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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: D8YE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00040

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245599**

2. STATE VENDOR OR MEDICAID NO. (L2) **356540800**

3. NAME AND ADDRESS OF FACILITY
(L3) **DIVINE PROVIDENCE COMMUNITY HOME**
(L4) **700 THIRD AVENUE NORTHWEST**
(L5) **SLEEPY EYE, MN** (L6) **56085**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/31/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **06/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **53** (L18)

13.Total Certified Beds **53** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	53			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 06/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 06/16/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **10/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245599

June 16, 2016

Ms. Jayna Groebner, Administrator
Divine Providence Community Home
700 Third Avenue Northwest
Sleepy Eye, MN 56085

Dear Ms. Groebner:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 27, 2016 the above facility is certified for:

53 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 53 skilled nursing facility.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 14, 2016

Ms. Jayna Groebner, Administrator
Divine Providence Community Home
700 Third Avenue Northwest
Sleepy Eye, MN 56085

RE: Project Number S5599026

Dear Ms. Groebner:

On April 26, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 14, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 31, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 17, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 27, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 14, 2016, effective May 27, 2016 and therefore remedies outlined in our letter to you dated April 26, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245599 Y1	A. Building B. Wing Y2	5/31/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0242	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.15(b)	Completed
LSC	05/27/2016	LSC	05/27/2016	LSC	05/27/2016
ID Prefix F0280	Correction	ID Prefix F0323	Correction	ID Prefix F0431	Correction
Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	05/27/2016	LSC	05/27/2016	LSC	05/27/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	6/14/2016	03048	5/31/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245599	A. Building 01 - MAIN BUILDING 01 B. Wing	5/17/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0021	Correction Completed 04/26/2016	ID Prefix Reg. # NFPA 101 LSC K0047	Correction Completed 04/20/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 6/14/2016	SIGNATURE OF SURVEYOR 35482	DATE 5/17/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/13/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: D8YE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00040

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245599**

2. STATE VENDOR OR MEDICAID NO. (L2) **356540800**

3. NAME AND ADDRESS OF FACILITY
(L3) **DIVINE PROVIDENCE COMMUNITY HOME**
(L4) **700 THIRD AVENUE NORTHWEST**
(L5) **SLEEPY EYE, MN** (L6) **56085**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/14/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **53** (L18)

13.Total Certified Beds **53** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	53			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Holly Kranz, HFE NF II 05/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 05/23/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION **10/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 26, 2016

Ms. Jayna Groebner, Administrator
Divine Providence Community Home
700 Third Avenue Northwest
Sleepy Eye, MN 56085

RE: Project Number S5599026

Dear Ms. Groebner:

On April 14, 2016, a standard 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 24, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 14, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 14, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		5/27/16

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

Electronically Signed | 05/05/2016

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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	245599	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 observation, interview and document review the facility failed to ensure allegations of abuse were thoroughly investigated and reported to the State Agency (SA) for 1 of 1 resident (R23) reviewed for allegations of abuse. Findings include: R23's quarterly Minimum Data Set (MDS) dated 1/20/16, identified R23 required limited assistance of one staff for bed mobility and extensive assistance of one staff for transfers. The MDS also identified R23 had a Brief Interview for Mental Status score of 15/15 (cognitively intact) and had no behavioral symptoms. R23's face sheet dated 4/14/16, identified a primary diagnosis of malignant neoplasm of the colon. R23's diagnosis listing dated 2/29/16, indicated an additional diagnosis of unspecified	F 225	On 7/6/2015 an incident report was completed on R23 when she reported pain in right shoulder from a nursing assistant pulling on her arm the previous night. On 7/7/15 Social Services designee interviewed resident and incident happened when nursing assistant assisted R23 from a supine to seated position in bed during the night to use the bathroom. Resident did not feel nursing assistant did this on purpose, but should be told how to transfer properly. A note placed in resident room to remind staff to transfer resident with a transfer belt, be careful of her arm, and raise bed to sitting position. On 4/13/16 Social Services designee reported alleged mistreatment to the administrator and the SA and started the investigation. On 4/18/16 Social Services Designee submitted completed Investigative Report to MDH/OHFC. On	

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F 225	Continued From page 2 injury of the muscle(s) and tendons(s) of the rotator cuff of the left shoulder. R23's care plan dated 4/14/16, identified approaches which included-not pulling on the arms with a history of pain during transfers and identified R23's arms did not lift higher than shoulder level with dressing activity. During interview on 4/11/16, at 3:59 p.m. R23 reported she was abused by a staff member. R23 stated a staff member pulled on her shoulder and arm when she was getting her up and it still hurt. R23 reported this to the facility and indicated the staff member no longer came into her room. Review of the incident reports submitted to the SA did not include any report for R23 related to the incident. No other/additional incident reports were noted at this time related to an incident involving R23's arm and nursing staff. During interview on 4/12/16, at 1:16 p.m. licensed practical nurse (LPN)-C, who was the social services designee, was questioned about any reports or investigations related to R23's shoulder or arm being pulled. LPN-C indicated there were none on file and she could find any submitted to the SA. LPN-C indicated there might be a "complaint" on file and thought R23's family member had brought up a concern with a night nurse at care conference. LPN-C stated she did the reporting of incidents to the SA as well as did the director of nursing (DON). During interview on 4/13/16, at 6:45 a.m. LPN-B indicated R23 had accused nursing assistant (NA)-F of hurting her shoulder and could not	F 225	4/18/16 Social Services designee received email from Office of Health Facility complaints that no further action by their office at this time. All residents who have had an incident report completed within the last year (5/1/15 to 4/30/16) will be reviewed by the Social Services designee or her designee to ensure appropriate reporting of any alleged violations involving mistreatment, neglect, abuse, injuries of unknown source, or misappropriation of resident property to the administrator and SA. Incident Reports policy updated to improve immediate reporting of alleged violations. All staff re-educated regarding immediate reporting of all allegations of mistreatment, neglect, abuse, injuries of unknown source, or misappropriation of resident property to the administrator and State Agency. Social Services or her designee will audit all incident reports to ensure compliance with immediate reporting to the administrator and SA of alleged mistreatment, abuse, neglect, injuries of unknown source and misappropriation of resident property. Her findings will be reviewed at the Quality Assurance meetings for compliance.	

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F 225	Continued From page 3	F 225		

recall a specific date related to this occurrence. LPN-B further stated it was "Really foremost in her [R23] mind, she always thinks about it and talks about it." LPN-B further stated R23 did report pain in her shoulders; however, would not take oral pain medications for the pain and had a history of shoulder problems.

During interview on 4/13/16, at 6:54 a.m. R23 again stated that someone pulled on her shoulder and ever since it bothered her. R23 stated this was a while ago, at least a "couple of months ago already," and the staff person could no longer come in her room. R23 reported she told the charge nurse at the time it happened, but couldn't recall whom.

During interview on 4/13/16, at 9:43 a.m. registered nurse (RN)-A indicated R23 had reported concerns about her arm being pulled and explained she had a bad rotator cuff upon admission. RN-A indicated that if any resident reported rough treatment it would warrant an immediate investigation and she would immediately notify the administrator.

During interview on 4/13/16, at 9:45 a.m. RN-B indicated R23 told everybody about the arm incident/rough treatment and that she should "sue" the person that did it; however, explained that R23 had some shoulder pain prior to the related incident.

During interview on 4/13/16, at 11:25 a.m. LPN-C stated R23 was in a reference period for another MDS assessment and had reported the incident again today, so she was filing a report with the SA.

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F 225	Continued From page 4	F 225		

During interview on 4/13/16, at 12:19 p.m. family (F)-A reported R23 had reported at some point last year that an aide had taken her shirt off too fast and hurt her shoulder. F-A indicated this staff member was no longer able to come into R23's room. F-A further stated R23 had a bad shoulder and limited range in the arm, and afterward there was a sign placed in her room.

During interview on 4/13/16, at 12:54 p.m. the DON stated rough treatment by staff would meet criteria for reporting to the administrator and SA under their abuse prohibition policies. The administrator was present during this interview and indicated just taking a shirt off may or may not meet criteria, it would depend on how the resident stated it.

During further interview on 4/14/16, at 8:41 a.m. the DON again reiterated the incident should have been reported and previously thought R23 only had concerns with NA-F on a personal level but not due to rough treatment.

During interview on 4/14/16, at 11:55 a.m. NA-F indicated there had been an incident during which R23 reported she hurt her shoulder. She explained that it occurred when she [NA-F] assisted R23 to sit up in bed. NA-F reported R23 had shoulder pain before she entered the room. NA-F assisted R23 on and off the toilet with the use of a transfer belt and assisted her back to bed, then told the charge nurse to get R23 something for pain. NA-F indicated R23 had reported this incident and was "going around saying this to everybody," and this upset her.

The facility policy, entitled Abuse Prevention, last revised 8/13 indicated all employees are required

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F 225	Continued From page 5 by law to report all allegations of abuse, neglect, or misappropriation of resident property and injuries of unknown source to the Administrator as soon as they become aware of these violations. Additionally, the policy indicated the Administrator will assign an employee to begin an investigation, interviewing all employees and residents who may have information about the incident and/or witnesses.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prohibition policies related to the immediate reporting to the administrator and State Agency (SA) and to conduct a thorough investigation for 1 of 1 resident (R32) reviewed for abuse allegation. Findings include: The facility policy, entitled Abuse Prevention, last revised 8/13 indicated all employees are required by law to report all allegations of abuse, neglect, or misappropriation of resident property and injuries of unknown source to the Administrator as soon as they become aware of these violations. Additionally, the policy indicated the Administrator will assign an employee to begin an	F 226	On 7/6/2015 an incident report was completed on R23 when she reported pain in right shoulder from a nursing assistant pulling on her arm the previous night. On 7/7/15 Social Services designee interviewed resident and incident happened when nursing assistant assisted R23 from a supine to seated position in bed during the night to use the bathroom. Resident did not feel nursing assistant did this on purpose, but should be told how to transfer properly. A note placed in resident room to remind staff to transfer resident with a transfer belt, be careful of her arm, and raise bed to sitting position. On 4/13/16 Social Services designee reported alleged mistreatment to	5/27/16

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F 226	Continued From page 6 investigation, interviewing all employees and residents who may have information about the incident and/or witnesses. The staff did not report an allegation of abuse when R23 reported such an incident to staff, nor was a thorough investigation conducted. R23's quarterly Minimum Data Set (MDS) dated 1/20/16, identified R23 required limited assistance of one staff for bed mobility and extensive assistance of one staff for transfers. The MDS also identified R23 had a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact) and had no behavioral symptoms. R23's face sheet dated 4/14/16, identified a primary diagnosis of malignant neoplasm of the colon. R23's diagnosis listing dated 2/29/16, indicated an additional diagnosis of unspecified injury of the muscle(s) and tendons(s) of the rotator cuff of the left shoulder. R23's care plan dated 4/14/16, identified approaches which included-not pulling on the arms with a history of pain during transfers and identified R23's arms did not lift higher than shoulder level with dressing activity. During interview on 4/11/16, at 3:59 p.m. R23 reported she was abused by a staff member. R23 stated a staff member pulled on her shoulder and arm when she was getting her up and it still hurt. R23 reported this to the facility and indicated the staff member no longer came into her room. Review of the incident reports submitted to the SA did not include any report for R23 related to	F 226	the administrator and the SA and started the investigation. On 4/18/16 Social Services Designee submitted completed Investigative Report to MDH/OHFC. On 4/18/16 Social Services designee received email from Office of Health Facility complaints that no further action by their office at this time. All residents who have had an incident report completed within the last year (5/1/15 to 4/30/16) will be reviewed by the Social Services designee or her designee to ensure appropriate reporting according to facility Abuse Investigation and Reporting policy of any alleged violations involving mistreatment, neglect, abuse, injuries of unknown source, or misappropriation of resident property to the administrator and SA immediately. Incident Reports policy updated to improve immediate reporting of alleged violations. All staff re-educated regarding Abuse Investigation Reporting policy and the requirement by law to immediately report all allegations of mistreatment, neglect, abuse, injuries of unknown source, or misappropriation of resident property to the administrator and State Agency. Social Services or her designee will audit all incident reports to ensure compliance with facility Abuse Investigation and Reporting policy which requires the immediate reporting to the administrator and SA of alleged mistreatment, abuse, neglect, injuries of unknown source and	

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F 226	Continued From page 7 the incident. No other/additional incident reports were noted at this time related to an incident involving R23's arm and nursing staff. During interview on 4/12/16, at 1:16 p.m. licensed practical nurse (LPN)-C, who was the social services designee, was questioned about any reports or investigations related to R23's shoulder or arm being pulled. LPN-C indicated there were none on file and she could find any submitted to the SA. LPN-C indicated there might be a "complaint" on file and thought R23's family member had brought up a concern with a night nurse at care conference. LPN-C stated she did the reporting of incidents to the SA as well as did the director of nursing (DON). During interview on 4/13/16, at 6:45 a.m. LPN-B indicated R23 had accused nursing assistant (NA)-F of hurting her shoulder and could not recall a specific date related to this occurrence. LPN-B further stated it was "Really foremost in her [R23] mind, she always thinks about it and talks about it." LPN-B further stated R23 did report pain in her shoulders; however, would not take oral pain medications for the pain and had a history of shoulder problems. During interview on 4/13/16, at 6:54 a.m. R23 again stated that someone pulled on her shoulder and ever since it bothered her. R23 stated this was a while ago, at least a "couple of months ago already," and the staff person could no longer come in her room. R23 reported she told the charge nurse at the time it happened, but couldn't recall whom. During interview on 4/13/16, at 9:43 a.m. registered nurse (RN)-A indicated R23 had	F 226	misappropriation of resident property. Her findings will be reviewed at the Quality Assurance meetings for compliance.	

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F 226	Continued From page 8	F 226		

reported concerns about her arm being pulled and explained she had a bad rotator cuff upon admission. RN-A indicated that if any resident reported rough treatment it would warrant an immediate investigation and she would immediately notify the administrator.

During interview on 4/13/16, at 9:45 a.m. RN-B indicated R23 told everybody about the arm incident/rough treatment and that she should "sue" the person that did it; however, explained that R23 had some shoulder pain prior to the related incident.

During interview on 4/13/16, at 11:25 a.m. LPN-C stated R23 was in a reference period for another MDS assessment and had reported the incident again today, so she was filing a report with the SA.

During interview on 4/13/16, at 12:19 p.m. family (F)-A reported R23 had reported at some point last year that an aide had taken her shirt off too fast and hurt her shoulder. F-A indicated this staff member was no longer able to come into R23's room. F-A further stated R23 had a bad shoulder and limited range in the arm, and afterward there was a sign placed in her room.

During interview on 4/13/16, at 12:54 p.m. the DON stated rough treatment by staff would meet criteria for reporting to the administrator and SA under their abuse prohibition policies. The administrator was present during this interview and indicated just taking a shirt off may or may not meet criteria, it would depend on how the resident stated it.

During further interview on 4/14/16, at 8:41 a.m.

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F 226	Continued From page 9 the DON again reiterated the incident should have been reported and previously thought R23 only had concerns with NA-F on a personal level but not due to rough treatment. No further investigation was documented. During interview on 4/14/16, at 11:55 a.m. NA-F indicated there had been an incident during which R23 reported she hurt her shoulder. She explained that it occurred when she [NA-F] assisted R23 to sit up in bed. NA-F reported R23 had shoulder pain before she entered the room. NA-F assisted R23 on and off the toilet with the use of a transfer belt and assisted her back to bed, then told the charge nurse to get R23 something for pain. NA-F indicated R23 had reported this incident and was "going around saying this to everybody," and this upset her.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to honor resident preferences related to bathing frequency for 1 of 3 residents (R42) reviewed for choices. Findings include:	F 242	RN Charge Nurse interviewed R42 on 4/12/16 and discussed her bathing preferences. Resident indicated to RN that she preferred to have a bath twice a week. Resident was given the options for day of the week, time of bath, type of bath	5/27/16

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F 242	Continued From page 10 R42 was admitted on 3/4/16, with diagnosis that included fracture of right lower leg according to facility face sheet. R42's admission Minimum Data Set (MDS), dated 3/10/16 identified R42 to have moderate cognitive impairment. Review of R42's activity preference interview, dated 3/7/16, revealed R42's preferred bath type was tub shower. The interview stated "A full bath is offered weekly, does that work for you? Resident response was "every other day." Review of R42's physician discharge orders, dated 3/4/16 revealed orders for ankle splint, keep clean and dry, may shower as usual, no bathing or soaking incision for one week. Follow-up appointment scheduled for 3/17/16, for splint change. Additional physician orders for R42, dated 3/17/16, revealed splint removed, walking boot applied, wear at all times except when bathing and dressing, may get wet and no submerging. R42's initial care plan, dated 3/4/16 revealed staff were directed to provide bed baths and daily thorough perineal cleaning and R42 required one staff assist for bathing (bed bath given) that week. The care plan identified that starting March 7 R42 can shower if right leg wrapped to keep dry. R42's care plan, dated 3/20/16 revealed problem of self care deficit, bathing, requires one assist, help in and out of tub, washes self as much as able, staff completes bath and keep ankle incisions out of water but may get wet.	F 242	and frequency. RN Charge Nurse adjusted the bath schedule for R42 and implemented the change in her bath plan immediately. The facility will complete an audit by reviewing the most recent resident preference interview on all current residents. The facility will review each resident□s bathing plan of care to determine that their preferences are being honored. Bathing preferences including the time of day, how many times a week and method of bathing will be discussed with the resident and family on admission and scheduled accordingly. When the Activity Director completes her interview with the resident on preferences, it will be reviewed by the MDS Coordinator and the plan of care will be adjusted to reflect the preferences of the resident. Preferences will be reviewed quarterly at the care conference and adjustments will be made as needed. When a licensed nurse schedules a bath in the electronic charting system, the button Preference Comments will allow the nurse to review the Preference Interview documentation to ensure the preferences are indeed being met. The Director of Nursing will provide education to all licensed nursing staff how to use the electronic charting system to view the resident preferences before scheduling bath plan. The facility Policy: Bathing, has been revised to indicate that the resident□s preferences of type of bath, time of bath and frequency will be	

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F 242	Continued From page 11 R42's care conference notes, dated 3/22/16 revealed the notes did not address bathing choices nor frequency. During interview on 4/11/16, at 3:52 p.m. R42 stated they were unable to choose bath frequency. R42 indicated a preference of three baths/week but understood that three baths/week could not be honored. During interview on 4/12/16, at 1:34 p.m. the social services designee stated resident bath choice and frequency was determined by the activity preference assessment. Social services designee stated the activity department completed the activity preference assessment. During interview on 4/12/16, at 1:38 p.m. the activity director (AD) verified she completed the activity preference assessment on admission to facility, annually and with a significant status change. The AD verified activity preference assessment questions included preferred bath type, statement that bath is offered weekly and is that ok, if not, how often do you want? She stated the activity preference assessment data is located in the computer system and is sent to all staff. The AD also stated bathing preference was routinely discussed at care conferences. The AD verified R42's response to the bathing questions dated 3/7/16. The responses were: preferred bath is tub shower and would prefer bath every other day. The AD stated the facility charge nurse set up the bathing schedule. During interview on 4/12/16, at 1:52 p.m. registered nurse (RN)-A stated facility routine was a nurse would review bath choices on admission and then set up the bath schedule for the nursing	F 242	reviewed with the resident and/or family on admission and then quarterly. The Director of Nursing will provide education to all nursing staff on the revised bathing policy. The Director of Nursing will oversee for overall compliance to ensure that the plan of care is being followed for each resident and that the resident□s choices are being honored. Any concerns will be addressed with the quality assurance team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING _____ B. WING _____	04/14/2016

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DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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F 242	Continued From page 12	F 242		

assistants. RN-A stated bath choices were reviewed by social services at care conferences. RN-A verified R42 was scheduled for a tub shower once a week. RN-A stated she was unaware R42 desired a bath three times/week. RN-A stated if R42 wanted baths more often, staff would try to accommodate the request according to staffing levels. RN-A stated R42 needed to communicate to nursing the preference for more frequent baths and confirmed R42 had intact cognition.

During interview on 4/12/16, at 2:06 p.m. director of nursing (DON) verified the activity department completed the activity preference assessment upon admission. She stated frequency is offered, required to give one bath a week and if request more often, facility would try to accommodate. The DON stated she expected when the activity department identified bathing preferences, they would notify nursing either verbally and/or written notice so nursing could schedule bathing preferences accordingly. The DON stated she expected as soon as R42's cast was removed, bathing frequency should have be discussed with the resident.

During interview on 4/12/16, at 2:13 p.m. RN-B stated baths are scheduled on admission by communicating with residents. RN-B stated she would check the activity preference assessment on the computer system, would check for bathing frequency, would check with resident and communicate choices to the charge nurse. RN-B stated the activity preference assessment was completed annually and reviewed quarterly at care conference. RN-B verified R42 was scheduled for a weekly bath. RN-B verified the activity preference assessment identified R42

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING _____ B. WING _____	04/14/2016

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F 242	Continued From page 13	F 242		

wanted a bath every other day on admission.

During interview on 4/12/16, at 2:30 p.m. the social services designee (SSD) verified that if a resident preferred more frequent baths, staff would try to accommodate requests. She verified R42's bathing request was missed.

During interview on 4/12/16, at 3:16 p.m. nursing assistant (NA)-C stated if a resident asked for more baths, she would refer to social services.

During interview on 4/12/16, at 3:40 p.m. RN-A stated she would have expected to offer resident more baths when R42's cast came off on 3/17/16.

During interview on 4/13/16, at 10:50 a.m. NA-E verified R42 was scheduled for one bath a week according to the resident bath assignment list.

During interview on 4/13/16, at 1:43 p.m. NA-B stated R42 received baths with plastic wrapped around the cast and also received bed baths.

During interview on 4/13/16, at 1:45 p.m. the DON verified R42 was scheduled for only one bath/week. She verified R42's assistance level: one staff assist, help in and out of tub and keep ankle incision out of water but may get wet. The DON stated R42 could have a tub bath with the use of a shower hose. The DON verified the initial care plan dated 3/4/16, directed that starting 3/7/2016, R42 can shower if right leg wrapped to keep dry. She verified the nursing assistant assignment sheet extra notes included: non-weight bearing, walking boot to be worn all times except for dressing and bathing, do not submerge right ankle in tub, may get wet, transfers with pivot disc and monitor

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	245599	A. BUILDING _____ B. WING _____	04/14/2016

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F 242	Continued From page 14 self-transfers. During interview on 4/13/16, 2:05 p.m. NA-A stated had given R42 sponge baths until the cast was removed and then provided tub showers with the boot off. Although R42 had requested a bath every other day according to the activity preference assessment, R42 received one bath a week. During interview on 4/13/16, at 3:00 p.m. the DON further verified R42 had requested a bath every other day and was scheduled for only a weekly bath. She stated lack of providing additional baths for R42 was a communication problem. Facility bathing policy dated 4/2015, was reviewed and did not address a choice related to frequency of bathing.	F 242		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280		5/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING _____ B. WING _____	04/14/2016

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DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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F 280	Continued From page 15 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to update the plans of care for 2 of 3 residents (R18 & R23) who utilized bed cane rails. Findings include: The occupational therapy note, dated 11/20/14, identified R18 as utilizing a bed cane (a type of bed rail) for assistance with bed mobility. The notes further indicated the bed cane device was appropriate for R18, to allow for independence with bed mobility. R18 demonstrated appropriate use of the bed cane. The current plan of care dated 4/13/16, indicated R18 was able to position self in bed but did not include the use of the bed cane rail. During observation on 4/11/16, at 1:52 p.m. p.m. a bed cane rail was observed on the inner right side of R18's bed. The current care plan dated 4/16/16, indicated R23 was able to position self in bed but it did not include whether R23 utilized the bed cane rail. During observation on 4/11/16, at 1:35 p.m. a bed cane rail was observed bilaterally on R23's bed. Interview with the director of nursing (DON) on	F 280	On 4/11/16 @ 2:30PM MDH RN strongly advised Director of Nursing (DON) to remove bed canes from R18 & R23 beds due to the risk for entrapment. DON had bed canes removed by 3PM on 4/11/16. It was noted that R18 used the assistive device appropriately to maintain her independence with her bed mobility. R18□s plan of care included the bed cane since 11/25/2014. The bed cane was removed from R18□s plan of care on 4/11/2016. When survey team reviewed current plan of care on 4/13/16, the bed cane had already been removed. R18□s care plan showing the discontinued entry for the bed cane since 11/25/2014 was faxed to MDH on 4/15/2016. Supportive devices assessment completed by RN 4/11/16 at 15:26 indicated that resident will benefit from a quarter side rail/SoftTouch side rail for head section only. The side rail was within the recommended safety zones/openings for potential entrapment. The measurement of the side rail was within the safety size recommended. The side rail was added to the plan of care for R18. R23□s bed cane was removed from her	

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	245599	A. BUILDING _____ B. WING _____	04/14/2016

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DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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F 280	Continued From page 16 4/11/16, at 2:30 p.m. indicated R18 has had the bed rail attached to her bed since admission on 11/12/14, and R23 since admission on 3/22/16. The DON confirmed the plans of care for both resident's had not included the use of the bed rails.	F 280	bed on 4/11/2016 @ 3PM. R23 was not independent with her bed mobility and stated she wasn□t using it anyway. R23 had brought the bed cane from home. R23□s bed cane was not added to her comprehensive plan of care. On 4/11/16 after RN assessment, RN updated physician and bilateral SoftTouch side rails were approved for R23□s use. The bed rails allow resident to participate with her bed mobility and staff assistance.Plan of care updated for R23. A supportive devices assessment will be completed on admission and then quarterly by a RN on each resident to determine if assistive devices are appropriate for each resident□s plan of care. The resident has the right to participate in planning care and treatment or any changes being made. The assessment for any type of bed rail must meet the recommended safety zone/openings and recommended safety size. Policy: Bed Safety has been revised 5/2/16. DON and RN Supervisor will complete an audit of all residents currently using any type of side rail to ensure appropriate care plan of the supportive device. Re-education will be provided to all Licensed Nursing Staff to ensure that any supportive devices are included in each resident□s comprehensive plan of care at the nurse□s meeting 5/26/15. Policy: Care Planning and Review was revised on 5/2/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 17	F 280	The Director of Nursing will oversee for compliance to ensure that the plan of care is being followed for each resident. Any concerns will be addressed with the quality assurance team.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 determine whether the use of a product called, bed cane rails, were safe for 2 of 3 residents (R18 & R23) who utilized these rails. In addition, the facility failed to ensure safe hot water temperatures were maintained in 4 of 30 resident rooms (Rooms 206, 208, 407 & 410) observed with hot bathroom sink water. Findings include: R18's quarterly MDS dated 1/27/16, identified current diagnoses of hypertension and dementia. The occupational therapy note dated 11/20/14, identified R 18 as utilizing a bed cane (a type of bed rail) for assistance with bed mobility. The notes further indicated the bed cane device was	F 323	Bed Cane--On 4/11/16 Bed cane rail removed from R18 & R23 and replaced with SoftTouch Siderail for Head Section Only to allow for independence with bed mobility according to RN assessment. Residents care plan updated on 4/11/16. All residents beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories) inspected by maintenance staff to identify any risks and safety problems including potential entrapment risks. Maintenance staff reviewed that any gaps within the bed system are within the dimensions established by the FDA. Also, ensured that bed side rails are properly installed using the manufacturer□s	5/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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F 323	Continued From page 18 appropriate for R18, to allow for independence with bed mobility and R18 demonstrated appropriate use of the device. The progress note did not include whether the cane bed rail had been determined to be safe. The current plan of care dated 4/13/16, indicated R18 was able to position self in bed but did not include the use of the bed cane rail. Review of R18's medical record did not include a determination as to whether the bed rail had been deemed safe for R18's use. Review of incident reports for the past year did not include any injuries nor potential injuries related to the cane bed rail utilized for R18. During observation on 4/11/16, at 1:52 p.m. a cane bed rail was observed on the inner right side of R18's bed. This rail was observed to have a wide opening that measured 12 1/4 inches in length and 5 1/4 inches at the widest part (opening) of the rail. The bed rail was in the shape of a cane. Measurements were confirmed by licensed practical nurse (LPN)-C at 2:30 p.m. and she also verified R18's bed cane rail was wide enough for potential entrapment of the head/neck. There was no fabric material covering the rail opening. Interview with the director of nursing (DON) on 4/11/16, at 2:30 p.m. indicated R18 has used the cane bed rail on her bed since admission on 11/24/14. The DON confirmed the residents bed rail could potentially cause entrapment and should be removed/replaced with a device that was within the recommended safety zones. The DON further indicated nursing staff assess resident use of the cane bed rail system but the	F 323	instructions to ensure proper fit. DON and RN Supervisor will complete an audit of all residents currently using any type of side rail to ensure there has been an interdisciplinary assessment of the resident, Physician order, and input from the resident or legal representative. Electric Bed Policy updated to Bed Safety Policy to ensure regular bed and related equipment inspections by maintenance staff to identify risk and problems including potential entrapment risks. Inspections will ensure that any gaps within the bed system are within the dimensions established by the FDA. Maintenance staff will all ensure that bed side rails are properly installed using the manufacturer□s instructions to ensure proper fit. If side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the Attending Physician, and input from the resident and /or legal representative. The facility□s education and training activities will include instruction and risk factors for resident injury due to beds, and strategies for reducing risk factors for injury, including entrapment. The maintenance department shall maintain a copy of bed safety inspections and report results to the Administrator and the QA Committee for appropriate action. The DON will ensure all residents with bed side rails have been assessed for safety. Any concerns will be addressed with the QA Committee for appropriate action.	

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	245599	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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F 323	Continued From page 19 safety of the bed cane rail had not been determined. R18's bed rail was observed to be removed on 4/11/16, at 3:00 p.m. and replaced with a grab bar/siderail that was within the recommended safety zones/openings for potential entrapment. The measurement of the grab bar/side rail was within the safety size recommended. R23's diagnoses according to her quarterly MDS, dated 1/6/16 included congestive heart failure and dementia. R23's care plan dated 4/16/16, indicated R23 was able to position self in bed but it did not include the use of the bed cane rail. R23's medical record did not include a determination as to whether the bed rail had been deemed safe for R23's use. Review of the incident reports for the past year did not include any injuries or potential injuries related to the use of the bed rail for R23. During observation on 4/11/16, at 1:35 p.m. a bed cane rail was observed bilaterally on R23's bed. The rails were observed to have a wide opening that measured 12 1/4 inches in length and 5 1/4 inches at the widest part (opening) of the rail. The bed rail was in the shape of a cane. Measurements were confirmed by licensed practical nurse (LPN)-C at 7:15 p.m. and she also confirmed R23's bed cane rail was wide enough for potential entrapment of the head/neck. There was no fabric material covering the rail opening. Interview with the DON on 4/11/16, at 2:30 p.m.	F 323	Water Temperatures--On 4/11/16 maintenance staff made adjustments to water heater to ensure water temperature remained between 105 degrees and 115 degrees. Daily record of water temperatures form shows temperatures within acceptable range. On 4/15/16 Klassen Mechanical (Plumber) repaired water heater controller on Aerco Water Heater that was causing erratic water temperatures. Master Form used for daily Water Temp Record updated to include Needs to be between 105 degrees and 115 degrees. If not adjust and recheck to ensure all maintenance employees understand the policy and to prevent any misunderstanding. The Maintenance Director or designee will continue to audit water temperatures daily in random rooms and adjust water temperatures as necessary and recheck the temperature to ensure that they are within a safe range. If an unacceptable temperature cannot be adjusted maintenance will notify the administrator. The administrator will discuss and review any water temperature concerns at Quality Assurance meetings to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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F 323	Continued From page 20	F 323		

indicated R23 has utilized the cane bed rail on her bed since admission on 3/22/16. The DON confirmed this bed rail could potentially cause entrapment and will be removed/replaced with a device that is within the recommended safety zones. The DON further indicated nursing staff assess for the appropriate use of the cane bed rail system but no one had determined whether the device was safe for use.

R23's bed rail was observed to be removed on 4/11/16, at 3:00 p.m.

During interview on 4/12/16, at 1:56 p.m. the administrator indicated R18 and R23 brought the bed cane rails from home to the facility upon admission and indicated the maintenance department staff installed these bed cane rails onto their beds. The administrator confirmed these rails had not been determined whether they were safe for use as the maintenance staff assumed the therapy department was responsible for this determination.

The bed cane manufacturer, Stander, also made available guidance to prevent entrapment including: "There is a risk of entrapment associated with bed rail products. Stander Inc. is committed to informing users of potential entrapment conditions when using bed rails as well as methods to prevent entrapment. Updated versions of this guide are located at www.stander.com. WHAT IS ENTRAPMENT? Entrapment is a situation where an individual can become caught by their head, neck, chest or other body parts in the tight spaces around the bed rail or bedside mobility aid. The below picture shows 2 bed rail products being used on a bed for illustration purposes. ARE THERE ANY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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F 323	Continued From page 21	F 323		

GUIDELINES TO HELP PREVENT ENTRAPMENT? The U.S. Food and Drug Administration (FDA) and the Hospital Bed Safety Workgroup (HBSW) have established the following guidelines to help prevent entrapment. These guidelines are categorized by seven zones. ZONE 1 - WITHIN THE RAIL Any open space between the perimeters of the rail can present a risk of head entrapment. The FDA recommended space is less than four and three quarters of an inch 4-3/4"). Some Stander products have included a fabric material cover around part, or all, of the bed rail. This cover helps reduce the risk of entrapment. The product should never be used when the cover is not securely attached. The cover should only be removed to clean it."

During observation on 4/11/16, at 7:05 p.m. room 410 had a water temperature reading of 124 degrees Fahrenheit (F), measured at the bathroom water faucet.

During observation and interview on 4/11/16, at 7:19 p.m. R22's (room 208) bathroom water temperature was felt to be too warm, with a noted temperature of 122 degrees F. R22 stated if the water got too hot it was his "own fault."

During observation on 4/11/16, at 6:18 p.m. room 407's hot water temperature reached 123.4 degrees F at the bathroom tap water.

During observation on 4/11/16, at 5:57 p.m. room 206's hot water temperature was observed at 126.5 degrees at the bathroom tap water.

During observation and interview on 4/11/16, at 6:56 p.m. with maintenance (M)-A the following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST SLEEPY EYE, MN 56085

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F 323	Continued From page 22	F 323		

room hot water temperatures were noted and recorded at the resident bathroom sinks with the facility thermometer:
- Room 206's temperature was 119 degrees F;
- Room 208's temperature was 121 degrees F;
- Room 407's temperature was 126 degrees F with visible steam coming up from the sink;
- Room 410's temperature was 121 degrees F.

M-A stated on 4/11/16, at 6:56 p.m. water temperatures are monitored daily in the utility rooms but did not measure the water temperature in individual resident rooms. M-A further stated if the hot water temperature was above 120 degrees he would contact his supervisor. M-A stated he contact the hot water heater vendor now about what could be done to address/correct this issue.

During further interview on 4/11/16, at 7:40 p.m. M-A stated he thought there was a thermostat on order and the administrator should have an invoice for this. M-A stated he was turning the water temperature to a lower temperature at this time.

A letter from Klassen Mechanical dated 4/12/16, indicated the controller for the hot water heater was required to correct it's erratic water temperature and the facility was to advise whether this should be replaced and/or cleaned to see if the problem could be corrected.

During interview on 4/11/16, at 6:35 p.m. the DON stated housekeeping had reported concerns to her in the last couple of weeks related to hot water temperature in the nourishment center. The DON stated there had been no burn incidents related to hot water but indicated a maintenance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245599	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE PROVIDENCE COMMUNITY HOME	700 THIRD AVENUE NORTHWEST 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 323	Continued From page 23 request was usually filled out for these type of issues; however, she had discussed this concern directly with maintenance staff. The facility policy entitled Procedure for Monitoring Temperatures, dated 6/05 indicated acceptable temperatures in patient care areas should be between 105- 115 degrees F. Additionally, the policy indicated if any temperatures are outside of acceptable limits, investigate possible causes and make adjustments as necessary.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked,	F 431		5/27/16

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F 431	Continued From page 24 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, interview and document review the facility failed to ensure expired medications were not available for use, opened multi-dose eye drop solutions were dated and medication carts were secure for 2 of 2 medication storage carts observed during medication pass. This had the potential to affect all 47 residents residing at the facility. Findings include: During observation of the medication pass on 4/13/16, at 7:42 a.m. the medication cart was observed unlocked and was located outside of a resident room. Licensed practical nurse (LPN)-A, was inside of the resident room with the door shut and not within direct observation of the medication storage cart. Located on top of this cart the following items were left unattended: creams, insulin, injectable's, eye drops and inhalers. When registered nurse (RN)-A left the room, she walked past the unlocked medication cart and observed the items stored on top. When RN-A attempted to leave the area, the surveyor questioned the practice of leaving unattended/unlocked medications on the cart.	F 431	On 4/14/2016 1 bottle of Nitrostat that had expired 12/30/15 was removed from medication cart for destruction. 1 vial of Lantus was reordered from the pharmacy since it did not have a date identifying the date the multi-dose medication was opened. 6 bottles of identified eye drops that were not properly dated when opened were also reordered from the pharmacy. The eye drops and Lantus Insulin not dated when opened were also destroyed. LPN noted to leave medication cart unlocked and unattended on 4/13/16 had met with the DON on 4/13/16 around 11:45 AM and discussed/reviewed the Use of Medications Policy. It was made clear to LPN that medication carts are to be locked and secure when left unattended or out of sight of medication nurse. LPN was also educated that narcotics are to be double locked and should not be set up prior to medication administration in order to prevent medication errors. If a medication is set up in advance, then a medication card	

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F 431	Continued From page 25 RN-A stated this would not be facility practice. RN-A then proceeded to inform LPN-A, who subsequently walked out of the room that medications were left on top of the cart, unlocked and unattended. The medication cart remained unlocked and out of direct view again on 4/13/16, at 7:50 a.m. when LPN-A entered the medication room and dished up narcotic medications for four (4) different residents and placed them in paper cups. LPN-A identified each cup by writing the resident's initials on the bottom of each cup. LPN-A stacked these cups on top of each other and placed them into the top drawer of the medication cart. No further resident identification and/or medication name was available while stored in the drawer. When interviewed on 4/13/16, at 7:55 a.m. LPN-A stated she had dished up the narcotics ahead of time so they would be available to administer while she was in the dining room passing medications. During observation on 4/13/16, at 7:58 a.m. the medication storage cart was again left unlocked, with three (3) narcotic medications stored and accessible in the drawer while LPN-A walked away to administer medications. The cart was not within direct view of LPN-A. During a subsequent observation on 4/13/16, at 10:14 a.m. the medication cart was left unlocked and unattended in the hallway while LPN-A nurse administered a nebulizer treatment. The unlocked medication cart was not in direct view of the nurse administering the medication as the door was shut. When interviewed on 4/13/16, at 10:20 a.m. the director of nursing (DON) indicated leaving the	F 431	must accompany the medication which includes the current physician order. The LPN performed against facility practice and was terminated from the facility. A new schedule for monitoring medications for proper labeling and expiration will be set up to ensure that all types of medications are checked on a routine basis by a licensed nurse for proper labeling and expiration. The expiration date must also be checked prior to administration of any medication. When opening a multi-dose container, the date opened shall be recorded on the container. Education will be provided for licensed nursing staff at meeting on 5/26/16 of implemented schedule, Use of Medication Policy and education on when medications expire. RN Charge Nurses will monitor for compliance and Director of Nursing will oversee for compliance by random audits done by DON or her designee. Any concerns with compliance will be addressed by the Quality Assurance Team.	

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F 431	Continued From page 26	F 431		

medication storage cart open and unattended was not facility practice. The DON further included medications removed from the narcotic box should have included a medication card that included each residents current physcian order.

During observation on 4/14/16, at 6:20 a.m. one bottle of Nitrostat was found to have an expiration date of 12/30/15 and a vial of Lantus insulin did not have a date identifying the date the multi-dose medication was opened. At this time, 6 bottles of opened eye drop solutions lacked a date on the bottle identifying the date they were opened. These eye drop medications included: Travatan (antiglaucoma), Erythromycin (antibacterial)- 2 bottles, Bromonidine (antiglaucoma), Olopatadine (antihistamine), and Latanoprost (antiglaucoma)eye drop solutions.

During interview on 4/14/16, at 6:30 a.m. LPN-D stated she was unaware of how long eye drops and/or insulin could be administered once the multi-use bottle/vial was opened.

When interviewed on 4/14/16, at 9:00 a.m. the DON stated that she had posted a cheat sheet at the nurses' station identifying each type of eye drop solution and/or insulin and the recommended timeframes for use after the containers were opened. She indicated the staff had not obviously utilized the information.

The facility policy titled Use of Medications, revised 3/2016 included: expiration dates must be checked prior to administration of medications. When opening a multi-dose container, the date opened shall be recorded on the container. Medication carts will be kept closed and locked when out of sight of the medication nurse.

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	245599	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/13/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on April 13, 2016. At the time of this survey, Divine Providence Community Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/05/2016

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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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Divine Providence Community Home is a one-story building with no basement. The building was constructed in 1993, and was determined to be of Type II(111) construction. The building is fully fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility also has automatic smoke detection in all Resident Rooms. The facility has a capacity of 58 beds and had a census of 52 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area	K 021		4/26/16

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K 021	Continued From page 2 enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1	K 021	On 4/26/16 Hawk Alarm Systems added a release device that automatically closes the North Service Hall door upon activation of the fire alarm system. The Maintenance Director or his designee will monitor to prevent a reoccurrence.	

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K 021	Continued From page 3 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. FINDINGS INCLUDE: On 04/13/2016 at 11:15 AM, observation revealed the North Service Hall Door was observed being held open by a magnet that was not connected into the fire alarm system that would release the door upon fire alarm activation. This finding was verified with the chief building engineer at the time of discovery.	K 021		
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) FINDINGS INCLUDE: On 04/13/2016 at 11:15 AM, observation revealed the three exit doors from the Dining Room were observed without exit signs and the Main Exit from the Mall Area was observed needing an exit sign. This finding was verified with the chief building	K 047	On 4/20/16 Electrician added 3 Exit signs above the 3 doors that exit the main resident dining room and added 1 exit sign to the Main exit from the Mall Area. The Maintenance Director or his designee will monitor to prevent a reoccurrence.	4/20/16

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K 047	Continued From page 4 engineer at the time of discovery.	K 047		