Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 8, 2025

Administrator
Divine Providence Community Home
700 Third Avenue Northwest
Sleepy Eye, MN 56085

RE: CCN: 245599
Cycle Start Date: March 4, 2025

Dear Administrator:

On May 1, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 8, 2025

Administrator
Divine Providence Community Home
700 Third Avenue Northwest
Sleepy Eye, MN 56085

Re: Reinspection Results
Event ID: FO6P12

Dear Administrator:

On April 3, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 4, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 10, 2025

Administrator
Divine Providence Community Home
700 Third Avenue Northwest
Sleepy Eye, MN 56085

RE: CCN: 245599
Cycle Start Date: March 4, 2025

Dear Administrator:

On March 4, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 4, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 4, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

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 _____	03/04/2025

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
E 000	Initial Comments On 3/3/25 through 3/4/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/3/25 through 3/4/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		3/31/25

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

Electronically Signed | 03/18/2025

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

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F 688	Continued From page 1 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to ensure staff provided a walking program to meet the assessed needs for 1 of 1 residents (R35) reviewed for restorative services. Findings include: R35's face sheet printed on 3/4/25, indicated primary diagnosis of chronic obstructive pulmonary disease (lung disease causing breathing difficulty), type two diabetes mellitus, chronic kidney disease, and heart failure. R35's quarterly Minimum Data Set (MDS) assessment dated 2/12/2025, indicated intact cognition, no rejection of care, use of a walker, wheelchair, and limb prosthesis, substantial assistance for bathing, partial assistance for	F 688	1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; educating staff to follow residents walking program, and to document refusals. Requested order for PT to evaluate and treat to ensure current program for R35 is still appropriate. 2. The facility will identify other residents having the potential to be affected by the same deficient practice by; reviewed the last 3 months (90 days), residents with walking programs; review revealed resident refusals are not always getting charted. Educated ROM CNA (and all staff at meeting TBD to review deficiencies) to prevent similar.	

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F 688	Continued From page 2 upper and lower body dressing, partial assistance for personal hygiene, setup assistance for transfers, supervision for walking 50 feet, and no restorative nursing program. R35's care plan dated 9/27/24, indicated R35 walked independently with one helper providing setup assistance and use of four wheeled walker with gait belt. R35's goal was to continue to be able to walk and transfer safely. R35's document titled Divine Therapy Referral to Nursing dated 12/20/23, indicated R35's physical therapy recommended ambulation/walking program instructed to walk with R35 with four wheeled walker, gait belt, contact guard assistance of one staff, wheelchair to follow to and from all meals (three times daily). During interview on 3/3/25 at 3:53 p.m., R35 stated he had not been walking as much he wanted to and stated staff did not always have the time to help him walk. R35 stated he would walk more if staff were available, and he could not walk on his own due to past falls. During observation on 3/3/25 at 5:35 p.m., R35 was observed propelling himself in his wheelchair in the hallway and was not observed walking to or from supper. During interview on 3/4/25 at 10:49 a.m., nursing assistant (NA)-B stated she was supposed to walk the residents on her assigned hallway during her shift and usually had time to get all of her assigned walks done. NA-B further stated completed walks would be documented in the electronic health record (EHR).	F 688	3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Facility to review current policy, to include walking residents based on therapy recommendations unless deemed unsafe. To include obtaining therapy orders for re-evaluation of current walking program as needed if nursing finding no longer appropriate. Policies to be reviewed and updated if needed include, but are not limited to the following; Assisting with Transfers and Walks. Policies and procedures to be enforced. 4. The facility will monitor its performance to make sure that solutions are effective by; Audit will be conducted per DON, or designated licensed nursing staff member, one time per month times six months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting.	

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F 688	Continued From page 3 During interview on 3/4/25 at 12:26 p.m., NA-C stated the restorative nursing assistant (RNA) did most of the walking of residents, but the NA would assist with walking when able. During interview on 3/4/25 at 12:39 p.m., NA-D stated both the RNA and NA are responsible for walking the residents on their assigned hallway. NA-D stated when walks were completed they were documented in the EHR and resident refusals would also documented in the EHR. During interview with the director of nursing (DON) on 3/4/25 at 2:42 p.m., she stated she would expect that R35's walks were completed as recommended and if R35 refused to walk she would expect that to be documented in the EHR. DON further stated R35 had not declined from not walking, but walking would be important to maintain his current level of function and prevent any decline in function. Review of an untitled facility provided document from the EHR printed 3/4/25, indicated from 2/16/25 through 3/2/25, R35 did not walk three times daily as recommended. Documented walks included the following: 2/16/25- one time 2/17/25- no walk 2/18/25- one time 2/19/25- no walk 2/20/25- two times 2/21/25- one time 2/22/25- two times 2/23/25- one time 2/24/25- one time 2/25/25- no walk 2/26/25- no walk 2/27/25- no walk	F 688		

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F 688	Continued From page 4 2/28/25- no walk 3/1/25- one time 3/2/25- one time Review of a facility policy titled Assisting with Transfers and Walks revised 5/24, did not include anything regarding walking residents based on therapy recommendations.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure oxygen administration was consistently monitored according to physician orders for 2 of 4 residents (R18, R19) observed during dining. Findings include: R18's facesheet printed on 3/5/25, included diagnoses of multiple fractured ribs and congestive heart failure (when the heart doesn't pump blood as well as it should). R18's admission MDS assessment dated 1/23/25, indicated R18 had moderately impaired cognition, clear speech, could usually understand	F 695	1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; review and/or revise policies and procedures to ensure residents' oxygen equipment are being monitored. Oxygen tanks are being moved to a more accessible location, to ensure easy access and compliance of oxygen needs/orders for R18 and R19. Monitoring of compliance for R18 and R19 oxygen use to ensure we are meeting their needs. Policy revision to include periodic checking of the amount of oxygen in the tank when in use.	3/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 695	Continued From page 5 and be understood. R18 required substantial assistance with ADL's and did not walk. R18 used continuous oxygen therapy. R18's physician orders dated 2/28/25, indicated chronic oxygen at 2 LPM (liters per minute) at HS (bedtime) PRN (as needed) and 1 LPM during the day to keep [oxygen saturation] above 90%. R18's care plan dated 2/12/25, did not include oxygen therapy. During an observation on 3/4/25 at 8:10 a.m., R18 was seated at the table in the dining room in her wheelchair. R18 had an oxygen cannula in her nares. Her oxygen tank on the back of her wheelchair indicated R18 was receiving 1 liter of oxygen, however, the arrow on the oxygen gauge was in the red REFILL section. LPN-A who was sitting next to R18 while R18 was taking her pills, looked at the gauge and stated, "oh, it's empty." LPN-A obtained a new oxygen tank and changed it out. R18 denied feeling short of breath. During an interview on 3/4/25 at 10:14 a.m., NA-A stated she had helped R18 get up that morning. NA-A stated she turned the portable oxygen tank on and saw there was hardly any oxygen left. NA-A stated she knew there would be enough oxygen to quick weigh R18 and bring her back to her room for breakfast. However, after being weighed, R18 decided she would eat in the dining room. NA-A stated at that point, she had totally forgot about the oxygen tank being almost empty. (NA)-A stated whoever put a resident in a wheelchair with their portable oxygen tank was responsible to ensure there was oxygen in the tank. NA-A stated nurses and nursing assistants had training on how to use and change an oxygen	F 695	2. The facility will identify other residents having the potential to be affected by the same deficient practice by; currently three, sometimes four, residents are utilizing portable tanks in the dining room. Audit conducted on 03/15/25, 03/16/25, and 03/18/25 revealing compliance. All resident utilizing portable oxygen were noted not having an empty tank (more than enough to get through the meal/back to room), valve open, and LPM set at MD order. 3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Oxygen to be moved to a location that is more accessible to CNA□s, to ensure compliance. Policies to be reviewed and updated if needed include, but are not limited to the following; Facility Oxygen Concentrators and Cylinders. Policies and procedures to be enforced. 4. The facility will monitor its performance to make sure that solutions are effective by; Audit will be conducted per DON, or designated licensed nursing staff member, one time per month times six months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting.	

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F 695	Continued From page 6 tank. R19's facesheet printed on 3/4/25, included diagnosis of chronic obstructive pulmonary disease (COPD), (a disease that blocks airflow making it difficult to breathe). R19's quarterly Minimum Data Set (MDS) assessment dated 2/5/25, indicated R19 was cognitively intact, had clear speech, could understand and be understood. R19 required partial assistance with activities of daily living (ADLs) and could walk short distances with supervision. R19 received oxygen therapy. R19's physician orders undated, indicated administer oxygen per cannula 1-4 liters as needed for shortness of breath (per standing order). Order dated 11/18/24, indicated to monitor O2 (oxygen) saturation and chart how often using oxygen. R19's care plan dated 9/3/24, indicated R19 had respiratory problems; got short of breath with exertion, but currently did not use oxygen. During an observation on 3/3/25 at 5:59 p.m., R19 was seated at the table in the dining room in her wheelchair. R19 had an oxygen nasal cannula in her nares. The oxygen tank on the back of her wheelchair indicated R19 was receiving 1.5 liters of oxygen, however the arrow on the oxygen gauge was in the red REFILL section. During an interview and observation on 3/3/25 at 6:04 p.m., licensed practical nurse (LPN)-B verified the arrow was in the red REFILL section and stated the tank was empty. LPN-B turned the	F 695		

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F 695	Continued From page 7 handle on the tank to the open position to make sure it was open, and the arrow remained in the REFILL section. During an observation on 3/3/25 at 6:07 p.m., LPN-B changed out the oxygen tank. During an interview on 3/3/25 at 6:14 p.m., R19 stated she had not felt short of breath while eating her meal, adding, she was only eating, not walking. During an interview on 3/4/25 at 2:31 p.m., the director of nursing (DON) stated in the morning, staff usually changed out the portable oxygen tanks if needed, and whoever was taking the resident with the portable tank should look at the level of oxygen remaining in the tank. Facility Oxygen Concentrator and Cylinders policy with revised date of 4/24, indicated oxygen would be provided to residents for whom oxygen had been ordered by a physician; oxygen concentrators would be used whenever possible and tanks only as needed. The policy described the steps for setting up an oxygen cylinder (tank). The policy did not include periodic checking of the amount of oxygen in the tank when in use.	F 695		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 10, 2025

Administrator
Divine Providence Community Home
700 Third Avenue Northwest
Sleepy Eye, MN 56085

Re: State Nursing Home Licensing Orders
Event ID: FO6P11

Dear Administrator:

The above facility was surveyed on March 3, 2025 through March 4, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00040	A. BUILDING: _____ B. WING _____	03/04/2025

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/3/25 through 3/4/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure and the following correction orders are issued.	2 000		

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2 000	Continued From page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 270	MN Rule 4658.0090 Use of Oxygen A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure oxygen administration was consistently monitored according to physician orders for 2 of 4 residents (R18, R19) observed during dining. Findings include: R18's facesheet printed on 3/5/25, included diagnoses of multiple fractured ribs and congestive heart failure (when the heart doesn't pump blood as well as it should). R18's admission MDS assessment dated 1/23/25, indicated R18 had moderately impaired cognition, clear speech, could usually understand and be understood. R18 required substantial assistance with ADL's and did not walk. R18 used continuous oxygen therapy.	2 270	Corrected	3/31/25

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2 270	Continued From page 2 R18's physician orders dated 2/28/25, indicated chronic oxygen at 2 LPM (liters per minute) at HS (bedtime) PRN (as needed) and 1 LPM during the day to keep [oxygen saturation] above 90%. R18's care plan dated 2/12/25, did not include oxygen therapy. During an observation on 3/4/25 at 8:10 a.m., R18 was seated at the table in the dining room in her wheelchair. R18 had an oxygen cannula in her nares. Her oxygen tank on the back of her wheelchair indicated R18 was receiving 1 liter of oxygen, however, the arrow on the oxygen gauge was in the red REFILL section. LPN-A who was sitting next to R18 while R18 was taking her pills, looked at the gauge and stated, "oh, it's empty." LPN-A obtained a new oxygen tank and changed it out. R18 denied feeling short of breath. During an interview on 3/4/25 at 10:14 a.m., NA-A stated she had helped R18 get up that morning. NA-A stated she turned the portable oxygen tank on and saw there was hardly any oxygen left. NA-A stated she knew there would be enough oxygen to quick weigh R18 and bring her back to her room for breakfast. However, after being weighed, R18 decided she would eat in the dining room. NA-A stated at that point, she had totally forgot about the oxygen tank being almost empty. (NA)-A stated whoever put a resident in a wheelchair with their portable oxygen tank was responsible to ensure there was oxygen in the tank. NA-A stated nurses and nursing assistants had training on how to use and change an oxygen tank. R19's facesheet printed on 3/4/25, included diagnosis of chronic obstructive pulmonary	2 270		

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2 270	Continued From page 3 disease (COPD), (a disease that blocks airflow making it difficult to breathe). R19's quarterly Minimum Data Set (MDS) assessment dated 2/5/25, indicated R19 was cognitively intact, had clear speech, could understand and be understood. R19 required partial assistance with activities of daily living (ADLs) and could walk short distances with supervision. R19 received oxygen therapy. R19's physician orders undated, indicated administer oxygen per cannula 1-4 liters as needed for shortness of breath (per standing order). Order dated 11/18/24, indicated to monitor O2 (oxygen) saturation and chart how often using oxygen. R19's care plan dated 9/3/24, indicated R19 had respiratory problems; got short of breath with exertion, but currently did not use oxygen. During an observation on 3/3/25 at 5:59 p.m., R19 was seated at the table in the dining room in her wheelchair. R19 had an oxygen nasal cannula in her nares. The oxygen tank on the back of her wheelchair indicated R19 was receiving 1.5 liters of oxygen, however the arrow on the oxygen gauge was in the red REFILL section. During an interview and observation on 3/3/25 at 6:04 p.m., licensed practical nurse (LPN)-B verified the arrow was in the red REFILL section and stated the tank was empty. LPN-B turned the handle on the tank to the open position to make sure it was open, and the arrow remained in the REFILL section. During an observation on 3/3/25 at 6:07 p.m.,	2 270		

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2 270	Continued From page 4 LPN-B changed out the oxygen tank. During an interview on 3/3/25 at 6:14 p.m., R19 stated she had not felt short of breath while eating her meal, adding, she was only eating, not walking. During an interview on 3/4/25 at 2:31 p.m., the director of nursing (DON) stated in the morning, staff usually changed out the portable oxygen tanks if needed, and whoever was taking the resident with the portable tank should look at the level of oxygen remaining in the tank. Facility Oxygen Concentrator and Cylinders policy with revised date of 4/24, indicated oxygen would be provided to residents for whom oxygen had been ordered by a physician; oxygen concentrators would be used whenever possible and tanks only as needed. The policy described the steps for setting up an oxygen cylinder (tank). The policy did not include periodic checking of the amount of oxygen in the tank when in use. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review, and/or revise policies and procedures to ensure residents' oxygen equipment was monitored. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 270		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion	2 895		3/31/25

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2 895	Continued From page 5 Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on interview, observation and document review, the facility failed to ensure staff provided a walking program to meet the assessed needs for 1 of 1 residents (R35) reviewed for restorative services. Findings include: R35's face sheet printed on 3/4/25, indicated primary diagnosis of chronic obstructive pulmonary disease (lung disease causing breathing difficulty), type two diabetes mellitus, chronic kidney disease, and heart failure. R35's quarterly Minimum Data Set (MDS) assessment dated 2/12/2025, indicated intact cognition, no rejection of care, use of a walker, wheelchair, and limb prothesis, substantial assistance for bathing, partial assistance for upper and lower body dressing, partial assistance for personal hygiene, setup assistance for transfers, supervision for walking 50 feet, and no	2 895	Corrected	

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2 895	Continued From page 6 restorative nursing program. R35's care plan dated 9/27/24, indicated R35 walked independently with one helper providing setup assistance and use of four wheeled walker with gait belt. R35's goal was to continue to be able to walk and transfer safely. R35's document titled Divine Therapy Referral to Nursing dated 12/20/23, indicated R35's physical therapy recommended ambulation/walking program instructed to walk with R35 with four wheeled walker, gait belt, contact guard assistance of one staff, wheelchair to follow to and from all meals (three times daily). During interview on 3/3/25 at 3:53 p.m., R35 stated he had not been walking as much he wanted to and stated staff did not always have the time to help him walk. R35 stated he would walk more if staff were available, and he could not walk on his own due to past falls. During observation on 3/3/25 at 5:35 p.m., R35 was observed propelling himself in his wheelchair in the hallway and was not observed walking to or from supper. During interview on 3/4/25 at 10:49 a.m., nursing assistant (NA)-B stated she was supposed to walk the residents on her assigned hallway during her shift and usually had time to get all of her assigned walks done. NA-B further stated completed walks would be documented in the electronic health record (EHR). During interview on 3/4/25 at 12:26 p.m., NA-C stated the restorative nursing assistant (RNA) did most of the walking of residents, but the NA would assist with walking when able.	2 895		

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2 895	Continued From page 7 During interview on 3/4/25 at 12:39 p.m., NA-D stated both the RNA and NA are responsible for walking the residents on their assigned hallway. NA-D stated when walks were completed they were documented in the EHR and resident refusals would also documented in the EHR. During interview with the director of nursing (DON) on 3/4/25 at 2:42 p.m., she stated she would expect that R35's walks were completed as recommended and if R35 refused to walk she would expect that to be documented in the EHR. DON further stated R35 had not declined from not walking, but walking would be important to maintain his current level of function and prevent any decline in function. Review of an untitled facility provided document from the EHR printed 3/4/25, indicated from 2/16/25 through 3/2/25, R35 did not walk three times daily as recommended. Documented walks included the following: 2/16/25- one time 2/17/25- no walk 2/18/25- one time 2/19/25- no walk 2/20/25- two times 2/21/25- one time 2/22/25- two times 2/23/25- one time 2/24/25- one time 2/25/25- no walk 2/26/25- no walk 2/27/25- no walk 2/28/25- no walk 3/1/25- one time 3/2/25- one time Review of a facility policy titled Assisting with	2 895		

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2 895	Continued From page 8 Transfers and Walks revised 5/24, did not include anything regarding walking residents based on therapy recommendations. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies related to the restorative walking program, educate staff on the policies, and conduct an audit of all residents on the program to ensure it is being completed and documented as ordered. In addition, they could audit to ensure a licensed nurse evaluates the program and each resident on the program periodically to ensure appropriate. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		

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	245599	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/06/2025. At the time of this survey, Divine Providence Community Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 03/20/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Divine Providence Community Home is a 1-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.	K 000		

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	245599	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2025**

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K 000	Continued From page 2 The facility has a capacity of 50 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 325 SS=D	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install Alcohol Based Hand Rub (ABHR) in accordance with the requirements of	K 325	A detailed description of the corrective action taken or planned to correct the deficiency:	3/31/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 325	Continued From page 3 NFPA 101, section 19.3.2.6.8. This deficient practice could have an isolated impact on the residents. Findings include: On 03/06/25 between 8:30 AM and 12:30 PM, it was revealed by observation that one ABHR dispenser was installed directly above an electrical switch located in the Snack Shop. An interview with the Maintenance Director verified this finding at the time of discovery.	K 325	On 3/7/25 the Alcohol Based Hand Rub (ABHR) located in the snack shop was moved so that it was not over the electrical light switch. Address the measures that will be put in place to ensure the deficiency does not reoccur: Maintenance will inspect all ABHR located throughout the facility for proper placement. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Education will be provided to employees regarding ABHR placement. Identify who is responsible for the corrective actions and monitoring of compliance. The Maintenance Director will be responsible for monitoring and ensuring continued compliance.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K 353		4/30/25

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	245599	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2025**

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K 353	Continued From page 4 b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 03/06/2025 between 8:30 AM and 12:30 PM, it was revealed by observation that there was ductwork resting on top of a sprinkler head located in mechanical room 521. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	A detailed description of the corrective action taken or planned to correct the deficiency: Sprinkler head in room 521 is part of an incomplete construction project replacing the Air Handler in the mechanical room. Contacted CMTA the professional mechanical and electrical engineers hired to oversee the project. CMTA will work with project general contractor, Gag Sheet Metal and subcontractor Summit Fire to move the sprinkler head. Address the measures that will be put in place to ensure the deficiency does not reoccur: During quarterly sprinkler system inspection, all sprinkler heads will be observed to follow NFPA 101 Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Quarterly sprinkler system inspection will monitor compliance Identify who is responsible for the corrective actions and monitoring of compliance.	

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K 353	Continued From page 5	K 353	The Maintenance Director will be responsible for monitoring and ensuring continued compliance.	
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the facility smoking policy per NFPA 101 (2012	K 741	A detailed description of the corrective action taken or planned to correct the deficiency:	3/31/25

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K 741	Continued From page 6 edition), Life Safety Code, section 19.7.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/06/2025 between 8:30 AM and 12:30 PM, it was revealed by observation that there was an employee smoking and disposing of a cigarette in a unapproved container located not within the designated smoking area per the smoking policy. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 741	Maintenance replaced two unapproved smoking containers with two new metal containers that meet the requirement and placed them in the designated smoking area. Address the measures that will be put in place to ensure the deficiency does not reoccur: Education will be provided to employees to only smoke in the designated smoking areas or at least 15 feet from the building. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Audit will be conducted by Administrator, or designee, one time per month times six months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting. Identify who is responsible for the corrective actions and monitoring of compliance. The Administrator will be responsible for monitoring and ensuring continued compliance.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled	K 920		3/31/25

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K 920	Continued From page 7 by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 03/06/2025 between 8:30 AM and 12:30 PM, it was revealed by observation in the Snack Shop the pop machine and snack machine were plugged into a power strip. Maintenance corrected this deficiency at the time if discovery.	K 920	A detailed description of the corrective action taken or planned to correct the deficiency: On 3/6/25, vending machines in the Snack Shop and refrigerator located in the maintenance shop power cords were moved from the power strip to the direct outlet in wall. Address the measures that will be put in place to ensure the deficiency does not reoccur: Maintenance will inspect all patient care areas for any other equipment plugged into a power strip. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.	

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K 920	Continued From page 8 2. On 03/06/2025 between 8:30 AM and 12:30 PM, it was revealed by observation that the refrigerator located in the maintenance shop was plugged into a 6 plug-in adapter. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	Education will be provided to employees on use of power strips. Identify who is responsible for the corrective actions and monitoring of compliance. The Maintenance Director will be responsible for monitoring and ensuring continued compliance.	