



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 2, 2025

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

RE: CCN: 245225
Cycle Start Date: April 11, 2025

Dear Administrator:

On April 24, 2025, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

The Minnesota Department of Health completed a Federal Monitoring revisit on May 29, 2025 to confirm that your facility had attained and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 11, 2025 did not go into effect. (42 CFR 488.417 (b))

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/16/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245225		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/11/2025	
NAME OF PROVIDER OR SUPPLIER SLEEPY EYE REHABILITATI CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085			
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F 000	INITIAL COMMENTS An unannounced Federal Monitoring Survey was conducted at Sleepy Eye Rehabilitation Center on April 7, 2025 through April 10, 2025. The defeciciencies contained in this report are based on observations, clinical record review and interview with residents and facility staff. Based on this survey, the facility was not in compliance with the following requirements of 42 CFR Part 483, subpart B, Requirements for Long Term care. The census on the first day of the survey was 51 residents. The total sampled residents for the survey process was 23.			F 000			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)			F 580			5/21/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/03/2025

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

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F 580	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, policy review and document review, it was determined that the facility failed to notify the resident's representative and physician in a timely manner regarding significant change in condition for one (R 104) of one resident reviewed for family notification in the sample of 23. Findings include: Review of facility's policy titled Notification of			F 580	• R104 has passed away at the hospital. • All residents have the potential to be affected by this deficiency. • The hospital transfer form will be utilized for each resident transfer and completed in its entirety. • Resident contact and provider will be informed of change of condition per policy.		

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F 580	Continued From page 2 changes dated 3/2024 revealed, "It is the policy of this facility that changes in a resident's condition or treatment be shared with the resident and /or the resident representative, according to their authority, and reported to the attending physician or delegate...Objective of the notification of change policy. The objective of the notification policy is to ensure that the facility staff makes appropriate notification to the physician and delegated non-physician practitioner and notification to the resident and/or the resident representative when there is a change in the resident's condition...The intent of the policy is to provide appropriate and timely information about changes relevant to a resident's condition..." Review of R 104's electronic medical record (EMR) under admission record form revealed that R104's husband and daughter were listed under "contacts." The admission record form included a home telephone number for R 104's husband and a mobile number for R 104's daughter. Review of R 104's medical diagnoses included dementia (loss of cognitive functioning - thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) and COVID-19 (coronavirus disease). Review of R 104's progress notes revealed the following: 8/14/24 at 8:52 pm - "...Rr [respiratory rate] 18 no c/o [complaints of] SOB [shortness of breath], or cough...General Health status: stable." 8/15/24 at 3:59 am - "Resident had a large loose BM [bowel movement] and was vomiting. The writer assessed the resident and noted that she has SOB and difficulty breathing. Resident had audible wheezing and crackles on lung sounds.	F 580	• Education will be provided to facility nurses and HIM for the proper use of the hospital transfer form. • Director of Nursing or designee will complete audits for compliance 3x weekly x1 week, weekly x3 weeks, monthly x2 months, and will review with QA committee for further recommendations.		

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F 580	Continued From page 3 Vitals [vital signs] were taken and B/P [blood pressure] was low 67/41, P [pulse] 67, O2 [oxygen saturation] 87, T [temperature] 97.3, R [respiration] 23. Resident was sweaty and clammy. Resident was started on 2 L [liters] oxygen as per standing orders and HOB [head of bed] raised. Called 911 [emergency number] at 2:10 [AM] to send the resident to the ED [emergency department] for evaluation and notified ADON [name of Assistant Director of Nursing]. Tried calling the family but no answer, a voice message left. Resident left the facility with the EMT [emergency medical technician] at 2:30 AM to [name of hospital]. The writer called the ED and gave a nurse to nurse report. Still waiting on the update from the ED." Further review of R 104's progress note revealed no evidence that staff made a follow-up call to R 104's family to notify them of significant change in resident's physical status. There was no documentation of physician notification when R 104 experienced symptoms that signify a significant change. There was no evidence of completed transfer form and there was no documentation that practitioner was notified of the transfer to hospital and of R 104's condition. Review of a blank hospital transfer form revealed the following: "Send this report with the following: resident face sheet, order summary, copy of current MARS [medication administration records], TARS [treatment administration records], Copy of the POLST [physician orders for life sustaining treatment] and ICAR [infection control assessment and response] information if indicated." Review of R 104's medical record revealed no			F 580			

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F 580	Continued From page 4 evidence that a transfer form had been completed on 8/15/24. In an interview with the Director of Nursing (DON) on 4/10/25 at approximately 4:06 PM, when asked about R 104's 8/15/24 transfer form, the DON reviewed R 104's medical record and stated, "I do not see the transfer form. So, most likely there is none [no transfer form] for her. The reason is because we are starting to implement the [use of] transfer form." When asked about notification of family or resident representative when R 104 vomited and developed shortness of breath and had low blood pressure, the DON reviewed R 104's record and stated that she expected the nurse to do a follow-up call to the family, to notify them on the change in condition. The DON checked R 104's progress notes and stated, "They did not document it."	F 580			
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600			5/21/25

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F 600	Continued From page 5 by: Based on interview, record review, and review of facility policy, the facility failed to protect the resident's right to be free from verbal abuse for one of one resident (Resident (R) 48) reviewed for abuse out of a total sample of 23. The facility failed to ensure R 48 was protected from verbal abuse/mistreatment by R 24. Findings include: Review of a facility policy titled, "Abuse Prohibition/Vulnerable Adult Policy" dated 03/2024 indicated, "...The philosophy of Monarch Healthcare Management is to provide quality long-term care in a loving and caring atmosphere. In accordance with Monarch Healthcare Management philosophy, this plan has been written to comply with...Federal Guidelines for prevention of maltreatment of vulnerable adults in health care centers...To protect residents against abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals, or self-abuse..." 1. Review of R 24's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), indicated the resident was admitted to the facility on 09/25/24 with diagnoses that included unspecified dementia. Review of R 24's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 12/07/24 and located under the "MDS" tab of the EMR, indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which revealed the resident was	F 600	• R48 and R24 are a married couple that have the right to communicate with each other. R24 has been place on target behavior monitoring for aggression towards her husband or others. R24's care plan has been updated for proper interventions. • The facility reviewed the situation between the married couple and deemed it as not abuse based on facility policy and state statute 626.557 Subd. 3a (2). • There are no other married couples in the facility at this time, however all residents that reside at the facility are considered vulnerable adults and have the potential of being affected from this deficiency • Facility residents are monitored for aggression upon admission and PRN. If so the resident is put on monitoring and their care plan is updated for proper interventions. • Facility wide education will be completed on abuse prevention. • Administrator or designee will conduct random audits of staff understanding of facility Abuse Prevention/Vulnerable Adult Policy and when to report allegations of abuse. Audits will be conducted weekly x 4, monthly x 2 and reported to QA committee for further review and recommendations.		

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F 600	Continued From page 6 cognitively intact. The assessment revealed the resident had no behaviors directed towards others. Review of R 24's "Behavior" progress notes, located under the "Prog (Progress) Note" tab of the EMR and dated 01/01/25, indicated Licensed Practical Nurse (LPN) 1 documented, "...was cart passing medications when resident [R 24] approached writer from family room. [R 24] was verbally upset stating that she was pissed off that her husband [R 48] forgot about her in the family room for 30 minutes, left her waiting. Writer [LPN 1] explained to resident [R 24] that her husband [R 48] was not alert and oriented to person place and time very well as he used to be. Resident [R 24] then went up to her husband [R 48] and began shouting in his face she was pissed off and that he forgot about her...husband [R 48] was confused on what was going on and asked what he did to piss her off. Resident [R 24] then repeated that he [R 48] forgot about her and proceeded to grab onto wheelchair arm rest and push... [R 48] away from her...[R 48] was redirected by cart nurse [LPN 1] on his hall for treatments...Writer [LPN 1] redirected...[R 24] to her room and offered her snacks and some rest time while her husband was getting his own cares done..." There was evidence in the clinical record that R 24 and R 48's representative and physician were notified of the resident-to-resident. 2. Review of R 48's "Admission Record," located under the "Profile" tab of the EMR, indicated the resident was admitted to the facility on 10/18/24 with diagnoses that included unspecified dementia. Review of R 48's admission "MDS," with an ARD	F 600			

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F 600	Continued From page 7 of 10/24/24 and located under the "MDS" tab of the EMR, indicated the resident had a "BIMS" score of seven out of 15, which indicated the resident was severely cognitively impaired. The assessment revealed the resident had no behaviors directed towards others. Review of R 48's "Care Plan," located under the "Care Plan" tab of the EMR and dated 10/28/24, indicated the resident had difficulty, due to his cognitive deficits, expressing his needs. In addition, the care plan indicated the resident was hard of hearing. During an interview on 04/08/25 at 4:00 PM, LPN 1 confirmed she witnessed the resident-to-resident incident between R 24 and R 48. LPN 1 stated R 24 shouted at R 48 and then pushed him away from her while R 48 was sitting in his wheelchair. LPN 1 stated she believed this was verbal abuse. During an interview on 04/10/25 at 9:11 AM, the Administrator stated he did not believe the resident-to-resident was verbal abuse. The Administrator stated that he meets with the administrative team, and they decide whether or not there was enough evidence to determine if abuse occurred.	F 600			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609			5/21/25

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F 609	Continued From page 8 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to report an allegation of verbal abuse to the State Survey Agency (SSA) within two hours for two of two residents (Resident (R) 24 and R 48) reviewed for abuse out of a total sample of 23. The facility failed to ensure an injury of unknown origin was reported to the SSA within two hours of receiving knowledge of the injury for one of one resident (R 24) reviewed for injuries of unknown origin out of a total sample of 23. Findings include: Review of a facility policy titled, "Abuse			F 609	• Director of Nursing and Administrator reviewed the facility "Abuse Prohibition/Vulnerable Adult Policy" and stated understanding of reporting requirements for verbal abuse and injuries from unknown origins. A thorough investigation was completed and determined that concerns for abuse were unsubstantiated. • All residents have the potential to be affected. • What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.		

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F 609	Continued From page 9 Prohibition/Vulnerable Adult Policy," dated 03/2024, indicated, "...All staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin (including suspicious bruises, skin tears, or other injuries)...Incidents that must be reported...Mistreatment...Neglect...Abuse...Abuse is the willful infliction of injury...includes verbal abuse...Injuries of unknown source...an injury should be classified as an 'injury of unknown source' when both of the following conditions are met...The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident, and...The injury is suspicious because of the extent of the injury or the location of the injury...Suspected Abuse shall be reported to the OHFC [Office of Health Facility Complaints] online reporting process not later than 2 hours after forming the suspicion of abuse...Five-day follow-up reports are still required ..." 1. a. Review of R 24's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), indicated the resident was admitted to the facility on 09/25/24. Review of R 24's "Behaviors," located under the "Prog (Progress) Note" tab of the EMR and dated 01/01/25, indicated R 24 shouted at R 48 when R 24 accused R 48 of leaving her for 30 minutes. The progress notes indicated that R 24 then grabbed R 48's wheelchair and pushed him away. b. Review of R 48 's "Admission Record," located under the "Profile" tab of the EMR, indicated the resident was admitted to the facility on 10/18/24. Review of a document provided by the facility	F 609	• Monarch corporate policy titled "Abuse Prohibition/Vulnerable Adult Policy" was reviewed 04/25 and includes areas on verbal abuse and injuries of unknown origins. • Staff were reeducated on facility Abuse Prevention/Vulnerable Adult Policy, including immediately reporting allegations of abuse. • Administrator or designee will conduct random audits of staff understanding of facility Abuse Prevention/Vulnerable Adult Policy and when to report allegations of abuse. Audits will be conducted weekly x 4, monthly x 2 and reported to QA committee for further review and recommendations.		

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F 609	Continued From page 10 titled, "...Investigation...", dated 01/02/25, indicated R 24 screamed at R 48 , her husband on 01/02/25. This date conflicted with the nursing progress notes of 01/01/25. The Administrator who wrote this document stated that R 24 gets frustrated with R 48. The document indicated that the physician and the residents' representative were notified. An investigation began immediately. R 24's physician was asked to begin R 24 again with psychotropic medication but the physician declined and directed the staff to use therapeutic non-pharmacological interventions. The Administrator noted that the state guidelines state per 626.557 Subd.[Subdivision] 3a (2) "...Verbal or physical aggression occurring between patients, residents, or clients of a facility, or self-abusive behavior by these persons does not constitute abuse unless the behavior causes serious harm. From <https://www.revisor.mn.gov/statutes/cite/626.557 > ..." Per the document, the Administrator noted both residents were assessed and there were no injuries and therefore did not report to the State Survey Agency (SSA) based on the state's reporting criteria. During an interview on 04/08/25 at 4:00 PM Licensed Practical Nurse (LPN) 1 stated she reported the resident-to-resident which involved R 24 and R 48. LPN 1 stated she reported the incident to her nurse manager. LPN 1 stated she believed the incident was verbal abuse. During an interview on 04/09/25 at 3:44 PM, the Administrator stated he followed the State requirements, and it was difficult to find the federal requirements in the state's reporting system.	F 609			

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F 609	Continued From page 11 During an interview on 04/09/25 at 9:43 AM, the Director of Nursing (DON) stated that she and the Administrator tag team on the investigations of alleged abuse. The DON stated the reason the facility did not report the incident between R 24 and R 48 to the State Survey Agency (SSA) was due to R 24 and R 48 sustained no harm and there were no criteria to report the resident-to-resident incident. 2. Review of R 24's nursing "Progress Notes," located under the "Prog Note" tab of the EMR and dated 02/25/25, revealed the resident began to complain of central chest pain. The resident was sent to the local hospital for evaluation. The progress notes revealed on this same date that the resident's representative notified the facility that the resident was found to have a fractured sternum. Review of a document provided by the facility for R 24 titled, "... Investigation ...," dated 02/25/25, indicated the resident complained of chest pain and was sent to the emergency room since the facility believed that the resident had a suspected heart attack. According to the document written by the Administrator, the resident's representative notified the facility of the sternal fracture. According to the document, the Administrator wrote that the resident's representative had informed the facility that the resident could not remember if she fell or how the fracture might have happened. The document recorded that the resident reported to the resident's representative that no one at the facility had hurt her. The facility did not report the fracture based on the State requirements outlined in 626.557. During an interview on 04/09/25 at 3:44 PM, the	F 609			

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F 609	Continued From page 12 Administrator stated he followed the State requirements, and it was difficult to find the federal requirements in the state's reporting system.	F 609			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to fully investigate an allegation of verbal abuse for two of two	F 610			5/21/25
			• Director of Nursing and Administrator reviewed the facility "Abuse Prohibition/Vulnerable Adult Policy" and		

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F 610	Continued From page 13 resident (Resident (R) 24 and R 48) reviewed for abuse out of a total sample of 23. The facility failed to fully investigate an injury of unknown origin for one of one resident (R 24) reviewed for injuries of unknown origin out of a total sample of 23. Findings include: Review of a facility policy titled, "Abuse Prohibition/Vulnerable Adult Policy," dated 03/2024 indicated "...Staff will take immediate and appropriate actions to prevent further abuse... The facility's investigation Team will review all Incident Reports regarding residents including those that indicate an injury of unknown origin, abuse...The Investigation Team will determine if further investigation is needed... The Investigation Team will continue the investigation. Investigation may include interviewing staff, residents, or other witnesses to the incident..." 1. a. Review of R 24's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), indicated the resident was admitted to the facility on 09/25/24. Review of R 24's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 12/07/24 and located under the "MDS" tab of the EMR, indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated the resident was cognitively intact. Review of R 24's "Behaviors," located under the "Prog (Progress) Note" of the EMR and dated 01/01/25, indicated R 24 told R 48 that she was	F 610	stated understanding of reporting requirements for verbal abuse and injuries from unknown origins. A thorough investigation was completed and determined that concerns for abuse were unsubstantiated. • All residents have the potential to be affected. • What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. • Monarch corporate policy titled "Abuse Prohibition/Vulnerable Adult Policy" was reviewed 04/25 and includes areas on verbal abuse and injuries of unknown origins. • Staff were reeducated on facility Abuse Prevention/Vulnerable Adult Policy, including immediately reporting allegations of abuse. • Administrator or designee will conduct random audits of staff understanding of facility Abuse Prevention/Vulnerable Adult Policy and when to report allegations of abuse. Audits will be conducted weekly x 4, monthly x 2 and reported to QA committee for further review and recommendations.		

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F 610	Continued From page 14 "pissed off" since R 48 left her for 30 minutes. The progress notes indicated R 24 shouted at R 48 and grabbed his wheelchair and pushed R 48 in his wheelchair. Licensed Practical Nurse (LPN) 1 documented that she was able to redirect R 24 and separate her from R 48. b. Review of R 48's EMR titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 10/18/24. Review of R 48's admission "MDS," with an ARD of 10/24/24 and located under the "MDS" tab of the EMR, indicated the resident had a "BIMS" score of seven out of 15, which indicated the resident was severely cognitively impaired. Review of a document provided by the facility titled "...Investigation...", dated 01/02/25, indicated R 24 screamed at R 48, her husband on 01/02/25. This date conflicts with the nursing progress notes of 01/01/25. The Administrator who wrote this document stated that R 24 gets frustrated with R 48. The document indicated that the physician and the residents' representative were notified. An investigation began immediately. Per the document, the Administrator noted both residents were assessed and there were no injuries. The document was a summary of the incident; however, there was no investigation. There were no documented staff or resident interviews related to the incident. During an interview on 04/08/25 at 4:00 PM, Licensed Practical Nurse (LPN) 1 stated she witnessed the resident-to-resident incident between R 24 and R 48. She stated she was not interviewed regarding her account, nor did she			F 610			

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F 610	Continued From page 15 provide a written statement. During an interview on 04/09/25 at 9:43 AM, the Director of Nursing (DON) stated typically, the facility requires nursing to document any event in the resident's clinical records. The DON stated that nursing completes a skin assessment if there is any physical touch. The DON stated the residents' representative, and the physician were both notified of the resident-to-resident incident which involved R 24 and R 48. During an interview on 04/10/25 at 9:11 AM, the Administrator stated it was his expectation that any time there was an allegation of verbal abuse or verbal mistreatment, the administrative staff huddle and determine if they need to gather additional information or not. The Administrator stated he did not hear the word potential "abuse" from LPN 1; therefore, the allegation was not investigated. The Administrator stated the facility would typically gather interviews from any potential witnesses. 2. Review of R 24's "Nursing" progress notes, located under the "Prog Note" tab of the EMR and dated 02/25/25, indicated the resident complained of central chest pain and was transported to the emergency room. On this same date, it was recorded the resident's representative notified the facility that the resident was found to have a fractured sternum and was going to be transported to a different hospital. Review of a document titled, "Clinic and Specialty Center," dated 02/26/25 and provided by the facility, indicated R 24 was admitted to the hospital via the emergency room and recorded the resident had a displaced sternal fracture and	F 610			

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F 610	Continued From page 16 the injury was unknown since the resident was a poor historian and was unable to provide the hospital staff any details how she may have injured her sternum. The resident voiced that she did not remember a fall or trauma but stated she had central chest pain. The resident reported that her memory was shot and was not aware that she lived at the facility while she was in the hospital. Review of a document provided by the facility for R 24 titled "...Investigation...", dated 02/25/25, indicated the resident complained of chest pain and was sent to the emergency room since the facility believed that the resident had a suspected heart attack. According to the document written by the Administrator, the resident's representative notified the facility of the fracture. According to the document, the Administrator wrote the resident's representative informed the facility that the resident could not remember if she fell or how the fracture might have happened. The document stated the resident reported to the resident's representative that no one at the facility hurt her. The facility did not report the fracture based on the State requirements outlined in 626.557. The document indicated that staff interviews were conducted; however, there was no documentation interviews were conducted with other residents in an effort to determine if there were residents with knowledge of the incident or abuse concerns. During an interview on 04/09/25 at 9:43 AM, the Director of Nursing (DON) stated typically, the facility requires nursing to document an event in the resident's clinical records. The DON stated the cameras were reviewed, and it could not be determined that abuse happened to R 24.	F 610			
F 657 SS=D	Care Plan Timing and Revision	F 657			5/21/25

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F 657	Continued From page 17 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. (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 interviews, record review and policy review, it was determined that the facility failed to revise care plan related to: 1) weight loss for one (R 49) resident, and 2) respiratory equipment for one (R 16) resident in the sample of 23. Findings include:	F 657	• R49 and R16 care plan related to weight loss and respiratory equipment has been updated • All residents on oxygen orders or respiratory care may be affected by this deficiency.		

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F 657	Continued From page 18 Review of facility policy titled Care Planning with a revision date of 11/2024 revealed, "...The care plan is to be modified and updated as the condition and care needs of the resident changes." 1. Review of R 49's electronic medical record (EMR) revealed an admission date of 12/12/24 and diagnoses included chronic obstructive pulmonary disease (COPD), diabetes mellitus and heart failure. Review of R 49's weight monitoring revealed the following: 12/12/24 - 194.5 (pounds) 1/19/25 - 180.4 lbs. 2/9/25 - 182.6 lbs. 3/2/25 - 179.6 lbs. Review of R 49's progress note dated 3/11/25 revealed, "...Noted with slow progressive weight loss...RD [registered dietician] will con [continue] to monitor intake, weights..." Review of R 49's care plan under focus revealed, "Current Nutritional Status." The Interventions included "diet." The care plan had not been revised to address R 49's weight loss and did not include interventions to improve nutritional status. In an interview with the Director of Nursing (DON) on 4/9/25 at approximately 2:30 PM, when asked about R 49's weight loss, the DON reviewed R 49's record and stated, "During IDT [interdisciplinary] meeting, we discussed weights..." The DON added, "We have weekly meetings for an hour. We have a list of people that we monitor, and make sure care plan [is reviewed], do interventions..."	F 657	• Education will be provided to nursing staff including oxygen flow rate and proper storage of respiratory supplies. • A house audit will be conducted on oxygen orders and proper storage of respiratory supplies. • Director of Nursing or designee will complete audits for compliance weekly x4 weeks, monthly x2 months, and will review with QA committee for further recommendations.		

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F 657	Continued From page 19 2. Review of R 16's EMR revealed diagnoses included COPD and respiratory failure with hypoxia (low blood oxygen). Review of R 16's Orders revealed the following: 10/8/24 - Aerobika Device (handheld breathing device a person breathe into) one application inhale orally two times a day 1/6/25 - Assist resident with applying CPAP [continuous positive airway pressure, device that helps a person breathe while sleeping] at HS [bedtime] and take off in the morning. Review of R 16's care plan under focus revealed, "...CPAP use r/t [related to] pulmonary emphysema [lung condition that causes shortness of breath and over time damages the thin walls of the air sacs in the lungs] respiratory failure with hypoxia." Further review of R 16's care plan revealed it had not been revised to include care of respiratory equipment including CPAP and Aerobika. During an interview with the DON on 4/8/25 at approximately 4:21 PM, the surveyor informed the DON that the care plan had not been revised to include care of R 16's respiratory equipment. The DON did not comment on the need to revise R 16's care plan.	F 657			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690			5/21/25

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F 690	Continued From page 20 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and policy review, it was determined that the facility failed to ensure: 1) order was complete related to the size of the foley catheter, and 2) resident with an indwelling catheter received appropriate care and services			F 690	• R7's provider was updated and orders received for catheter size. • All residents requiring a catheter have the potential to be affected.		

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F 690	Continued From page 21 and implementation of resident's care plan for one (R 7) of one resident reviewed for urinary catheter in the sample of 23. Findings include: Review of facility policy titled Medication and Treatment Orders Policy dated 8/21 revealed, "...1. The RN [registered nurse] is responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the client's records...and that changes in orders are addressed in the resident's service plan and are communicated to the other staff...7. A client's MAR [Medication Administration Record]/eMAR [electronic medication administration record] and TAR [Treatment Administration Record] will be audited regularly by licensed nurse or designee for documentation compliance..." Review of facility policy titled Care Planning dated 11/24 revealed, "...The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident..." Review of R 7's quarterly Minimum Data Set (MDS, federally mandated assessment tool) dated 2/13/25, located in the EMR [electronic medical record] revealed R 7's Brief Interview for Mental Status (BIMS) score was 14, indicating intact cognition. "Section GG - Functional Abilities and Goals" revealed R 7 required substantial or maximum assistance with toileting hygiene, lower body dressing, taking off footwear, sit to stand and during transfers. "Section H - Bladder and	F 690	• Nurses will be educated on following physician orders and Notification of Changes policy. House audit will be conducted to ensure appropriate orders are in place and are being followed for catheter size. • Director of Nursing or designee will complete audits of compliance weekly x4, monthly x2, and report to QA committee for further recommendations.		

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F 690	Continued From page 22 Bowel" revealed R 7 had a catheter. Review of R 7's care plan revealed, "Alteration in elimination r/t [related to] dx [diagnosis] BPH [benign prostatic hyperplasia, occurs when prostate gland enlarges, potentially slowing or blocking the urine stream] and urinary retention. Current indwelling foley placement. 18 Fr [French, size of catheter] 10 ml [milliliter]. The interventions included provide assistance with peri-cares [sic] AM [morning], HS [at bedtime] and PRN [as needed], monitor for s/s [signs and symptoms] of UTI [urinary tract infection], monitor foley catheter output, change foley catheter per policy and foley catheter care per policy. Review of R 7's Orders revealed the following: 5/6/24 - Follow EBP (enhanced barrier precautions) while providing urinary catheter maintenance, contact with the catheter, tubing, and collection bag, and other high contact care activities every shift 11/15/24 - Change foley catheter bag on shower day every day shift every Friday 11/15/24 - Change graduate used for catheter output weekly every day shift on Friday 12/24/24 - Change foley catheter every (three) weeks and PRN every day shift every 21 days 2/17/25 - Flush foley catheter bid (twice a day) and PRN with 120 cc (cubic centimeter) normal saline every day and evening Further review of R 7's orders revealed no evidence of the size of foley catheter. Review of R 7's Hospital Note dated 1/20/25 revealed, "...Foley catheter, 18F placed upon arrival...Stated Complaint. Catheter problems/stones. Health Concerns. Review			F 690			

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F 690	Continued From page 23 Problems and other documentation throughout for health concerns...Additional Instructions/Education. Patient has a UTI. Antibiotics have been sent to the pharmacy. Patient did receive his first dose in the ER [emergency room]. Foley catheter, 18 F placed upon arrival..." Review of R 7's progress notes revealed the following: 12/8/24 at 10:23 PM - "Foley cath [catheter] was plugged and n able [sic] to irrigate. Foley cath was changed with Fr 18 and 10 cc balloon" 12/16/24 at 10:44 PM - "...A new size 18 F Foley catheter inserted per providers orders. Balloon inflated with 10 ml of sterile saline..." 1/1/25 at 3:22 PM - "...Res. [resident] foley unable to flush and c/o bladder pressure. Foley catheter was changed wit [sic] Fr. 16 and 30 cc balloon..." 4/3/25 at 11:28 PM - "2200 [10:00 PM] tried to flush foley but with resistance. Foley cath was changed with Fr 16-30cc balloon." Further review of R 7's medical record revealed no evidence that the physician ordered to change foley catheter using 16 Fr - 30 ml catheter. During interview and observation of R 7 on 4/7/25 at approximately 12:40 PM, R 7 stated he had a foley catheter but was unsure why he had it. A sign of Enhanced Barrier Precaution (EBP) was posted on the door, and an isolation cart was placed outside of R 7's room. R 7 was wearing day clothes including pants and surveyor could not observe R 7's foley catheter and leg bag underneath his clothes. Observation on 4/9/25 at approximately 8:26 AM, revealed Certified Nursing Assistant (NA) 5	F 690			

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F 690	Continued From page 24 assisting R 7 with toileting. R 7's foley catheter was attached to a leg bag. However, NA 5 could not identify the size of R 7's foley catheter. During an interview with the Director of Nursing (DON) on 4/9/25 at approximately 10:00 AM, when asked what should be included in the physician orders for a resident with foley catheter, the DON stated, "Have the doctor [order] on the care, to change [foley catheter] every 28 days, size of the catheter and foley care instructions, if they follow with [a] urologist. When asked to verify order for R 7's size of the indwelling catheter, the DON reviewed R 7's orders and care plan and stated, "[The size of the foley catheter was] not included in R 7's orders but was included in his care plan." The DON stated R 7 had 18 French catheter on his care plan and added, "[It] should be both on orders and care plan." When asked about her expectation on writing the size of the indwelling catheter under orders, the DON stated, "Get the size, the French, the type of the catheter." During observation of R 7's catheter irrigation on 4/9/25 at approximately 10:19 AM, revealed Licensed Practical Nurse (LPN) 2 performed hand hygiene before the procedure, put on personal protective equipment (PPE, gown and gloves) and provided privacy to R 7 by adjusting the privacy curtain. LPN 2 lifted resident's pants, place cloth pad under resident's right leg, and revealed a leg bag on R 7's right lower leg filled with yellowish urine output. LPN 2 irrigated the foley catheter with 120 ml of normal saline. LPN 2 verified that R 7 had a 16 Fr (catheter size) - 30 ml (milliliter) foley catheter. LPN 2 removed her PPE and performed hand hygiene.	F 690			

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F 690	Continued From page 25 In a follow-up interview with the DON on 4/10/25 at approximately 3:31 PM, the surveyor informed the DON of the two entries in progress notes dated 1/2025 and 4/2025 in which staff indicated the use of 16 Fr - 30 ml catheter, and that the size of R 7's foley catheter during observation of catheter irrigation was 16 Fr - 30 ml, which did not have a physician's order. The DON did not comment on the surveyor's findings.	F 690			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and policy review, it was determined that the facility failed to: 1) monitor	F 692	R49 has been assessed for weight loss and provider and dietician has been updated.	5/21/25	

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F 692	Continued From page 26 weights, 2) notify physician of missing weights, 3) develop specific interventions for one (R 49) of five residents reviewed for nutrition, in the sample of 23. Findings include: Review of facility policy titled Assessment of Nutritional Status and Integrating Nutrition in the Comprehensive Care Plan dated 9/2012 revealed, "...Detailed and food intake monitoring data will be utilized as a source of data as well as the resident's chart, family, resident, staff and/or existing care plan...The data collected within the Nutritional Assessment Form will be analyzed by the Hospitality Services Manager to establish current nutritional status, identify residents at nutritional risk and identify nutrition-related problems and needs. Consultation with the registered dietician, Director of Nursing or other staff specialists will occur as needed...The care planning team will establish goals and approaches to nutrition related problems and needs identified for a resident. These goals and approaches will be individualized, specific, measurable and outcome oriented..." Review of R 49's electronic medical record (EMR) revealed an admission date of 12/12/24 and diagnoses included chronic obstructive pulmonary disease, diabetes mellitus and heart failure. Review of R 49's quarterly Minimum Data Set (MDS, federally mandated assessment tool) dated 3/19/25 revealed R 49's Brief Interview for Mental Status (BIMS) score was 15, indicating intact cognition. "Section GG - Functional Abilities and goals" indicated R 49 required set up or			F 692	• All residents have the potential to be affected. • Education of weight Monitoring policy and facility expectations to nursing staff • A complete house audit will be completed for residents currently triggering for weight loss or gain and will be addressed by provider and/or dietician • Director of Nursing or designee will complete audits of compliance weekly x4, monthly x2, and will review with QA committee for further recommendations.		

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F 692	Continued From page 27 clean up assistance when eating. "Section K - Swallowing/Nutritional Status" revealed R 49's weight was 180 pounds. Review of R 49's care plan under focus revealed, "Current Nutritional Status." The Interventions included diet. R 49's care plan failed to address weight loss and failed to develop and implement interventions to improve nutritional status. Review of R 49's weight monitoring revealed the following: 12/12/24 - 194.5 lbs (pounds) 1/19/25 - 180.4 lbs 2/9/25 - 182.6 lbs 3/2/25 - 179.6 lbs Review of R 49's orders revealed the following: 12/16/24 - Breeze supplement two times a day 1/10/24 - Regular diet, IDDSI (International Dysphagia Diet Standardisation Initiative) Level 4: pureed texture IDDSI Level 0: thin liquids consistency 3/9/25 - Weekly weights Review of R 49's March 2025 Treatment Administration Record (TAR) revealed no evidence R 49's weight was taken on 3/9, 3/16, 3/23 and 3/30/25. Review of R 49's April 2025 TAR revealed no evidence resident's weight was taken on 4/6/25. Review of R 49's progress notes revealed the following: 12/20/24 at 3:05 pm - "...Weight currently 187.6. No prior weights noted. Pt [patient] has been bed-bound x 2 year..." 12/20/24 at 4:26 pm - "Resident was admitted to [name of hospice] today..."	F 692			

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F 692	Continued From page 28 12/30/24 at 3:37 pm - hospice discharge summary, "Reason for discharge: Pt had decided to pursue medical treatment including curative measures..." 3/11/25 - "...Noted with slow progressive weight loss...Rt [resident] is currently receiving regular diet, pureed texture, Ensure Clear supplement 8 ounces BID [twice a day]. Recommended changing supplement to Ensure Plus to augment intake and promote muscle maintenance. BMI [body mass index] remains elevated at 30.1. RD [registered dietician] will con [continue] to monitor intake, weights..." 4/1/25 - "A quarterly care conference was held this afternoon in [name of R 49] room..." The documentation on care conference did not include discussing R 49's weight loss. Further review of R 49's medical record including progress notes revealed no evidence R 49's weight was monitored weekly in March 2025 and during the first week in April 2025. There was no documentation that the physician and registered dietician were notified of missing weights. Review of R 49's Mini Nutritional Assessment dated 3/18/25 revealed the following: - weight of 179.6 -no decrease in food intake -weight loss during the last 3 months - weight loss greater than 3 kg [kilograms] (6.6 lbs) Further review of R 49's Mini Nutritional Assessment dated 3/18/25 failed to indicate the weight loss of 14.9 lbs since December 2024, which was 7.66% weight loss in three months. During an interview with R 49 on 4/7/25 at approximately 4:16 PM, the resident stated she	F 692			

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F 692	Continued From page 29 lost weight since December 2024. In an interview with the Director of Nursing (DON) on 4/9/25 at approximately 2:30 PM, when asked about R 49's weight loss and order for weekly weights, the DON reviewed R 49's recorded weights and stated, "During IDT [interdisciplinary meeting], we discussed weights. It was on a Sunday [weight schedule]. She was placed on Breeze supplement. It was a dietary order." The DON verified there was no weekly weights documented for March and first week of April. During an interview with Licensed Practical Nurse (LPN) 2 on 4/10/25 at approximately 10:37 AM, when asked about the procedure on weekly weights, LPN 2 stated, "The CNAs are able to weigh people, done in the morning before breakfast. If resident refused, the nurse goes on [talk to resident]. They have the right to refuse. Document it [weight] in MAR [Medication Administration Record], TAR and reflect refused."	F 692			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record and policy reviews, it was determined that the	F 695	• R49's provider was updated and new order was received and implemented.		5/21/25

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F 695	Continued From page 30 facility failed to ensure: 1) oxygen therapy order included oxygen flow rate for one (R 49) resident, and 2) respiratory supplies were stored in a sanitary manner in accordance with professional standards for two (R 16, R 49) of two residents reviewed for respiratory care in the sample of 23. Findings include: Review of facility policy titled Nebulizer Treatment dated 11/2019 revealed, "...Nebulizer treatments must be administered according to the prescriber orders...Policy implementation...8. Instruct and remind client to clean nebulizer after treatment is complete. This prevents bacteria growth...Responsible Staff...nursing staff..." Review of facility policy titled Oxygen administration revealed, "...Verify the practitioner's order for the oxygen therapy, because oxygen is considered a medication or therapy and should be prescribed...Select the most appropriate oxygen delivery device based on the practitioner's order and the patient's status..." 1. Review of R 49's admission record revealed R 49's diagnoses included chronic obstructive pulmonary disease (COPD, lung condition caused by damage to the lungs) and heart failure (lifelong condition in which the heart muscle can't pump enough blood to meet the body's need for blood and oxygen). Review of R 49's quarterly Minimum Data Set (MDS, federally mandated assessment tool) dated 3/19/25, revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of 15, indicating R 49 was cognitively intact. "Section			F 695	• R49 and R 16 respiratory supplies were replaced and stored in a sanitary manner. • All residents on oxygen orders or respiratory care may be affected by this deficiency. • Education will be provided to nursing staff including oxygen flow rate and proper storage of respiratory supplies. • A house audit will be conducted on oxygen orders and proper storage of respiratory supplies. • Director of Nursing or designee will complete audits for compliance weekly x4 weeks, monthly x2 months, and will review with QA committee for further recommendations.		

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F 695	Continued From page 31 GG - Functional Abilities and Goals" indicated that R 49 required partial to maximum assistance with activities of daily living (ADLs). "Section O - Special Treatments and Programs" indicated R 49 received oxygen therapy. Review of R 49's care plan under focus revealed, "Alteration in oxygen/gas exchange, respiratory status due to COPD stage 4 and lung mass. Becomes SOB [short of breath] during exertion and when laying [sic] flat in bed. The interventions included HOB (head of bed) elevated while in bed R/T [related to] SOB while lying flat, Monitor oxygen saturations as ordered and prn [as needed], Administer oxygen as ordered, Monitor for cyanosis, accessory muscle use, shortness of breath, increased respirations, and difficulty coughing up sputum, Keep MD (physician) informed of changes. Review of R 49's orders revealed the following: 12/12/24 - Albuterol Sulfate (bronchodilator) inhalation nebulization solution 2.5 mg (milligrams) orally every four hours as needed for SOB and wheezing 12/15/24 - Oxygen - change oxygen tubing weekly 12/15/24 - Wipe down oxygen concentrator weekly 12/18/24 - HOB elevated while in bed R/T SOB while lying flat 12/18/24 - Oxygen delivery system use O2 (oxygen) concentrator to keep O2 above the level of 90% 12/21/24 - Ipratropium-Albuterol (bronchodilator) inhalation solution 0.5-2.5 mg/3 ml (milliliter) four times a day for COPD 1/12/25 - Change oxygen bubbler monthly			F 695			

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F 695	Continued From page 32 Further review of R 49's orders and Treatment Administration Record (TAR's) did not include oxygen flow rate or oxygen setting. Review of R 49's Progress Notes revealed the following: 2/24/25 at 7:30 AM - "...Oxygen saturations 99 [%] @ [at] 6 LPM [liters per minute]." 3/16/25 at 12:15 PM - "...94% on 7L [liters] O2 that husband keeps it at. no signs or symptoms of sob." 4/1/25 at 3:38 PM - "The writer went to check the resident's oxygen concentrator setting and the husband screamed at the writer stating, "Don't touch it! "...the husband stated once again not to touch the resident's oxygen concentrator. The writer stated that they were just recording the LPM that the resident was currently on (9). The husband stated that he had to remove the knob the adjusts the levels because a NOC [night nurse] turned the LPM down to 5...The writer assured the husband that they did not plan on adjusting it. The resident's O2 is 90% on 9LPM. The writer reported the incident to the nurse manager." 4/1/25 at 7:18 PM - "A Quarterly Care Conference was held this afternoon in [name of R 49]'s room. [R49's] husband was not present, but [name of R 49] noted that we could hold the conference as she speaks for herself... " 4/2/25 9:20 pm - "Resident spouse came, was here indicating that resident cant [sic] is having trouble breathing, write [sic] was in room shortly before spouse came in. When assessed resident's O2 sat was 96% NC [nasal cannula] 6 l...Resp [respiration]18. Spouse increased O2 to 8LNC [liters per nasal cannula]. O2 sat was 94%-97% via NC 8L. HOB was elevated." 4/3/25 1:34 AM - "...Oxygen saturation 98% at 9			F 695			

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F 695	Continued From page 33 LPM" Further review of R 49's medical record revealed no evidence that interdisciplinary team (IDT) discussed with R 49 the issue of resident's husband changing the oxygen flow rate during her care conference. In addition, there was no documentation that staff verified the oxygen flow rate orders with the physician nor notifying the physician of R 49's husband changing the oxygen flow rate. Review of 24-hour daily nurse report dated 4/8/25 revealed no documentation on R 49's oxygen use. Observation on 4/7/25 at approximately 4:06 PM revealed nebulizer mask on top of R 49's bedside table next to her meal tray. The nebulizer mask was not covered, had marks on both sides and not stored in a clean bag or surface. The nebulier mask was labeled with R 49's name. R 49 was receiving oxygen, and the oxygen concentrator was set at 9 LPM. Observation on 4/8/25 at approximately 8:30 AM revealed R 49 sleeping in bed. R 49 was receiving oxygen via nasal cannula and oxygen flow rate was set at 9 LPM. R 49's nebulizer mask had marks and was hanging near her door, and the nebulizer machine was sitting on top of a garbage can turned upside down. During interview with Licensed Practical Nurse (LPN) 1 on 4/8/25 at approximately 2:50 PM, LPN 1 stated, "There are residents who use oxygen and nebulizers." When asked about R 49, LPN 1 stated, "[R 49 is] on oxygen and nebulizer." When asked about staff responsibilities related to care			F 695			

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F 695	Continued From page 34 of respiratory equipment, LPN 1 stated, "The mask, tubing, (cup) that holds the medication itself stored in a plastic bag or container with washcloth. We go daily swapping of washcloth. Neb [nebulization] mask and tubing changed weekly. Use tape and label." The surveyor and LPN 1 entered R 49's room. LPN 1 verified that the nebulizer mask was hanging near the door and had marks, R 49's nebulizer cup had fluid inside and had not been rinsed after use. LPN 1 verified that R 49 used the nebulizer every day. When asked about R 49's oxygen flow rate, LPN 1 stated, "[R 49's] husband is very particular in concentrator and would set it to 8 or 9 and he removed the knob [so staff could not adjust the oxygen flow rate]. Managers talked with him. Doctors talked with him. When we tried [to explain] the family [R 49 and her husband] gets worked up about it. We have educated them. She has COPD." Review of R 49's care conference dated 3/28/25 revealed no documentation that facility staff discussed with the resident about concerns with R 49's husband changing the oxygen setting or flow rate. Review of R 49's medical record revealed no evidence that staff verified the oxygen flow rate with the physician nor the physician notified regarding R 49's husband changing the oxygen flow rate. 2. Review of product and manufacturing information on Aerobika revealed, "...Cleaning Instructions...3. Soak 15 minutes in soapy water, agitate gently and rinse. 4 . Shake out water and dry vertically...5. Reassemble device...Monthly cleaning tap water can leave mineral build up on			F 695			

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F 695	Continued From page 35 your device. To remove this, soak the disassembled device in 1 cup vinegar and 1 cup water for 1 hour, then wash as normal." Review of R 16's electronic medical record (EMR) revealed diagnoses included COPD, obstructive sleep apnea (breathing stops and restarts many times while you sleep) and respiratory failure with hypoxia (low blood oxygen). Review of R 16's annual MDS dated 2/11/25 revealed the resident had a BIMS score of 13, indicating R 16 was cognitively intact. "Section GG - Functional Abilities and Goals" indicated that R 16 required partial to maximum assistance on several ADLs. "Section O - Special Treatments and Programs" indicated that R 16 received oxygen therapy and non-invasive mechanical ventilator. Review of R 16's care plan under focus revealed, "Oxygen/CPAP [continuous positive airway pressure, device that helps a person breathe while sleeping] use r/t [related to] pulmonary emphysema [lung condition that causes shortness of breath and over time damages the thin walls of the air sacs in the lungs]/respiratory failure with hypoxia." The interventions included oxygen use and CPAP at HS. Further review of R 16's care plan did not include care of respiratory equipment including CPAP and Aerobika. Review of R 16's Orders revealed the following: 10/10/24 - Change nebulizer tubing and mask weekly, rinse and dry nebulizer cup after each nebulizer treatment 10/8/24 - Aerobika Device (handheld breathing	F 695			

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F 695	Continued From page 36 device a person breath into) one application inhale orally two times a day 10/24/24 - Albuterol Sulfate Inhalation nebulization 2.5 mg /3 ml inhale orally via nebulizer two times a day 1/6/25 - Assist resident with applying CPAP at HS and take off in the morning 10/8/24 - Clean CPAP mask and tubing with gentle soap and warm water. Let air dry. Observation on 4/8/25 at approximately 9:24 AM revealed R 16's nebulizer tubing sitting on top of her blanket in her recliner. The nebulizer was not stored on a clean surface, had no cover or storage bag. R 16 stated nurses checked on her oxygen, nebulizer and tubing regularly. R 16's CPAP machine was sitting on top of chair with the CPAP head gear and mask stuck between the chair and the wall, not covered, stored in a bag or kept on a clean surface. During an interview with Certified Nursing Assistant (NA) 6 on 4/8/25 at approximately 2:59 PM, NA 6 verified that the nebulizer hose was hanging by the wall, labeled 4/7 (April 7, 2025) and the handheld device, Aerobika was sitting on top of R 16's bed without linen. NA 6 stated, "Need to keep it [respiratory items] sterile." During an interview with the Director of Nursing (DON) on 4/8/25 at approximately 4:21 PM, the surveyor informed the DON on observations with R 49 and R 16. When asked about her expectation from staff with resident receiving respiratory services, the DON stated, "That the nurse administer the neb [nebulizer] and after it's done, take the [nebulizer] mask off and wash with soap and water and we have a plastic container and let it air dry. [Clean] everything, the whole			F 695			

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F 695	Continued From page 37 system." When asked about R 49's husband's action, adjusting the oxygen setting, the DON stated, "[They are] Noncompliant and they do whatever they want. [R 49's husband] moves stuff around and bring things he's not supposed to. [It] Contradicts things that we manage. He [R 49's husband] said he has been her caretaker, and this is the first time she's been in a nursing home. IDT talked to him in conference. [name of Social Service Director] conducts IDT conference." The surveyor informed the DON that R 49's care conference note on 3/28/25 did not include discussion about R 49's adjusting the oxygen flow rate. The DON stated, "Yes, it should be addressed in the care conference."			F 695			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and policy review, it was determined that the facility failed to: 1) provide hemodialysis care and services consistent with professional standards of practice, 2) ensure ongoing communication between the facility and dialysis center and resident's response during dialysis were completed and maintained in the medical record for one (R 156) resident reviewed for dialysis, in the sample of 23. Findings include:			F 698	• R156 no longer requires hemodialysis or a fluid restriction. • No other residents at the facility are currently affected. • Reviewed Monarch's Hemodialysis policy and Fluid Restriction Guidelines. Will educate appropriate staff as needed. • Director of Nursing or designee will complete audits for compliance weekly x4,		5/21/25

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F 698	Continued From page 38 Review of facility policy titled Hemodialysis dated 11/22/19 revealed, "The facility will ensure that residents who require dialysis, receive such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences...The facility staff and the dialysis center will have ongoing communication and collaboration regarding dialysis care and services...Ongoing communication and collaboration for the development and implementation of the dialysis plan of care should be maintained by the facility and dialysis team...Communication shared between the facility and dialysis provider can include, but is not limited to the resident's response to the dialysis treatment, medications administered, labs drawn and their results, the resident's end weight, changes in condition or mood, and evaluation of the access site. If run information is not received with the resident upon return, facility staff will call the dialysis unit to obtain the information...Documentation requirement will be met to assure that treatments are provided as ordered by the nephrologist, attending practitioner, and dialysis team. Documentation should include, but is not limited to pre and post dialysis assessment/observation, daily check of the access site (fistula, graft or external catheter), evaluation for signs and symptoms of infection, and fluid intake amounts for each shift with a 24-hour total, if a fluid restriction is in place..." Review of facility policy titled Fluid Restriction Guidelines dated 9/2012 revealed, "...1500 cc [cubic centimeter] 1. Done with doctor's order only. 2. Staff will be notified of resident's fluid restriction as needed per verbal and written			F 698	monthly x2, and will review with QA committee for further recommendations.		

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F 698	Continued From page 39 communication. 3. Communication between Hospitality Services Director and /or Dietician, Director of Nursing, and/or Nurse Manager with resident will be done to set up amounts of fluid to be given and times suggested. Suggested Amounts: 900 cc total to be given with 3 meals plus a. 150 cc in A.M. b. 200 cc 1 - 4 P.M. c. 150 cc 4 - 11 P.M. d. 100 cc 11 - 7 A.M..." Review of R 156's electronic medical record (EMR) revealed R 156 was admitted on 3/21/25 and diagnoses included kidney failure and heart failure. Review of R 156's Admission/Initial Data Collection dated 3/21/25 revealed resident had no memory problem and was receiving therapeutic diet. However, there was no documentation that R 156 had dialysis access site. Review of R 156's care plan, under focus revealed, "Risk for complications r/t [related to] dialysis." The interventions included "For uncontrolled bleeding at dialysis site, call 911 [emergency service]...dialysis 2 lumen [part of catheter] right internal jugular [of the neck]...Dialysis per schedule on Monday, Wednesday, [and] Fridays at [name of dialysis center] ...Treatment and dressing protocol to dialysis site per MD [physician] order...Send communication folder to dialysis with each run...Fluid restriction per order..." There was no documentation of dietary and nursing portion of fluid restriction and there was no suggested amount of fluid and the times to be given.	F 698			

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F 698	Continued From page 40 Review of R 156's orders revealed the following: 3/24/25 - Dialysis - Vital signs after dialysis every day shift every Monday, Wednesday and Friday 3/24/25 - Dialysis at [name of dialysis center] Monday, Wednesday and Friday of each week 3/24/25 - Complete dialysis communication form and send with resident to dialysis every day shift every Monday, Wednesday and Friday 3/26/25 - Restrict fluid intake to 1500 cc/24 hrs. 3/26/25 - Renal diet IDDSI (International Dysphagia Diet Standardisation Initiative) Level 7 (regular food may be used if you do not have problems with chewing or swallowing that increase the risk for choking): regular texture thin liquids 4/1/25 - Daily weights: call/notify PCP (primary care physician) if weight increases by two lbs. (pounds) in 24 hours or 5 lbs in 7 days in the morning 4/1/25 - Dialysis Appt in [location of dialysis center] chair time at 11:45 [AM]* P/U (pick up) 10:00 AM. Further review of R 156's orders for fluid restriction revealed no indication of fluid portion for dietary and nursing departments. Review of R 156's April 2025 Treatment Administration Record (TAR) revealed the following: 4/2 = 208.5 4/3 = 209 4/4 = 211 4/5 = 211 4/6 = 208 4/7 = 210 4/8 = 207.5 Review of R 156's clinical record revealed no			F 698			

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F 698	Continued From page 41 evidence that physician was notified of the two-pound weight gain on 4/4 and on 4/7/25. Review of 24-Hour Daily Nurse report dated 4/8/25 revealed R 156 on "EBP [enhanced barrier precaution], Foley [catheter], Dialysis Port Fluid restriction-1500 cc /24 hours." Review of R 156's meal ticket dated 4/9/25 revealed "Renal - Regular Consistency Thin." There was no documentation of fluid restriction on the meal ticket and there was no indication of dietary portion and amount of fluid for each meal. Review of R 156's Dialysis Center Communication Records revealed the following: 3/24/25 - missing pre-treatment weight (completed by facility staff) 3/26/25 - missing post dialysis weight (completed by licensed nurse after dialysis prior to return to facility). 3/28/25 - missing pre treatment weight and post dialysis weight 3/31/25 - dialysis nurse 'section' was left blank. 4/2/25 - missing post dialysis weight. The form revealed, "Wrong patient's medication [and] face sheet sent with pt [patient]. Shredded - please send correct med list Friday." 4/4/25 - missing pre-treatment weight 4/7/25 and 4/9/25 - missing dialysis forms During observation and interview with R 156 on 4/7/25 at approximately 3:53 PM, revealed Enhanced barrier precaution sign posted outside of resident's room. R 156 stated he received dialysis on Mondays, Wednesdays and Fridays. R 156 showed surveyor the transparent dressing on his right upper chest. There were two lumens hanging below the transparent dressing and			F 698			

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F 698	Continued From page 42 wrapped with a gauze. R 156 stated that dialysis staff provided dressing changes to his dialysis access site. R 156 added, "They [facility staff] check [my] vitals and weight [before dialysis]. R 156 stated that dialysis staff weigh him before and after treatment and "I take papers here and [dialysis staff] give me papers to bring back." When asked about his diet and if he was on fluid restriction, R 156 stated, "Renal, fluid [is] one liter and a half a day." R 156 had a case of bottled water on top of his table and stated that staff told him he could drink one bottle (16 ounces) of water, plus he would drink the liquid that comes with his meal tray and what nurses gave him with his medications. Observation on 4/8/25 at approximately 8:53 AM revealed no precaution sign "No IV [intravenous], blood draws, or blood pressures on right internal jugular" inside R 156's room. On 4/7/25 at approximately 12:19 PM, during the Entrance Conference, the Administrator stated that facility had no agreement with the dialysis center. The Administrator stated that the agreement was between the R 156 and the dialysis center. During an interview with Licensed Practical Nurse (LPN) 2 on 4/10/25 at approximately 10:27 AM, LPN 2 stated, "With him [R 156], I can't tell you what dietary [department] offered but I believe [he got] 1 water cup in the room. Nursing does this [filling the water cup]. He has water bottles in there, one water bottle [per day]. What we do for nursing [is] we bring [water] in for medications. During an interview with Registered Nurse (RN) 2 on 4/10/25 at approximately 9:25 AM, when			F 698			

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F 698	Continued From page 43 asked how nurses would care for residents on fluid restriction, RN 2 stated, "That is usually in the MAR [Medication Administration Record]." When asked how nurses would know the nursing portion of fluid restriction, RN 2 stated, "I guess I don't give too much [fluid] and look at the meal and the tray [how much resident got from dietary]." When asked how she knew the amount given to the resident, RN 2 stated, "usually per shift, they have it in the MAR." During an interview with the Director of Nursing (DON) on 4/10/25 at approximately 3:31 PM, when asked if there was documentation that staff notified R 156's physician of two pound weight gain on 4/4 and 4/7/25, the DON reviewed R 156's medical record and stated, "I don't see any sort of [physician's] notification." The DON stated that she expected nurses to notify physician of weight gain of two pounds on both dates. The surveyor showed R 156's meal ticket and verified that fluid restriction had not been documented on the meal ticket. When asked about the amount of fluids that R 156 received with his meals, the DON was unsure. When asked if it was important to have the fluid restriction on R 156's meal ticket. The DON stated, "She [dietary manager] is working on her end to implement it." The surveyor informed the DON of the missing information on R 156's dialysis communication records. The DON did not make additional comments.	F 698			
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:	F 732			5/21/25

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F 732	Continued From page 44 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility document and policy review, it was determined that the facility failed to ensure that the nurse staffing data was placed in a prominent place readily accessible to families and visitors and had			F 732	• Posted nursing staffing information was updated immediately upon discovery. • All residents have the potential to be affected by this practice.		

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F 732	Continued From page 45 all the required information. This had the potential to affect all 51 residents residing in the facility at the time of the survey. Findings include: Review of facility policy titled Nursing Hours Posting dated 10/2/22 revealed, "It is the policy of [Name of facility] to post nursing staffing data on a daily basis at the beginning of each shift as follows: 1. Facility name, 2. The current date 3. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: a. Registered Nurses: Licensed practical nurses or licensed vocational nurses...certified nursing assistants. 4. Resident census..." On 4/9/25 at approximately 9:28 AM, revealed nurse staffing information had not been posted on the bulletin board near the dining room or a location that was easy to view by residents and visitors. On 4/9/25 at approximately 9:30 AM, the surveyor and the Administrator checked the bulletin board where nurse staffing was posted the previous day. The Administrator verified that the nurse staffing was posted on the bulletin board near the dining room and confirmed that nurse staffing was not posted for 4/9/25. The Administrator indicated that the scheduler (E 2) was responsible for posting that information on the bulletin board. On 4/9/25 at approximately 9:34 AM, E 2 who was standing by the front office was observed filling out the nurse staffing form for April 9, 2025.	F 732	• An educational moment was provided to staff responsible for posting. A follow up plan was also established for continuity of posting • Director of Nursing or designee will complete audits for compliance 3x weekly x1 week, weekly x3 weeks, monthly x2 months, and will review with QA committee for further recommendations.		

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F 732	Continued From page 46 E 2 stated that they keep the records for a year and forms would be sent down to Medical Record for storage. Review of facility's nurse staffing forms revealed the "census" was left blank for 1/26 - 2/23, 2/28, 4/1, 4/2 - 4/6/25. During an interview with the Director of Nursing (DON) on 4/9/25 at approximately 10:00 AM, when asked about her expectation on the nurse staff posting and should the form be available at the beginning of the shift, the DON stated, "My expectation for [name of scheduler] when she comes in the morning, and she puts it up." When surveyor informed the DON that the census was left blank on above-mentioned dates, the DON stated that census should be on the nurse staff posting form.			F 732			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			F 761			5/21/25

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F 761	Continued From page 47 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and policy review, it was determined that the facility failed to ensure medications requiring refrigeration were stored at proper temperatures to preserve their integrity affecting five (R32, R4, R9, R6, R7) residents. Findings include: Review of facility's policy titled Medication Storage in the Facility dated 5/22 revealed, "...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier...A. Medications and biologicals are stored at their temperature and humidity according to the United States Pharmacopeia guidelines for temperature ranges...C. Medications requiring refrigeration are kept in a refrigerator at temperatures between 36 degrees F [Fahrenheit] (2 degrees C, Celsius) and 46 degrees F (8 degree C) with a thermometer to allow temperature monitoring...E. The facility should maintain a temperature log in the storage area to record temperature at least once a day. F. The Facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day, per CDC [Centers for Disease Control and Prevention]	F 761	• Medication refrigerator temperature was adjusted to ensure proper temperature required to improve medication integrity for R32, R4, R9, R6, R7. • All residents receiving medications requiring refrigeration have the potential to be affected. • Reviewed facility Medication Storage policy • Educate nurses on Medication Storage policy and appropriate actions when temp is out of range. • Director of Nursing or designee will complete audits for compliance 3x weekly x1 week, weekly x3 weeks, monthly x2 months, and will review with QA committee for further recommendations.		

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F 761	Continued From page 48 guidelines..." During medication (med) storage room observation with Licensed Practical Nurse (LPN) 3 on 4/10/25 at approximately 8:40 AM revealed a small refrigerator with temperature log for March and April 2025. The form revealed, "Temperature for medication refriderator [sic] should be between 33-41 degrees F [Fahrenheit] or below. If temperature is not adequate, notify appropriate individuals [name of Maintenance Director] for repair and remove refrigerator contents to another refrigerator for storage. Document action taken, initial, and date. Place forms in [name of Health Information Manager]'s box." Further review of the same document revealed temperature (temp) of 28 to 32 degrees F was recorded for 26 days in March 2025 and a temp of 30 to 32 F for ten out of ten days in April 2025. Further observation with LPN 3 revealed medications inside the refrigerator included: -R32's two unopened Humalog KwikPen (rapid acting insulin) with expiration date of 3/3/26 -R32's five unopened Lantus SoloStar (long-acting insulin) with expiration date 4/9/26 -R6's two unopened Humalog KwikPen with expiration date of 3/4/26 -R4's five unopened Humalog KwikPen with expiration date of 3/10/26 -R9's one unopened Humalog KwikPen with expiration date of 2/24/26 -Aplisol (intradermal solution used as an aid in the diagnosis of tuberculosis) 5 STU (tuberculin units)/0.1 ml (milliliter) - 5 ml vial with expiration date of 5/2026 and an "open date" of 3/25/25 -R7's Prevnar 20 (vaccine that provides protection against pneumococcal disease for adults) in a 0.5 ml syringe with expiration date of	F 761			

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F 761	Continued From page 49 5/14/25 -15 House stock Acetaminophen suppositories, 650 mg with an expiration date of 3/2026 -10 House stock Dulcolax (laxative) suppositories with expiration date of 1/31/26 During an interview with LPN 3 on 4/10/25 at approximately 8:45 AM, when asked about the procedure when medication refrigerator temp was outside the recommended range, LPN 3 stated, "They [nurses] would notify the DON [Director of Nursing]." LPN 3 added, "Night nurse typically checks it [temp]." LPN 3 verified the temp readings that were lower than the recommended temperature in March and in April. LPN 3 verified that above mentioned medications were currently being used by residents in the building. LPN 3 confirmed that there was no documentation in the temp log that Maintenance Director or DON had been notified of temps being out of range in March and April 2025. During an interview with the DON on 4/10/25 at approximately 3:31 PM, the surveyor informed her of the observations inside the med storage room and medication refrigerator log. When asked about her expectation from staff when med refrigerator temp were out of range, the DON stated, "Inform Maintenance." When asked why it was important to report to the Maintenance Director when temp was out of range, the DON stated, "Many things could affect the expiration date [of medications]. It [temp] could affect the effectiveness or medication lifespan."	F 761			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880			5/21/25

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F 880	Continued From page 50 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 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	F 880			

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F 880	Continued From page 51 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. §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 observations, staff interviews, record reviews, and a review of facility policy, the facility failed to implement appropriate infection prevention and control practices. Specifically, staff failed to ensure the proper use of personal protective equipment (PPE) during therapy for one resident (R 156) in a sample of 23. Additionally, Dietary Aide (E)1 failed to perform hand hygiene while distributing beverages to residents, and staff did not offer residents an opportunity to perform hand hygiene prior to the start of the dinner meal. These deficient practices had the potential to contribute to the spread of			F 880	• Verbal re education was provided with therapy staff working with R156 on PPE use, dietary aide passing ice water on hand hygiene, and with staff bringing residents into the dining room on offering residents hand hygiene opportunities. • All residents have the potential to be affected. • Staff were educated on Monarch's Enhanced Barrier Precautions policy, Handwashing policy, and hand hygiene		

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F 880	Continued From page 52 infection and cross-contamination among all 51 residents who consumed food prepared and served by the facility. Findings include: Review of facility policy titled Enhanced Barrier Precaution [EBP] dated 4/1/24 revealed, "...Implement enhanced barrier precautions for residents with any of the following: i. wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers...Implementation of Enhanced barrier Precautions a. make gowns and gloves available...4. High-contact resident care activities include a. dressing. Enhanced barrier precaution should be followed...when working with residents..." Review of Enhanced barrier precautions sign revealed, "... providers and staff must also: wear gloves and a gown for the following high-contact resident care activities dressing..." Review of R 156's clinical record revealed that R 156 was admitted on 3/21/25 and diagnoses included unstageable pressure ulcer on right heel and left ankle diabetic ulcer. Further review of R 156's clinical record revealed the resident had an indwelling foley catheter and a two-lumen right internal jugular dialysis line. Observation on 4/9/25 at approximately 8:19 AM revealed an EBP sign was posted on R 156's door. Occupational Therapy Assistant who also served as the Program Manager (E) 2 entered R 156's room without donning gown and gloves. E 2 gave R 156 instructions on removing and putting on his socks. R 156 was sitting in his recliner and			F 880	expectations. Dietary ice water pass includes ice scoop to reduce risk of cross contamination. Resident hand hygiene opportunities are offered prior to meals with provided wipes. • Director of Nursing or designee will complete audits for compliance 3x weekly x1 week, weekly x3 weeks, monthly x2 months, and will review with QA committee for further recommendations.		

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F 880	Continued From page 53 had a walker in front of him. E2 initially asked R 156 to remove the sock on his left foot. R 156 struggled but was able to remove his left sock. R 156 had bandages on both feet. E 2 then instructed R 156 to remove his right sock. R 156 removed his right sock. E 2 paused and instructed the resident to put on both socks. R 156 moved in a slow manner. After giving the resident enough time to try and do the task himself, E 2 without wearing PPE, assisted the resident in completing the task first with the right sock followed by the left sock. E2 left the room and performed hand hygiene. During an interview with the Director of Nursing (DON) on 4/9/25 at approximately 9:18 AM, when asked if she expected staff to wear PPE when entering a resident's room on EBP, the DON stated, "When they do direct contact care." When asked if she expected Occupational Therapist (OT) to wear gown and gloves when providing exercises inside a resident's room who was on EBP, the DON stated, "No. We don't have it set up that way." The surveyor informed the DON of the observation during an OT session inside the resident's room. The DON stated, "The [occupational] therapist should have worn gloves. The precautions apply to any direct contact specifically for open wounds." Review of a facility policy titled, "Handling Ice," dated 04/07/25, indicated "...Ice must be protected from splash, drip and hand contamination during storage and service...Always wash hands thoroughly before handling the ice scoop...The ice scoop should be stored according to state and local regulations..." Review of a facility policy titled, "Infection			F 880			

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F 880	Continued From page 54 Prevention and Control Program," dated 08/2017, indicated, "...The primary mission of Monarch Healthcare Management is to establish and maintain a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections...educating staff and ensuring that they adhere to proper technique and procedures..." During a meal observation conducted on 04/07/25 at 5:16 PM, staff were observed bringing residents into the main dining room. During the observation E 1 was observed to push a cart around to each of the residents' tables and pass ice and juice out. When the staff brought a resident into the dining room, the staff did not offer any of the residents the opportunity to perform hand hygiene even though there were disposable wipes on each of the dining tables. E 1 was observed to retrieve a fresh glass from the cart and place ice in the glass. E1 retrieved the ice from a transparent plastic pitcher and then after the resident was served the drink, placed the scoop back in the transparent plastic pitcher. E 1 would then touch different surfaces and retrieved a personal cup from a resident, filled it with ice and then placed the scoop back in the pitcher. E 1 repeated this until 5:50 PM, when the Dietary Manager (DM) was asked to observe this process. The DM confirmed the observation and stated this was an infection control issue and there was a potential for cross-contamination since E 1 did not perform hand hygiene after she touched surfaces and retrieved the ice scoop and then placed the scoop back into the pitcher. DM stated that the Nursing Assistants (NA) were to offer each resident an anti-bacterial wipe after they were brought into the dining room for a meal.	F 880			

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F 880	Continued From page 55 During an observation and interview beginning on 04/07/25 at 6:01 PM, NA 4 was observed to bring an unidentified male resident to the dining room. NA 4 did not offer hand hygiene for the resident. NA 4 confirmed that he brought the resident into the main dining room and forgot to offer the resident a hand wipe. NA 4 stated he typically offers each resident the opportunity to perform hand hygiene after a resident was brought into the dining room for a meal. During an interview on 04/10/25 at 8:50 AM, Registered Nurse (RN)1 stated it was his expectation that the NA staff offer each resident the opportunity to perform hand hygiene before meals. During an interview on 04/10/25 at 9:47 AM, the DON stated it was her expectation that staff would offer residents hand wipes to reduce the potential of spreading infections.	F 880			
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative	F 883			5/21/25

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F 883	Continued From page 56 has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			F 883			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/16/2025
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/11/2025
NAME OF PROVIDER OR SUPPLIER SLEEPY EYE REHABILITATI CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085		
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F 883	Continued From page 57 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review, medical record review, and the Centers for Disease Control and Prevention (CDC) website review, the facility failed to ensure that the resident/resident representative was provided education on the risks and benefits of the updated pneumococcal vaccinations and failed to offer the updated pneumococcal vaccinations when eligible to four (R 17, R 23, R 48, AND R 49) residents of six residents reviewed for immunization in the sample of 23. Findings include: Review of the facility's policy titled "Pneumococcal Policy" revised date 2/2024, revealed "...Purpose: To follow recommendations of the Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control (CDC) and/or the state Department of Health for prevention of Pneumococcal disease by identifying those residents at risk for Pneumococcal disease and offering Pneumococcal vaccination...Procedure...3. Refer to the current CDC Recommended Adult Immunization Schedule to determine recommended vaccines...5. Before receiving the vaccine, the resident or resident representative shall receive information and education regarding the benefits and possible side effects of the pneumococcal vaccine..." According to the CDC website: chrome-extension://efaidnbmnnnibpcajpcgclefindmkaj/https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/adult/adult-combined-schedule.pdf	F 883	" R17, R23, R48, and R49 were offered the updated pneumococcal vaccination and administered as requested. " All residents who have not received the updated pneumococcal vaccination have the potential to be affected. " Nurse leaders were educated on Monarch's Pneumococcal policy, the CDC's Recommended Adult Immunization Schedule 2025, and facility expectations. House audit completed to ensure current residents were up to date with their pneumococcal vaccinations, consented to receiving the updated pneumococcal vaccination, or were educated on the risks and benefits of pneumococcal vaccination. " Director of Nursing or designee with conduct random audits of compliance weekly x4 weeks, monthly x2 months, and will review with QA committee for further recommendations.		

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F 883	Continued From page 58 U.S. Department of Health and Human Services Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report (MMWR) September 12, 2024, Vol. 73 No. 36 "...Streptococcus pneumoniae (pneumococcus) is a common bacterial cause of respiratory tract infections, bacteremia, and meningitis. Invasive pneumococcal disease (IPD), a pneumococcal infection in a normally sterile site... can result in severe morbidity or mortality. Adults with certain underlying conditions or risk factors that increase the risk for pneumococcal disease (risk conditions) and those aged 65 years are at increased risk and have experienced IPD case fatality ratios exceeding 10% (1). The Advisory Committee on Immunization Practices (ACIP) recommends receipt of a pneumococcal conjugate vaccine (PCV) by all adults aged 65 years as well as those aged 19-64 years with a risk condition who have not received PCV or whose vaccination history is unknown. Options include either 20-valent PCV alone or 15-valent PCV... followed by 23-valent pneumococcal polysaccharide vaccine (PPSV23) Additional recommendations for the use of PCV20 exist for adults who commenced their pneumococcal vaccination series with 13-valent PCV (PCV13) (2). On June 17, 2024, the Food and Drug Administration for use in persons aged 18 years (3). PCV21 does not contain certain serotypes in other licensed vaccines but adds eight new serotypes (Figure). This report summarizes the evidence considered by ACIP regarding the use of PCV21 for adults, highlighting considerations of immunogenicity, safety, and resource use..." Review of R 17's electronic medical record (EHR) revealed that R 17 was admitted to the facility on 7/19/2024. R 17 was 97 years old. R 17 had			F 883			

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F 883	Continued From page 59 diagnoses that included unspecified protein-calorie malnutrition and unspecified nicotine dependence. Review of R 17's EHR under the "immunization" tab revealed that R 17's pneumococcal polysaccharide vaccine (PPSV)23, which contains antigens from 23 different pneumococcal serotypes, was administered on 7/10/2009. R 17's pneumococcal conjugate vaccine (PCV)13 was administered on 2/22/2016. Review of R 17's EHR revealed that R 17 or R 17's representative was not provided with information and education regarding the benefits and possible side effects of the updated pneumococcal vaccine and was not offered pneumococcal immunization when eligible. Review of R 23's EHR revealed that R 23 was admitted to the facility on 4/21/23. R 23 was 92 years old. R 23's medical diagnoses included unspecified chronic bronchitis. Review of R 23's EHR under the "immunization" tab revealed that Pneumovax 23 was administered on 8/25/2014, and PCV 13 was administered on 8/26/2015. Review of R 23's EHR revealed that R 23 or R 23's representative was not provided with information and education regarding the benefits and possible side effects of the updated pneumococcal vaccine and was not offered pneumococcal immunization when eligible. Review of R 48's EHR revealed that R 48 was admitted to the facility on 10/18/24. R 48 was 101 years old. R 48's medical diagnoses included	F 883			

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F 883	Continued From page 60 mucopurulent chronic bronchitis and chronic congestive heart failure. Reviewing R 48's EHR Minnesota Immunization Information Connection (MIIC) record revealed that he received his PPSV23 on 5/1/2009 and PCV13 on 11/20/2015. Review of R 48's EHR revealed that R 48 or R 48's representative was not provided with information and education regarding the benefits and possible side effects of the updated pneumococcal vaccine and was not offered pneumococcal immunization when eligible. Review of R 49's EHR revealed that R 49 was admitted to the facility on 12/12/2024. R 49 was 87 years old. R 49's medical diagnoses included chronic obstructive pulmonary disease. Review of R 49's MIIC record revealed that she received her PPSV 23 on 10/15/2003 and PCV 13 on 11/24/2014. Review of R 49's EHR revealed that R 49 or R 49's representative was not provided with information and education regarding the benefits and possible side effects of the updated pneumococcal vaccine and was not offered pneumococcal immunization when eligible. During an interview on 4/9/25 at 3:14 PM, when asked what type of pneumococcal vaccine was offered to the residents, the Director of Nursing (DON) stated the facility offered PCV15 and PCV20. When asked if R 17, R 23, R 48, and R 49 and their representatives were given information and education on the updated pneumococcal vaccine's benefits and potential	F 883			

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F 883	Continued From page 61 side effects, the DON reviewed the abovementioned residents' EHR. The DON stated and confirmed that R 17, R 23, R48, and R49 were eligible to receive PCV15, PCV20, or PCV21 and that the facility did not provide information and education to the four residents and their representatives regarding the updated pneumococcal vaccines. When asked what would happen to a resident if the updated pneumococcal vaccine was not offered when eligible, the Regional Nurse Consultant (RNC) emphasized that residents may potentially be at higher risk of pneumococcal disease, which could lead up to hospitalization.	F 883			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 4, 2025

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

RE: CCN: 245225
Cycle Start Date: February 25, 2025

Dear Administrator:

On February 25, 2025, 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:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 May 25, 2025 (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 August 25, 2025 (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>

Sleepy Eye Rehabilitati Center

March 4, 2025

Page 4

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,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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E 000	Initial Comments On 2/24/25 through 2/25/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 2/24/25 through 2/25/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52258363C (MN00106292), H52258364C (MN00106289), H52258365C (MN00105839). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/12/2025

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

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F 000	Continued From page 1			F 000			
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure most recent survey results were readily accessible for residents or visitors to view. This had the potential to affect all 53 residents who resided in the facility and visitors.			F 577			3/24/25
					" No residents were affected by this deficiency. " The prior year survey results have been placed in the required posted space across from the vending machines in the hallway going to the business office, beauty shop and chapel.		

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F 577	Continued From page 2 Findings include: On 2/24/25 at 12:55 p.m., the hallway leading to the chapel across from the vending machines a three-ring binder labeled Survey Results was located in a acrylic wall mount. The survey results in the binder were dated 4/20/23. The results of the most recent federal recertification survey dated 5/15/24, were not included. There was no posted information indicating any other results were available. On 02/25/25 at 10:53 a.m., the administrator stated he was responsible to place the most recent survey results in the binder and confirmed the most recent survey results from 5/15/24, were not located in the binder as expected. No policy regarding posting of survey results was provided.	F 577	" All residents may be affected by this deficient practice. All residents have access to this location. " The residents are informed at each resident council meeting of the location of the survey results. A follow up MEMO has been distributed to each resident describing the location of the survey results posting. " The administrator or designee will post the survey results after the plan of correction is accepted. " This task has been added to an annual checklist for survey preparation. The Therapeutic Rec director will audit the binder for the most up to date survey before each resident council meeting		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an oxygen tank was handled safely for 1 of 1 resident (R54)	F 689	R4 was not directly affected by this deficient practice although could have been at risk if the O2 tank was dropped		3/21/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 3 reviewed for safety hazards. Findings include: R54's facesheet printed on 2/25/25, indicated R54 had been admitted on 2/24/25, with a diagnosis of acute exacerbation of chronic obstructive pulmonary disease (COPD) (inflammation of the airway causing difficulty breathing). R54's physician orders dated 2/24/25, included oxygen delivery system via nasal cannula 3-4 LPM (liter per minute) every shift. During an observation on 2/24/25 at 5:14 p.m., observed licensed practical nurse (LPN)-A, carry an E-sized metal oxygen tank, holding it to her chest with both arms wrapped around it, down hallway three. LPN-A walked from the oxygen storage room at the beginning of hallway three to the last room on hallway three. During an interview on 2/24/25 at 5:19 p.m., LPN-A stated she did not know an oxygen tank should not be carried. LPN-A was able to verbalize if dropped, an oxygen tank could explode or become a projectile injuring residents and staff. Together with LPN-A, went to the oxygen storage room where there were three empty oxygen tank hand carts available for use. During an interview on 2/25/25 at 1:23 p.m., nursing assistant (NA)-A stated, "you don't carry an oxygen tank, you put it on a wheelie," adding, she didn't want to get blown to pieces if she dropped it. NA-A stated she knew this because she had training.			F 689	during transport. Staff will not carry O2 tanks in an unsafe manner. Any resident in the vicinity of the transport could be affected. Staff will not transport O2 tanks in an unsafe manner. The surveyor stopped to question the staff member at the time of the incident. The staff member was verbally educated by the DON when the LPN reported her discussion with the surveyor shortly after the incident. The surveyor confirmed the education with the DON at a later time during the survey. The nursing department will be educated on proper safe handling of oxygen tanks. Safe handling of oxygen tanks will be added to the annual skills fair and new hires for regular competency checkoffs. Education will be recorded for each staff member. The facility will audit safe handling of oxygen tanks 2 per times shift per week for one month, 1 time per shift per week for one month. The DON or designee is responsible for compliance This information will be reviewed by the QAPI team if further action is needed.		

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F 689	Continued From page 4 During an interview on 2/25/25 at 2:07 p.m., the director of nursing (DON) stated LPN-A informed her she had carried an oxygen tank to a resident's room because she didn't know she shouldn't. The DON stated staff should not travel with an oxygen tank as it was a safety risk. Skills training that occurred in July 2024, indicated LPN-A received training on "oxygen use." The training did not specifically identify safe handling of an oxygen tank. A policy on safe handling of oxygen tanks was requested and a competency titled Oxygen Administration dated 2/14, was received indicating oxygen tanks must be transported in oxygen cart or immediately placed in approved holder on a wheelchair.	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245225		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - SLEEPY EYE CARE CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2025	
NAME OF PROVIDER OR SUPPLIER SLEEPY EYE REHABILITATI CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085			
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/25/2025. At the time of this survey, Sleepy Eye Care Center 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.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/12/2025

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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: 1. 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. The original building was constructed in 1972 and was determined to be of Type II(000) construction. In 1985, addition was constructed and was determined to be of Type II(000) construction. There are 3 smoke compartments with smoke detectors in the corridors and spaces open to the corridors. The facility is fully sprinkled. The facility has a capacity of 61 beds and had a			K 000			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	Continued From page 2 census of 54 at the time of the survey.	K 000			
K 712 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/25/2025 between 9:00 AM and 12:00 PM, it was revealed by a review of available documentation that the facility was not varying times or testing alarms during the night shift fire drills. An interview with the Maintenance Director	K 712	All fire drills will be varied within the shift as directed by the regulation. The alarms will be tested the following day after a night shift drill per regulation. The Maintenance Director and Assistant were educated at the time of discovery by the fire marshal. The fire drill timing will be monitored by the safety committee for compliance. The Maintenance Director or designee will be responsible for compliance.	3/21/25	

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K 712	Continued From page 3	K 712			
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain Electrical Systems per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 02/25/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that the electrical panels located in hallway 4 were not secured from being opened by unauthorized personnel. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 911			2/25/25
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920	The deficiency was corrected at the time of discovery by the Maintenance Director by locking the electrical panels. All hallway electrical panels have been locked. The facility panels will remain locked unless being worked on by a trained professional. The maintenance director, maintenance assist and administrator were trained by the fire marshal at the time of discovery. Only specified positions will have access to the panel keys for emergency situations as designated by the safety committee. The maintenance director or designee will audit the panels during weekly rounds. The Maintenance Director will be responsible for compliance.		2/25/25

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K 920	Continued From page 4 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) assemblies 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 REQUIREMENT 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 patterned impact on the residents within the facility. Findings include:	K 920	The Maintenance Director removed the extension cord immediately and unplugged the nebulizer from the power strip upon discovery. The facility staff will be trained to remove extension cords and the appropriate uses of power strips within the patient care vicinity. The maintenance director will audit the patient rooms for extension cords and appropriate uses of power cords via our		

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K 920	Continued From page 5 1. On 02/25/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that a nebulizer was plugged into a power strip in Room 24. Maintenance corrected deficiency at time of discovery. 2. On 02/25/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that a orange extension cord was being used to power a fan in Room 24. Maintenance corrected defidency at time of discovery. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	preventative maintenance program one time per week for one month and monthly ongoing. The audit results will be reviewed by the Safety Committee for any further actions. The director of Maintenance will be responsible for compliance.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 9, 2025

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

RE: CCN: 245225
Cycle Start Date: February 25, 2025

Dear Administrator:

On April 2, 2025, 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.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 4, 2025

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

RE: CCN: 245225
Cycle Start Date: February 25, 2025

Dear Administrator:

On February 25, 2025, 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:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 May 25, 2025 (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 August 25, 2025 (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>

Sleepy Eye Rehabilitati Center

March 4, 2025

Page 4

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,

A handwritten signature in black ink, appearing to read "M. Poepping".

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2025
FORM APPROVED
OMB NO. 0938-0391

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E 000	Initial Comments On 2/24/25 through 2/25/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 2/24/25 through 2/25/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52258363C (MN00106292), H52258364C (MN00106289), H52258365C (MN00105839). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/12/2025

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245225		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2025	
NAME OF PROVIDER OR SUPPLIER SLEEPY EYE REHABILITATI CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1105 3RD AVENUE SOUTHWEST SLEEPY EYE, MN 56085			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	Continued From page 1			F 000			
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure most recent survey results were readily accessible for residents or visitors to view. This had the potential to affect all 53 residents who resided in the facility and visitors.			F 577			3/24/25
					" No residents were affected by this deficiency. " The prior year survey results have been placed in the required posted space across from the vending machines in the hallway going to the business office, beauty shop and chapel.		

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F 577	Continued From page 2 Findings include: On 2/24/25 at 12:55 p.m., the hallway leading to the chapel across from the vending machines a three-ring binder labeled Survey Results was located in a acrylic wall mount. The survey results in the binder were dated 4/20/23. The results of the most recent federal recertification survey dated 5/15/24, were not included. There was no posted information indicating any other results were available. On 02/25/25 at 10:53 a.m., the administrator stated he was responsible to place the most recent survey results in the binder and confirmed the most recent survey results from 5/15/24, were not located in the binder as expected. No policy regarding posting of survey results was provided.	F 577	" All residents may be affected by this deficient practice. All residents have access to this location. " The residents are informed at each resident council meeting of the location of the survey results. A follow up MEMO has been distributed to each resident describing the location of the survey results posting. " The administrator or designee will post the survey results after the plan of correction is accepted. " This task has been added to an annual checklist for survey preparation. The Therapeutic Rec director will audit the binder for the most up to date survey before each resident council meeting		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an oxygen tank was handled safely for 1 of 1 resident (R54)	F 689	R4 was not directly affected by this deficient practice although could have been at risk if the O2 tank was dropped		3/21/25

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F 689	Continued From page 3 reviewed for safety hazards. Findings include: R54's facesheet printed on 2/25/25, indicated R54 had been admitted on 2/24/25, with a diagnosis of acute exacerbation of chronic obstructive pulmonary disease (COPD) (inflammation of the airway causing difficulty breathing). R54's physician orders dated 2/24/25, included oxygen delivery system via nasal cannula 3-4 LPM (liter per minute) every shift. During an observation on 2/24/25 at 5:14 p.m., observed licensed practical nurse (LPN)-A, carry an E-sized metal oxygen tank, holding it to her chest with both arms wrapped around it, down hallway three. LPN-A walked from the oxygen storage room at the beginning of hallway three to the last room on hallway three. During an interview on 2/24/25 at 5:19 p.m., LPN-A stated she did not know an oxygen tank should not be carried. LPN-A was able to verbalize if dropped, an oxygen tank could explode or become a projectile injuring residents and staff. Together with LPN-A, went to the oxygen storage room where there were three empty oxygen tank hand carts available for use. During an interview on 2/25/25 at 1:23 p.m., nursing assistant (NA)-A stated, "you don't carry an oxygen tank, you put it on a wheelie," adding, she didn't want to get blown to pieces if she dropped it. NA-A stated she knew this because she had training.	F 689	during transport. Staff will not carry O2 tanks in an unsafe manner. Any resident in the vicinity of the transport could be affected. Staff will not transport O2 tanks in an unsafe manner. The surveyor stopped to question the staff member at the time of the incident. The staff member was verbally educated by the DON when the LPN reported her discussion with the surveyor shortly after the incident. The surveyor confirmed the education with the DON at a later time during the survey. The nursing department will be educated on proper safe handling of oxygen tanks. Safe handling of oxygen tanks will be added to the annual skills fair and new hires for regular competency checkoffs. Education will be recorded for each staff member. The facility will audit safe handling of oxygen tanks 2 per times shift per week for one month, 1 time per shift per week for one month. The DON or designee is responsible for compliance This information will be reviewed by the QAPI team if further action is needed.		

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F 689	Continued From page 4 During an interview on 2/25/25 at 2:07 p.m., the director of nursing (DON) stated LPN-A informed her she had carried an oxygen tank to a resident's room because she didn't know she shouldn't. The DON stated staff should not travel with an oxygen tank as it was a safety risk. Skills training that occurred in July 2024, indicated LPN-A received training on "oxygen use." The training did not specifically identify safe handling of an oxygen tank. A policy on safe handling of oxygen tanks was requested and a competency titled Oxygen Administration dated 2/14, was received indicating oxygen tanks must be transported in oxygen cart or immediately placed in approved holder on a wheelchair.	F 689			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/25/2025. At the time of this survey, Sleepy Eye Care Center 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.	K 000			

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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: 1. 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. The original building was constructed in 1972 and was determined to be of Type II(000) construction. In 1985, addition was constructed and was determined to be of Type II(000) construction. There are 3 smoke compartments with smoke detectors in the corridors and spaces open to the corridors. The facility is fully sprinkled. The facility has a capacity of 61 beds and had a	K 000			

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K 000	Continued From page 2 census of 54 at the time of the survey.	K 000			
K 712 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/25/2025 between 9:00 AM and 12:00 PM, it was revealed by a review of available documentation that the facility was not varying times or testing alarms during the night shift fire drills. An interview with the Maintenance Director	K 712	All fire drills will be varied within the shift as directed by the regulation. The alarms will be tested the following day after a night shift drill per regulation. The Maintenance Director and Assistant were educated at the time of discovery by the fire marshal. The fire drill timing will be monitored by the safety committee for compliance. The Maintenance Director or designee will be responsible for compliance.	3/21/25	

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K 712	Continued From page 3 verified this deficient finding at the time of discovery.	K 712			
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain Electrical Systems per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 02/25/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that the electrical panels located in hallway 4 were not secured from being opened by unauthorized personnel. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 911			2/25/25
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920	The deficiency was corrected at the time of discovery by the Maintenance Director by locking the electrical panels. All hallway electrical panels have been locked. The facility panels will remain locked unless being worked on by a trained professional. The maintenance director, maintenance assist and administrator were trained by the fire marshal at the time of discovery. Only specified positions will have access to the panel keys for emergency situations as designated by the safety committee. The maintenance director or designee will audit the panels during weekly rounds. The Maintenance Director will be responsible for compliance.		2/25/25

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K 920	Continued From page 4 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) assemblies 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 REQUIREMENT 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 patterned impact on the residents within the facility. Findings include:	K 920	The Maintenance Director removed the extension cord immediately and unplugged the nebulizer from the power strip upon discovery. The facility staff will be trained to remove extension cords and the appropriate uses of power strips within the patient care vicinity. The maintenance director will audit the patient rooms for extension cords and appropriate uses of power cords via our		

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K 920	Continued From page 5 1. On 02/25/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that a nebulizer was plugged into a power strip in Room 24. Maintenance corrected deficiency at time of discovery. 2. On 02/25/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that a orange extension cord was being used to power a fan in Room 24. Maintenance corrected deficiency at time of discovery. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	preventative maintenance program one time per week for one month and monthly ongoing. The audit results will be reviewed by the Safety Committee for any further actions. The director of Maintenance will be responsible for compliance.		