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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VTVK

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 **09/28/2021** (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 :
Elizabeth Silkey, Unit Supervisor 10/06/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 10/06/2021 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
09/08/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 6, 2021

CMS Certification Number (CCN): 245599

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

Dear Administrator:

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 August 30, 2021 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 beds.

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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 6, 2021

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

RE: CCN: 245599
Cycle Start Date: July 22, 2021

Dear Administrator:

On September 28, 2021, 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, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VTVK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00040

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(L3) **DIVINE PROVIDENCE COMMUNITY HOME**
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(L5) **SLEEPY EYE, MN** (L6) **56085**

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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 **07/22/2021** (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

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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 :
Karrin Witte, HFE NE 08/29/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 09/03/2021 (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)

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3. Both of the Above :
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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

Electronically delivered
August 12, 2021

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

RE: CCN: 245599
Cycle Start Date: July 22, 2021

Dear Administrator:

On July 22, 2021, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
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 October 22, 2021 (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 January 22, 2022 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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 _____	C 07/22/2021

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 7/19/21- 7/22/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 7/19/21 - 7/22/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5599030C (MN00046037), H5599031C (MN00057554), H5599032C (MN00062025), H5599033C (MN00066629), and H5599034C (MN00073066). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

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

Electronically Signed | 08/18/2021

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.

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 _____	C 07/22/2021

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	Continued From page 1 regulations has been attained.	F 000		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §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 observation, interview and document review the facility failed to ensure range of motion program for upper and lower extremities was implemented for 1 of 2 residents (R27) reviewed who had limited range of motion. Findings include: R27's face sheet, printed 7/22/21, identified diagnoses of hemiplegia (paralysis) following intracranial hemorrhage (bleeding in the brain) of left nondominant side and pain. R27's quarterly Minimum Data Set (MDS)	F 688	1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; Implementing procedure for days restorative range of motion (ROM) aide is not scheduled/re-arranging position to direct care due to change in certified nursing assistant schedule. It will be the responsibility of the certified nursing assistant assigned to the hall/wing to perform and chart ROM for the resident found to be affected by the deficient practice. ROM program for R27 has been added to the caregiver worksheet to alert	8/30/21

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 _____	C 07/22/2021

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 688	Continued From page 2 assessment dated 6/36/21, identified R27 had intact cognition, limited range of motion of both upper and lower extremities on one side and required extensive assist of 2 or more persons for transfers, bed mobility and extensive assist of one for personal hygiene, toileting and dressing. R27's care plan, dated 4/5/21, identified a problem requiring assistance for transferring, repositioning, and moving from one place to another because of a stroke, tires easily, has weak muscles and hemiplegia of left side. Approach included complete ROM as ordered and report changes. Active ROM for right side and passive ROM to left side. R27 was observed and interviewed on 7/19/21, at 5:04 p.m. lying in her bed with her left hand on a pillow and a washcloth present in her hand with her fingers curled in towards the washcloth. R27 indicated she is paralyzed on the left side from a stroke. R27 stated they do range of motion (ROM) sometimes, but only when they have time, which has not been very often. R27 was unable to move left hand or arm. During observation and interview on 7/20/21, at 1:35 p.m., R27 stated no one has offered to complete ROM for quite awhile and if they do, they claim they are completing it while transferring me but they don't really complete it like it should be done. R27 was unsure if her ROM had changed due to it not being done. Left hand remains elevated on a pillow with left hand in a rolled up washcloth. Fingers are curled in towards palm to the washcloth. An Occupational Therapy Toolkit undated, was present in the medical record with instructions	F 688	the certified nursing assistant and prevent similar. Policy and procedure for ROM will be revised to reflect change(s). 2. The facility will identify other residents having the potential to be affected by the same deficient practice by; reviewing all residents functional maintenance program (FMP), as well as if they are receiving ROM on the dates scheduled per FMP. 3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; Implementing procedure for days ROM aide is not scheduled/re-arranging position to direct care due to change in certified nursing assistant schedule. It will be the responsibility of the certified nursing assistant assigned to the hall/wing to perform and chart ROM for the resident(s) with FMP's in place. Policy and procedure for ROM will be revised to reflect change(s). 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 week times four weeks, then one time per month times two months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting. Staff will take a written test at the end of licensed staff/certified nursing assistant meeting held on 08/30/2021 to ensure understanding and compliance of policy	

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 _____	C 07/22/2021

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 688	Continued From page 3 and pictures that included passive ROM exercises to shoulder, elbow, wrist, forearm, wrist, fingers and thumb with amount of repetitions to complete. An Occupational Therapy (OT) plan of care dated 9/15/17, included at rest R27's left hand is in a half fist with possibility of contractures, and skin breakdown. A notification from discharge from therapy included a date of 8/22, lacked year indicated R27 was discharged to restorative program. Prior OT plan of care dated 5/13/14 indicated the patient will participate with maintenance program three times per week to maintain ROM and strength. The electronic medical record (EMR) task list included restorative ROM last updated 8/23/19, with active ROM to right upper and lower extremity and passive ROM to left upper extremity and lower extremity to follow master copy (OT toolkit). Task was to be completed in morning, afternoon or evening, three times a week on Monday, Wednesday and Friday excluding holidays. The task in 2021 was completed three times in January, six times in February, nine times in March, one time in April, five times in May, six times in June and two times in July. During interview on 7/21/21, at 8:37 a.m., nursing assistant (NA)-A indicated she is assigned restorative duties unless someone calls in unexpectedly, then she provides direct patient care. NA-A stated range of motion is completed on R27 on Monday, Wednesday and Friday and includes the elbow, shoulders and fingers and R27 is generally cooperative with the ROM treatment. NA-A further added she gets pulled to	F 688	and procedure. 5. Dates when corrective action(s) will be completed are as follows; Residents affected by deficient practice identified. Implementing procedure for days ROM aide is not scheduled/re-arranging position to direct care due to change in certified nursing assistant schedule will be completed and presented by 08/30/2021. Policy and procedure for ROM will be revised to reflect change(s) and completed by 08/30/2021. Audit results to be reviewed and discussed at quarterly Quality Assurance meeting following the next scheduled (08/23/2021), date to be determined.	

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	245599	A. BUILDING _____ B. WING _____	C 07/22/2021

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F 688	Continued From page 4 direct patient care duty a lot and tries to complete ROM if she has time which isn't very often. During interview on 7/22/21, at 9:16 a.m., NA-C indicated the nursing assistants on the floor do not complete range of motion exercises for residents. During interview on 7/22/21, at 10:14 a.m., NA-B indicated nursing assistants do not complete ROM exercises even if the restorative aid gets pulled from restorative duty to other tasks. During interview on 7/22/21, at 10:27 a.m., the director of nursing (DON) indicated the nursing assistants are responsible for completing ROM exercises if the restorative aide is providing direct patient care due to an absence of another staff member. The DON indicated she used to add ROM to the assignment sheet to complete but quit doing that. The DON confirmed if the task is on the treatment record, it should be completed. A policy and procedure for ROM was requested, but none was received.	F 688		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 883		8/18/21

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F 883	Continued From page 5 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and	F 883		

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F 883	Continued From page 6 (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the pneumococcal conjugate (PCV13) vaccine was offered or administered as recommended by the Centers for Disease Control (CDC) for 2 of 5 residents (R16 and R22) reviewed for immunizations. Findings include: R22 R22's facesheet printed on 7/22/21, indicated an age of 83 years and an admission date of 4/24/20. Diagnoses included anemia, thrombocythema (bone marrow makes too many platelets), and protein-calorie malnutrition. R22's significant change Minimum Data Set (MDS) assessment dated 6/16/21, indicated R22 had severe cognitive impairment, adequate hearing and speech, could usually understand and was usually understood. R22 was independent or required supervision with bed mobility, transfers, walking, toileting and eating. During record review, the status in R22's EMR (electronic medical record) under immunizations for PCV13 indicated "not recommended." A paper copy of R22's immunization status printed from the EMR, indicated "PCV13 is not a recommended immunization per MDH (Minnesota Department of Health) MIIC (Minnesota Immunization Information	F 883	1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice by; Offering the resident(s) found to be affected by the deficient practice a pneumococcal immunization, as well as providing education, unless the immunization is medically contraindicated. R16 and R29 were offered the appropriate pneumococcal immunization, accepted, and received immunization. 2. The facility will identify other residents having the potential to be affected by the same deficient practice by; DON will review the (Minnesota Immunization Information Connection (MIIC) report for each resident residing at Divine Providence Community Home (DPCH), as well as conduct a diligent investigation to ensure knowledge of resident(s) immunization status if not listed on the MIIC report. Newly admitted residents will be evaluated for immunization status, and offered recommended immunizations based off of Centers for Disease Control (CDC) recommendations versus the MIIC report. 3. Measures put into place or systemic changes made to ensure that the deficient practice will not recur are; DPCH will follow CDC recommendations for	

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F 883	Continued From page 7 Connection) report." Notations were entered into the EMR by nursing staff when immunization status was assessed on admission. R16 R16's facesheet printed on 7/22/21, indicated an age of 88 years and an admission date of 5/27/21. Diagnoses included diabetes, chronic kidney disease and anemia. R16's admission Minimum Data Set (MDS) assessment dated 6/1/21, indicated R16 had moderately impaired cognition, adequate vision, minimal difficulty hearing, clear speech, could make self understood, and could understand others. R16 required supervision for bed mobility, transfers, walking, dressing and toileting. During record review, the status in R16's EMR under immunizations for PCV13 indicated "not recommended." A paper copy of R16's immunization status printed from the EMR, indicated "MIIC does not list PCV13 as an immunization recommended." Notations were entered into the EMR by nursing staff when immunization status was assessed on admission. During an interview on 7/22/21, at 9:45 a.m., the director of nursing (DON) provided a paper copy of the facility standing orders which were utilized for all residents upon admission and which indicated: pneumococcal vaccine to be given on admission, if not done within 3 months prior. Facility policy will be followed. Facility policy, dated 11/16, indicated the pneumococcal vaccination included PPSV23 and PCV13, and would be encouraged according to	F 883	immunizations upon admission versus the MIIC report. Policy and procedure will be revised to reflect changes. Education/training will be provided to licensed nursing staff on 08/30/2021 to prevent similar. 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 week times four weeks, then one time per month times two months. Audits will continue if deemed necessary. Audit information will be reviewed at the quarterly Quality Assurance meeting. Staff will take a written test at the end of licensed staff/certified nursing assistant meeting held on 08/30/2021 to ensure understanding and compliance of policy and procedure. 5. Dates when corrective action(s) will be completed are as follows; Residents affected by deficient practice identified. Implementing procedure for residents affected by deficient practice completed. Policy and procedure for vaccinations offered has been revised to reflect change(s). Audit results to be reviewed and discussed at quarterly Quality Assurance meeting following the next scheduled (08/23/2021), date to be determined.	

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F 883	Continued From page 8 the standing order if, after diligent investigation: -no record can be found of the resident having had a pneumococcal vaccine -it is not medically contraindicated -if one was received prior to age 65 During an interview on 7/21/21, at 12:45 p.m. with both the DON and administrator, when asked why the PCV13 was not recommended, the DON stated the facility used a MIIC report to determine which immunization(s) a resident still needed upon admission, and R22 and R16's MIIC reports did not indicate the PCV13 was needed. Upon review of R22 and R16's individualized MIIC reports, the reports indicated: "This report contains immunizations submitted to MIIC. Provider participation is voluntary. Please check with your healthcare provider if you notice missing vaccinations." On the MIIC report was a section titled Immunization History which did not include PCV13, and a section titled Immunizations Recommended which did not include PCV13. The DON stated she thought if PCV13 was not listed under Immunizations Recommended, that a resident did not need that vaccine, adding "I thought the MIIC report could be used; now I know it's not the final word on immunizations. We'll need to change our process." Facility policy titled: Pneumococcal Vaccination, dated 11/16, indicated the facility encouraged all residents to receive the pneumococcal vaccine as recommended by the CDC in order to minimize the risk of residents contracting, transmitting or experiencing illness from pneumococcal bacteria. Residents would be assessed on admission to determine if pneumococcal vaccination has occurred. The facility would check the MIIC or contact past	F 883		

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F 883	Continued From page 9 providers to access this information. The pneumococcal vaccination would be encouraged according to the standing order if, after diligent investigation: -no record can be found of the resident having had a pneumococcal vaccine -it is not medically contraindicated -if one was received prior to age 65	F 883		

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	245599	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/29/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/29/2021. 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		08/18/2021

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 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	K 000		

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K 000	Continued From page 2 Rooms. The facility has a capacity of 58 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
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 _____ 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 automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, and 9.7.8, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.5. This deficient	K 353	The 3rd quarter 2021 automatic sprinkler system annual inspection was completed and documented on July 15, 2021.Sprinkler system inspections will be completed each quarter. Fire Sprinkler System Policy created.	8/18/21

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K 353	Continued From page 3 condition could have an isolated impact on the residents within the facility. FINDINGS INCLUDE: On a facility tour between 10:00 AM and 1:00 PM on 07/29/2021, it was revealed that there were no records to review to show that a quarterly sprinkler inspection was conducted during the 1st and 2nd quarters of 2021. This deficient condition was verified by the Facility Maintenance Director.	K 353	Environmental Services Preventative Maintenance Monthly and Quarterly Schedule will be followed and documented The Maintenance Director will be responsible for monitoring and ensuring continued compliance.	