepam 0.5MG Tablet Dose Ordered: (1 tablet / 0.5mg) by mouth daily HS, FOR: Date of order: 01/29/2025 FOR:restless behavior, TXI:F03.90 TXI:F29 ; TXI:R45.1 Please provide specific behaviors or symptoms when providing rationale to continue the above medications if not implementing GDR, and why it would be clinically contraindicated (if not implementing GDR). The facility will identify other residents having the potential to be affected by the same deficient practice by; Working with consulting pharmacist to identify residents potentially affected. Consulting pharmacist found five residents that did not receive a GDR, stating to continue or no change without rationale. Consulting pharmacist re-sent recommendation with revised wording specifically asking for a GDR for the five residents found to be potentially affected. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Working with consulting pharmacist to revise wording of recommendations, and to be very precise of what documentation is needed if clinically contradicted to implement a GDR. Education to be provided to medical director and nursing staff of systemic changes made to ensure deficient practice will not reoccur. Policies to be reviewed and revised as needed; Psychotropic Medication The facility will monitor its corrective action by; Audit will be conducted per DON, or designated licensed nursing staff member, one time per month for six months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting.	05/13/2026

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F0605 SS = D	Continued from page 14 indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was attempted for 2 of 5 sampled residents' (R3 and R8) on psychotropic medications. Findings include:	F0605		05/13/2026

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F0605 SS = D	Continued from page 15 R8's 3/27/26, accepted quarterly Minimum Data Set (MDS) assessment identified R8's cognition was severely impaired. R8 had inattention that fluctuated. R8 took scheduled pain, antianxiety, and antidepressant medication. R8's diagnoses list identified unspecified psychosis, depression, restlessness and agitation. R8's physician orders identified Zoloft 25 milligrams (mg) by mouth daily in the evening for depression with a start date of 6/6/23. Review of R8's GDR information provided by the facility identified on: 12/4/23, a fax to the provider by registered nurse (RN)-C that read, "Resident was due for a 6-month review of psychotropic medications. She was currently taking Ativan, Lyrica and Zoloft. She has not had any adverse reactions to the medication. Okay to continue for another 6 months?" The medical doctor responded ON 12/5/23, "Patient is stable on above medications…will not change". 7/2/24, the medical provider notes identified an assessment and plan for cognitive decline was to continue sertraline (Zoloft). R8 had no behavior issues. Staff were to encourage participation with facility activities for increased engagement and interaction. 6/22/25, a fax to the provider by RN-C that read, "Resident was due for a 6-month review of scheduled psychotropic medications. The resident has orders for Zoloft 25 mg daily in evening. The medication is effective and well tolerated. May we have orders to continue for another 6 months? She also has Ativan 0.5 mg daily in evening. This medication is effective and well tolerated. May we have orders to continue for another 6 months?" The medical doctor responded on 2/24/25 with "yes". 3/3/26, medical provider note identified the assessment and plan for cognitive was to continue sertraline (Zoloft). R8 had no behavior issues. Staff were to encourage participation with facility activities	F0605		05/13/2026

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F0605 SS = D	Continued from page 16 for increased engagement and interaction. 12/27/25, a fax to the provider by RN-C read, “Resident was due for a 6-month review of scheduled psychotropic medications. The resident has orders for Zoloft 25 mg daily in evening. The medication is effective and well tolerated. May we have orders to continue for another 6 months? She also has Ativan 0.5 mg daily in evening. This medication is effective and well tolerated. May we have orders to continue for another 6 months?” The medical doctor responded on 2/24/25, with “yes”. R8’s pharmacy reviews for October, November, and December of 2025 and January, February, and March of 2026 had no mention of psychoactive medication review or a GDR recommendation. R8’s undated, current care plan identified R8 had the potential to feel anxious, angry, sad, confused or forgetful, and have episodes of depression. Staff were to evaluate situational stressors and re-orient R8 unless it makes her agitated. Offer her choices and relaxation techniques. Interview on 4/15/26 at 4:14 p.m., with the administrator identified she would expect the regulations would be followed and gradual dose reductions (GDR) would be attempted as required. R3’s comprehensive MDS assessment, accepted on 9/11/25 identified she was admitted to the facility in August 2025. R3 had diagnoses of depression, restlessness and agitation, unspecified dementia without behavioral or psychotic disturbance. She had moderate cognitive impairment, and her Patient Health Questionnaire-9 (PHQ-9) score was 1, indicating little to no depressive symptoms with no behaviors noted during the lookback period. R3’s last physician’s orders in September 2025, identified she received: Sertraline HCL (anti-depressant) 50 milligrams (mg), 1.5 tablets daily. Seroquel (antipsychotic) 12.5 mg in the a.m., and 25 mg in the evening.	F0605		05/13/2026

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F0605 SS = D	Continued from page 17 R3's pharmacy recommendations identified on: 9/26/25, pharmacist (RPh)-A made recommendations for lab tests. 10/27/25 and 11/24/25, RPh-A noted no problems with medications were identified. 12/11/25, review of allergy medication and cholesterol medications were reviewed and recommended to be discontinued. 1/23/26, Tylenol was recommended for a dose reduction from polypharmacy (multiple-like) medications. Seroquel 12.5 mg dose was as needed (prn) at that time and RPh-A recommended it to be discontinued as it was overdue for a 14 day face to face review. The physician was encouraged to discontinue that prn dose at that time. 2/19/26, and again on 3/19/26, RPh-A indicated no problems were identified. There was no indication RPh-A recommended a GDR attempt within her 1st 6 months of admission. R3's nursing progress notes identified on 12/1/26, staff noted R3 was due for 6 month scheduled psychotropic medication evaluation upcoming on 5/30/26 for her Seroquel. There was no indication nursing staff identified R3 should have had a GDR attempt requested within 6 months of admission. Interview on 4/11/26 at 3:22 p.m., with registered nurse (RN)-B identified nursing listed the medications for physicians when completing rounds and only asked if they would like to continue them. They made no mention to the physician if a resident was due for a GDR to be attempted. Interview on 4/15/26 at 10:15 a.m., with RPH-A identified GDR are listed in her notes as a review of medications. She does not specifically recommend GDR's. RPh-A identified she had recommended a review of medication in May 2026, as she made an	F0605		05/13/2026

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F0605 SS = D	Continued from page 18 error as she thought R3 had been admitted in January. She felt the nursing staff were to inquire about GDR's. RPh-A thought R8 had a GDR done and would check. Interview on 4/15/26 at 12:18 p.m., with RN-A identified she was under the understanding the RPH would ask about GDR in their medication reviews and was unsure if GDR's were discussed or mentioned at that time. Interview on 415/26 at 2:50 p.m., with the administrator identified she was unaware GDR were not being performed and/or documented for R3 or R8, only mediation reviews were being requested to either continue or discontinue the medication. The administrator agreed GDR must be requested and attempted as required. If the request from the physician was denied, a rational for the denial was required and must be documented. Review of the December 2022, Pharmaceutical Services, Psychotropic Drugs policy identified residents who use psychotropic drugs were to receive GDR's unless contraindicated in an effort to discontinue the drug. Review of the undated, Psychotropic Medication policy, identified a psychotropic drug review would be completed by the consulting pharmacist with a collaborated goal of reduction or discontinuation of psychotropic medication. The purpose of the gradual dose reduction was to find an optimal dose or to determine if the continued use of the medication was beneficial to the residents. Accepted standards of practice for GDR were within the first year of a resident admission on a psychotropic medication or after the start of a psychotropic medication the facility must attempt a GDR in two separate quarters with at least one month between the attempts, unless clinically contraindicated. After the first year a GDR must be attempted annually, unless clinically contraindicated.	F0605		05/13/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each	F0656	Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; Care plan for R3 to be revised to include the use of anticoagulation therapy, including potential side effects and safety measures. The facility will identify other residents having the	05/13/2026

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F0656 SS = D	Continued from page 19 resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure care plans were appropriately developed for 1 of 5 sampled residents (R3) who received anticoagulant therapy. Findings include:	F0656	Continued from page 19 potential to be affected by the same deficient practice by; Reviewing resident MARs (medication administration record) for anticoagulant therapy use. Care plan to be revised to include the use of anticoagulation therapy, including potential side effects and safety measures. Twelve residents identified having the potential to be affected by the same deficient practice. Care plan to be revised for those twelve residents, same as above. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Anticoagulation therapy and safety to be added to our person-centered care plan. Policy and procedure for anticoagulation therapy to be created. Education to be provided on added Anticoagulation therapy to care plans, and policy and procedure. The facility will monitor its performance to make sure that solutions are effective by; An audit will be conducted by DON, or designated licensed staff member, to ensure residents on anticoagulation therapy have appropriate care plan that reflects the use of anticoagulation therapy, increased risk of bleeding, monitoring, and safety measures. Audit will be conducted one time per month for six months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting.	05/13/2026

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F0656 SS = D	Continued from page 20 R3's comprehensive MDS assessment, accepted on 9/11/25 identified she was admitted to the facility in August 2025. R3 had moderate cognitive impairment, with diagnoses of heart disease, cardiovascular and coagulation treatment, atrial fibrillation (heart's inability to appropriately contract, causing potential blood clots), and a history of heart attack. R3 required staff assistance with Activities of Daily Living (ADL) such as bathing, dressing and toileting. R3 used a walker, wheelchair, and cane or crutch for mobility and had a physical impairment on one side of her body. R3's current Medication Administration Record (MAR) indicated R3 received Xarelto, 15 milligrams (mg) daily related to their diagnosis of atrial fibrillation. R3's current, undated care plan identified R3 was at risk for falls as she was weaker and was known to be more fatigued than normal and may not remember to call staff for assistance. R3 had dementia and was known to be confused. R3 had muscle weakness and unsteadiness. R3's goal was to stay safe while out or moving about, transferring, and to avoid injury. There was no mention on the care plan R3 was at increased risk of bleeding and there were no bleeding precautions noted. Interview and care plan review on 4/15/26 at 12:18 p.m., with registered nurse (RN)-A identified she agreed there were no bleeding precautions listed on the care plan to alert staff what to monitor for since R3 was on an anti-coagulant. "We probably haven't thought of that". RN-A agreed residents on anticoagulants should have increased monitoring related to increased risk of bleeding. Interview on 4/15/26 at 2:50 p.m. with the administrator identified she was unaware R3's care plan did not have any bleeding precautions. The administrator was unaware if any residents on anti-coagulants had interventions as they were at high risk for bleeding. The administrator agreed care plans needed to be developed as appropriate. Review of the current, undated Xaralto (anti-coagulant) patient safety information, located at:	F0656		05/13/2026

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F0656 SS = D	Continued from page 21 https://www.xarelto-us.com/what-is-xarelto/?utm_source=bing&utm_medium=cpc&utm_campaign=EG-DTCB-BR-NA-Xarelto-JJ-Priority/Top-Phrase-NA&utm_content=Core+Branded-TXT-National-NA-1-PH&utm_term=xarelto&gclid=8931e1615f0a13ed37da8886d53418dc&gclsrc=3p.ds&msclkid=8931e1615f0a13ed37da8886d53418dc, identified Xarelto was a blood thinner that treats and helps prevent blood clots that are related to certain conditions involving the heart and blood vessels. Anticoagulants lower your blood's ability to clot by stopping specific proteins and enzymes, also known as clotting factors, from doing their job to help blood clots form. Side effects of Xarelto included increased risk of bleeding. Patients were likely to bruise more easily, and it may take longer for bleeding to stop which can be serious and may lead to death. Patients were to notify a physician or receive medical attention if a patient developed signs or symptoms of bleeding such as: Unexpected bleeding or bleeding that lasts a long time, such as: Nosebleeds that happen often. Unusual bleeding from gums. Menstrual bleeding that is heavier than normal, or vaginal bleeding. Bleeding that is severe or you cannot control. Red, pink, or brown urine. Bright red or black stools (looks like tar). Cough up blood or blood clots. Vomit blood or your vomit looks like "coffee grounds". Headaches, feeling dizzy or weak. Pain, swelling, or new drainage at wound sites. Left upper belly (abdominal) pain, pain below the left rib cage or at the tip of your left shoulder or diffuse abdominal discomfort (these may be symptoms of the rupture of the spleen). Review of the National Library of Medicine (NLM)	F0656		05/13/2026

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F0656 SS = D	Continued from page 22 article located at: https://pmc.ncbi.nlm.nih.gov/articles/PMC12284669/, “To anti-coagulate or not to anti-coagulate—that is the question in patients with fall risks”, identified falls were associated with an increased risk of traumatic bleeding events and death. Another NLM article located at: https://pmc.ncbi.nlm.nih.gov/articles/PMC11242576/, “Traumatic Brain Injury in Patients under Anticoagulant Therapy: Review of Management in Emergency Department” identified the National Institute for Health Care Excellence (NICE) suggested considering conducting a head CT scan for people who have sustained a traumatic brain injury (TBI) [ex: hitting their head from a fall] and have no other indications for a head CT scan, except being on anticoagulant therapy. There was no policy related to anti-coagulation monitoring provided by the end of survey.	F0656		05/13/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F0657	Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; Care plan revised/updated for R4. The facility will identify other residents having the potential to be affected by the same deficient practice by; All current residents care plans to be reviewed to ensure up to date and accurate. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Staff education to be provided on importance of updating care plans. Designation/appointing one RN after IDT to document interventions and update care plan. Policies to be reviewed and revised as needed; Care Planning and Review, Fall and Post-Fall Assessment. The facility will monitor its performance to make sure that solutions are effective by; An audit will be conducted by DON, or designated licensed staff member, to ensure resident interventions are reflected on the Plan of Care. Audit will be conducted one time per month for six months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting.	05/13/2026

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F0657 SS = D	Continued from page 23 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to revise the care plan for 1 of 1 sampled resident (R4) reviewed for falls. Findings include: R4's 4/2/26, accepted admission Minimum Data Set (MDS) assessment identified R4's cognition was severely impaired. R4 required substantial assistance from staff for activities of daily living (ADL's) and was incontinent of bowel and bladder. R4 had a history of falls prior to admission, had 2 falls since admission (1 with minor injury and 1 with major injury). R4 was identified to have delirium, inattention, disorganized thinking, and altered mental status that fluctuated. R4 took scheduled pain, antipsychotic, antianxiety, antidepressant, diuretic, and opioid medication. She was also noted during the assessment period to take an antibiotic. R4 was receiving occupational and physical therapy. R4's diagnoses list identified dementia with psychotic disturbance, anxiety, cardia arrhythmia, high blood pressure, depression, osteoporosis, weakness and malnutrition. R4's fall reports identified on: 2/17/26, R4 had an unwitnessed fall in her room, and was found next to the chair. R4 was assessed and assisted in her chair and then toileted. She reported she thought she bumped her head when she tried to walk. The call light was not on at time of fall. The Corrective action/solution was to place alarm on her bed, chair, and wheelchair. 2/22/26, R4 had an unwitnessed fall in the facility living room and was found next to a recliner leaning on her right side. Her glasses were broken, and she had a laceration (cut) near her left eye. Prior to her fall R4 had been sitting on a chair near the window in the living room. At time of fall there were no staff in the area due to residents finishing up lunch and transporting residents out of the dining room. R4 had tried to walk and fell. The Corrective action/solution was to make sure she was sitting on her chair alarm, to not take her out of dining room	F0657		05/13/2026

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F0657 SS = D	Continued from page 24 until staff were around the living room area and have a staff member be in dining area when she was in dining area. Review of 3/10/26, interdisciplinary team (IDT) meeting note identified the IDT did a review of R4's 2/22/26 fall on 2/24/26 with a new identified intervention of having R4 in the living room area for supervision as much as able, and to continue with her therapy treatments. R4's current, undated care plan, identified R4 required 2 staff to assist with transfers and toileting. R4 did not understand instructions and was not able express her needs. R4 had a wander guard on her wheelchair. R4 could not safely transfer without assistance and had a bed and chair sensor alarm in place that connected to and turned on the call light and/or pager. The care plan lacked identification that R4 should remain in the dining room until staff were around the living room area and to ensure staff were in the dining room area while R4 was there or that R4 should be in the living room area as much as possible for supervision. Interview and care plan review on 4/15/26 at 2:17 p.m., with registered nurse (RN)-A identified R4 had been admitted to the facility for failure to thrive and dementia. R4 had 2 falls since admission in February 2026. RN-A identified the only intervention on her care plan was to have a bed and chair alarm. RN-A confirmed the interventions that had been identified on the 2/22/26, fall report had not been added to the care plan following R4's second fall that resulted in a fractured of her pelvis. RN-A identified when a fall occurred, that the charge nurse would complete a fall report and that person was to update the care plan with the new interventions. Then the IDT meets weekly and reviews any falls and would review interventions. The IDT also should update the care plan if the intervention was changed after review. RN-A stated the care plan should be updated any time care needs change for a resident. Interview on 4/15/26 at 4:14 p.m., with the administrator identified she would expect that R4's care plan would reflect her current care needs including identified fall interventions. Any time a new intervention or care need was identified to care for a resident that the care plan would be updated.	F0657		05/13/2026

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F0657 SS = D	Continued from page 25 Review of undated Fall and Post-Fall Assessment identified that following a fall the nurse would assess the resident and provide necessary medical attention. The environment would be evaluated for possible causes and necessary action would be taken to correct as needed. The family and medical doctor would be updated and notified of new interventions. Interventions would be added to the care plan and communicated to the staff.	F0657		05/13/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to weekly assess and measure a pressure ulcer for 1 of 2 sampled residents (R5). Findings include: R5's 4/2/26, accepted quarterly Minimum Data Set (MDS) assessment identified R5 had severe cognitive impairment. R5 required partial assistance with activities of daily living (ADL). R5 had 1 unhealed stage 3 pressure ulcer (full thickness tissue loss subcutaneous fat may be visible, but bone, tendon or muscle are not exposed) that was not present on admission and had moisture associated skin damage. R5 had a pressure relieving device on her bed and in her wheelchair. She took daily antidepressant and pain medication.	F0686	Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; Wound measured and assessed for appropriate treatment, and documented for R5. The facility will identify other residents having the potential to be affected by the same deficient practice by; Currently, five residents in total have PU (pressure ulcer), including R5. The other four residents identified had assessment and treatment as ordered, as well as weekly measurements completed. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Staff education to be provided on importance of completing weekly measurements and assessments. PU measurements to be scheduled for day shift versus evening shift, as well as scheduling Monday through Friday (avoiding weekends) to prevent similar (R5 only resident scheduled for evening measurements). Policies to be reviewed and revised as needed; Pressure Ulcer Assessment, Pressure Ulcer Prevention. The facility will monitor its performance to make sure that solutions are effective by; An audit will be conducted by DON, or designated licensed staff member, to ensure resident PU measurements are being completed weekly. Audit will be conducted one time per week for one month, every other week for two months, monthly for two months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting.	05/13/2026

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F0686 SS = D	Continued from page 26 R5's 4/14/26, diagnoses list identified dementia with anxiety, panic disorder, major depressive disorder, legal blindness, osteoarthritis, disorder of skin and subcutaneous tissue right buttocks cheek, and mixed incontinence of bladder. R5's 12/10/25, fax to physician identified communication that R5 had a pressure area measuring 3 centimeters (cm) x 3 cm on her right buttock with treatment set up to apply Mepilex every 3 days, and a note from staff asking if the physician would like to provide any further orders. . R5's 12/23/25, provider communication identified staff were to report if R5's wound worsened or failed to resolve. R5's 4/14/26, printed care plan identified the nurse was to assist to reduce pressure and friction between R5 and her bed or chair. R5 had a pressure reducing mattress and cushions in her wheelchair and recliner. The nurse was to provide wound care to her right buttock and assess and measure the wound weekly. R5 would be monitored for nutrition and hydrating intake. Staff were to help R5 stay clean and dry and use a thin layer of barrier cream on red areas or previous problem areas. Staff were to report any redness to the nurse. Observation on 4/14/26 at 10:17 a.m., with registered nurse (RN)-A of R5's right buttocks wound identified RN-A prepped the supplies, washed her hands and donned gloves. RN-A removed the dressing and washed the wound. Observation of the wound identified a small open area with a pink wound bed. RN-A described the wound as stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed) with a thin layer of skin missing and measured the wound. RN-A identified interventions noted were for staff to promote healing and prevent further breakdowns including pressure relieving mattress and ensure a cushion was in her wheelchair and recliner. Interview on 4/14/26 at 12:07 p.m., with RN-A identified R5 had a treatment order to measure R5's wound every Monday. She revealed according to the documentation for February, March, and April of 2026 a measurement had only been completed on 3/9/26 and also what she had done earlier in the	F0686		05/13/2026

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F0686 SS = D	Continued from page 27 day. She confirmed the nurses had been charting that they had held the treatment and did not perform the task on all other Mondays. The nurse was to complete an assessment of the wound and measure every Monday until healed. R5’s treatment administration record (TAR) identified an order to measure right buttocks open area one time a week on Monday until healed, start date of 2/2/26. Apply an Allevyn dressing and change every 3 days until healed, start date 2/7/26. Review of February, March, and April 2026 identified the following charting: 2/2/26, was documented as held and not performed 2/9/26, there was no documentation that the measurement was completed or not completed 2/16/26, was documented as held and not performed 2/23/26, was documented as held and not performed 3/2/26, was documented as held and not performed 3/9/26, was documented as completed 3/16/26, was documented as held and not performed 3/23/26, was documented as held and not performed 3/30/26, was documented as held and not performed 4/6/26, was documented as held and not performed 4/13/26, was documented as held and not performed 4/14/26, documented as completed R5’s wound assessment for February, March, and April 2026 identified the following documentation: 2/2/26, R5’s Allevyn (absorbent foam dressing) was intact on R5’s right buttock. 2/9/26, R5’s Allevyn dressing was intact on R5’s right buttock. 2/16/26, R5’s Allevyn dressing was as intact on R5’s right buttock. R5’s left buttock was noted, however, staff failed to document concerns with the	F0686		05/13/2026

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F0686 SS = D	Continued from page 28 left buttock. 2/23/26, R5's Mepilex (absorbent silicone foam dressing) was intact on R5's right buttock. 3/2/26, R5's Allevyn dressing was intact on R5's right buttock. 3/9/26, R5 had 2 open areas measuring 0.5 cm around. The areas were cleaned and Allevyn dressings were applied. 3/16/26, R5's Allevyn dressing was identified as intact on R5's right buttock. 3/23/26, R5s right buttock was as opened and cleaned with an Allevyn dressing applied. 3/30/26, R5's right buttock was not open however, an Allevyn dressing was applied 4/5/26, R5's right buttock was opened and cleaned with an Allevyn dressing applied 4/6/26, R5's Allevyn dressing was intact on R5's right buttock 4/13/26, R5's Allevyn dressing was identified as intact on R5's right buttock 4/14/26, R5's right buttock had a stage 2 pressure ulcer with the wound tissue being pink and surrounding tissue identified as dark discolored. The right buttock wound measured 1 cm x 0.7 cm, the area was cleaned, and an Allevyn dressing was applied. Prior to the surveyor's observation of the wound and treatment with the RN-A on 4/14/26, there was no evidence to support the nurse appropriately assessed and measured R5's wound weekly to monitor for worsening, remaining the same, or if they showed improvement. Interview on 4/14/26 at 12:21 p.m., with RN-B confirmed the nurse should be following the treatment orders to assess and measure R5's wound weekly. She was unsure why this was not being completed. Interview on 4/15/26 at 4:14 p.m., with administrator identified she would expect the licensed nurses would follow the facility policy on wound monitoring and measuring.	F0686		05/13/2026

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F0686 SS = D	Continued from page 29 Review of April 2017, Pressure Ulcer Assessment policy identified pressure ulcers would be evaluated, measured and characteristics of the wound would be documented weekly to determine worsening or improvement.	F0686		05/13/2026
F0868 SS = D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.	F0868	Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; IP (infection preventionist) will provide reports relating to employee surveillance/infection log to review and discuss. QAPI will discuss of any trends noted, if tracking was occurring appropriately, if transmission-based precautions were needed or implemented timely. Minutes recorded to be more detailed in explanation, and expand to all aspects needed to meet the requirements set forth by state guidelines. The facility will identify other residents having the potential to be affected by the same deficient practice by; All current residents were affected by the deficient practice. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Staff education to be provided on all areas of discussion to be added to our QA (Quality Assurance) meeting. Documentation of minutes to be more precise and detailed. QAPI plan to be reviewed and revised. Policies to be reviewed and revised as needed; Quality Assurance and Performance Improvement, Quality Assurance Committee. The facility will monitor its performance to make sure that solutions are effective by; An audit will be conducted by the administrator, or designated licensed staff member, to ensure documentation of meeting minutes include all aspects needed, provide interventions and outcomes, and is detailed, covering all addressed at quality insurance meeting, including employee surveillance. Audit will be conducted quarterly for one year. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting.	05/13/2026

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F0868 SS = D	Continued from page 30 This REQUIREMENT is NOT MET as evidenced by: Based on interview, and document review, the Quality Assurance (QA) committee failed to ensure they received reports from the infection preventionist relating to employee surveillance for 4 of 4 quarters reviewed. Refer to F865 and F880 Findings include: Review of the QAPI meeting minutes submitted for review identified for review of the past 4 Quarters of QAPI meeting minutes identified review of each quarter is as follows: Quarter 1 (April 2025): Attendees included the medical director, DON, RN staff development coordinator (RN-A), the pharmacist, dietary manager, facility director, vice president, maintenance supervisor, the administrator, and social services attended. Data submitted included: Infections: 18. 15 were urinary tract infections (UTI), and 3 were skin. The DON reviewed infection statistics. QAPI noted the IDT team would continue to review falls weekly and interventions, however there was no indication of a comprehensive review by QAPI occurred of any benchmarks, goals or analysis of IDT data. There was also no indication employee surveillance was being reviewed or discussed. Quarter 2 (July 2025): Attendees included the medical director, DON, RN staff development coordinator (RN-A), the pharmacist, facility director, the administrator, the vice president, and social services attended. Those areas included: Resident infection data was documented as reviewed. There were 18 total infections, with 9being UTI, 3 skin infections, and 6 respiratory infections. Staff were encouraged to utilize McGeer’s criteria and follow antibiotic stewardship, however no benchmarks or goals were discussed, and no analysis of data was documented to have occurred to identify trends, or if tracking was occurring appropriately, if transmission-based precautions were needed or implemented timely etc. There was also no employee surveillance reviewed.	F0868		05/13/2026

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F0868 SS = D	Continued from page 31 Quarter 3 (October 2025): Attendees included the medical director, DON, RN staff development coordinator (RN-A), the pharmacist, facility director, the vice president, the administrator and social services attended. Those areas included: Resident infection data was reviewed. 13 in total with 7 UTI, 4 were skin, and 2 respiratory. Again, no employee surveillance was included. Quarter 4 (January 2026): Attendees included the medical director, director of nursing (DON), social services, the administrator, the Minimum Data Set (MDS) nurse, and pharmacist. No other departments were noted to have attended. Topics discussed were: Resident infections were discussed in numbers but no there was no data documented as being reviewed, there were no benchmarks or goals, and no analysis identified. There was also no mention employee surveillance having been discussed. Interview and document review on 4/15/26 at 3:45 p.m., with the administrator identified she was in charge of PIP and the director of nursing (DON) was in charge of the rest of discussion and documentation of QAPI. There was no evidence to support the IP had brought employee surveillance to QAPI for oversight. The administrator agreed with that discussion and understood need for documenting the oversight. Review of the February 2026, Quality Assurance/Assessment and Performance Improvement Plan identified QAPI would make quality improvement decisions based on data analysis with input from residents, families, staff and the community. QAPI was to set goals for performance and measures progress toward those goals. The committee was to include representatives from all departments including nursing, food and nutrition, laundry, housekeeping, maintenance, health information technology, therapeutic recreation, therapy, business office and administration. There was no specific mention to the IP bringing all surveillance data to QAPI for review. Review of the January 2026, Infection Control Coordinator policy, identified the infection control	F0868		05/13/2026

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F0868 SS = D	Continued from page 32 coordinator was to report information related to compliance to Administrator and Quality Assurance and Assessment Committee. The IP was to collect, analyze, and investigate data and trends to nursing staff and health practitioners; maintain infection logs for staff and residents; consult on strategies for infection prevention; and implement evidence-based control practices. Infection logs –summaries of infections.	F0868		05/13/2026

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	245599	A. BUILDING **01 - MAIN BUILD...** B. WING	**04/15/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 04/15/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Divine Providence Community Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		04/29/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245599	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/15/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Divine Providence Community Home is a one-story building with no basement. The building was constructed in 1993, and was determined to be of Type II(111) construction. The building is fully fire sprinkler protected throughout. The facility has a capacity of 50 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		04/29/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and	K0353	Detailed description of the corrective action taken or planned to correct the deficiency: The facility contacted the fire sprinkler service provider to reproduce and install the permanent hydraulic calculation nameplates on the sprinkler riser. These plates specify the design density, required flow, and pressure demands. The air compressor obstructing the riser will be relocated. A	06/10/2026

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K0353 SS = F Bldg. 01	Continued from page 2 Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.2, 5.2.6, and 13.2.3 These deficient findings could have a widespread impact on residents within the facility. Findings include: 1. On 04/15/2026 at 9:53 AM, it was revealed by observation that the calculation nameplates were not installed on the fire sprinkler riser. 2. On 04/15/2026 at 9:53 AM, it was revealed by observation that the sprinkler riser was obstructed and restricting access by a generator, an air compressor, and water softener tanks. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0353	Continued from page 2 clearance of at least 36 inches will be established around the riser to ensure unimpeded access for inspections and emergency operations. Address the measures that will be put in place to ensure the deficiency does not reoccur: The floor around the sprinkler riser has been painted with safety striping paint to prevent the accidental placement of equipment or storage in the exclusion zone. The facility requested the fire sprinkler service inspector verify the presence and legibility of all hydraulic nameplates during every quarterly inspection. Indicate how the facility plans to monitor future performance to ensure solutions are sustained: The Maintenance Director or designee will conduct monthly walk-throughs for 6 months to ensure no obstructions to the riser. The results of these audits will be documented and reported to the Quality Assurance Performance Improvement (QAPI) Committee at the next quarterly meeting. The committee will determine if further education or a change in the monitoring frequency is necessary based on compliance trends. Identify who is responsible for the corrective actions and monitoring of compliance: Maintenance Director	06/10/2026
K0211 SS = E Bldg. 01	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously	K0211	Detailed description of the corrective action taken or planned to correct the deficiency: Hydration cart moved to another location that does not block exit door. Address the measures that will be put in place to ensure the deficiency does not reoccur:	05/13/2026

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K0211 SS = E Bldg. 01	Continued from page 3 maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install door locks or maintain egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, and 7.1.10.1. This deficient finding could have a patterned impact on the occupants within the facility. Findings include: On 04/15/2026 at 10:57 AM, it was revealed by observation that the exit door located outside the Shop near the kitchen was obstructed with a hydration cart. An interview with the Environmental Service Director verified this deficient finding at the time of discovery.	K0211	Continued from page 3 All staff have been instructed to keep exit doors and the paths leading to them unobstructed at all times (24/7). Indicate how the facility plans to monitor future performance to ensure solutions are sustained: The Maintenance Director or designee will conduct weekly walk-throughs for 90 days to ensure all exits are clear. The results of these audits will be documented and reported to the Quality Assurance Performance Improvement (QAPI) Committee at the next quarterly meeting. The committee will determine if further education or a change in the monitoring frequency is necessary based on compliance trends. Identify who is responsible for the corrective actions and monitoring of compliance: Maintenance Director	05/13/2026
K0372 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility.	K0372	Detailed description of the corrective action taken or planned to correct the deficiency: The unsealed penetration in the smoke barrier wall located above/near Door 100 will be sealed using an approved UL-listed fire-rated caulk. Address the measures that will be put in place to ensure the deficiency does not reoccur: The Maintenance Director or designee conducted a comprehensive above-ceiling survey of all smoke barrier walls throughout the facility to identify and repair any other potential unsealed penetrations or gaps. All contractors are now required to have their work inspected by the Maintenance Department upon completion of a project to ensure that any new penetrations are sealed with approved fire-rated materials. Indicate how the facility plans to monitor future performance to ensure solutions are sustained: The Maintenance Director or designee will conduct monthly inspections for 6 months of smoke barrier walls in (2) randomly selected areas of the facility to ensure the integrity of the firestop systems.	05/13/2026

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K0372 SS = E Bldg. 01	Continued from page 4 Findings include: On 04/15/2026 at 11:03 AM, it was revealed by observation that there was an unsealed penetration in the smoke barrier located at door 100. An interview with the Environmental Service Director verified this deficient finding at the time of discovery.	K0372	Continued from page 4 The results of these audits will be documented and reported to the Quality Assurance Performance Improvement (QAPI) Committee at the next quarterly meeting. The committee will determine if further education or a change in the monitoring frequency is necessary based on compliance trends. Identify who is responsible for the corrective actions and monitoring of compliance: Maintenance Director	05/13/2026
K0741 SS = E Bldg. 01	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on document review, observation, and staff interview, the facility failed to enforce smoking policies per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.4(6). This deficient finding could have a patterned impact on the occupants within the	K0741	Detailed description of the corrective action taken or planned to correct the deficiency: All non-compliant smoking containers were immediately removed from the permitted smoking areas and discarded. The facility has purchased and installed non-combustible metal containers with self-closing lids in all designated smoking areas to ensure safe cigarette butt disposal. Address the measures that will be put in place to ensure the deficiency does not reoccur: The facility has standardized the type of smoking receptacle permitted on grounds. No other containers (e.g., coffee cans, plastic buckets) are permitted. Smoking – Employees/Visitors policy updated. Signage has been posted in designated smoking areas reminding staff and visitors to use only the provided fire-safe receptacles for smoking materials. All departments have been informed on the requirements, emphasizing that only approved metal, self-closing containers are to be used for cigarette disposal. Indicate how the facility plans to monitor future performance to ensure solutions are sustained: The Maintenance Director or a designee will conduct weekly rounds of all designated smoking areas for 90 days to ensure only approved containers are in use and that they are in good working order (lids closing properly). The Maintenance Director will report the audit findings to the Quality Assurance Performance Improvement (QAPI) Committee quarterly. The committee will review the data to ensure 100% compliance and determine if the frequency of monitoring can be reduced.	05/13/2026

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K0741 SS = E Bldg. 01	Continued from page 5 facility. Findings include: On 04/15/2026 at 8:09 AM, it was revealed by observation that the facility was not following their smoking policy and did not have a metal container with a self-closing cover into which ashtrays can be emptied readily available to all areas where smoking is permitted. An interview with the Environmental Service Director verified this deficient finding at the time of discovery.	K0741	Continued from page 5 Identify who is responsible for the corrective actions and monitoring of compliance: Maintenance Director	05/13/2026
K0920 SS = A Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a widespread impact on the residents within the facility.	K0920		04/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245599	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Providence Community Home	**700 THIRD AVENUE NORTHWEST , SLEEPY EYE, Minnesota, 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
K0920 SS = A Bldg. 01	Continued from page 6 Findings include: On 04/15/2026 at 10:06 AM, it was revealed by observation that there was a hair dryer plugged into a power strip in the beauty shop. On 04/15/2026 at 10:36 AM, it was revealed by observation that there was an extension cord plugged into a power strip in the front lobby. On 04/15/2026 at 10:48 AM, it was revealed by observation that there was an extension cord plugged into a power strip in the activity room. NOTE - All of these deficiencies were corrected at the time of discovery by the Environmental Service Director An interview with the Environmental Service Director verified this deficient finding at the time of discovery.	K0920		04/29/2026