Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 11, 2025

Administrator
SLEEPY EYE REHABILITATI CENTER
1105 3RD AVENUE SOUTHWEST
SLEEPY EYE, MN 56085

RE: CCN: 245225
Cycle Start Date: July 17, 2025

Dear Administrator:

On September 5, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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September 11, 2025

Administrator
SLEEPY EYE REHABILITATI CENTER
1105 3RD AVENUE SOUTHWEST
SLEEPY EYE, MN 56085

Re: Reinspection Results
Event ID: 872L-H2

Dear Administrator:

On 09/05/2025 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 07/17/2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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Federal Enforcement | Health Regulation Division
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An equal opportunity employer.

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August 12, 2025

Administrator
SLEEPY EYE REHABILITATI CENTER
1105 3RD AVENUE SOUTHWEST
SLEEPY EYE, MN 56085

RE: CCN:245225
Cycle Start Date: July 17, 2025

Dear Administrator:

On July 17, 20245, a survey was completed at your facility by the Minnesota Departments of Health 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us

Office (507) 206-2728

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 17, 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 January 17, 2026, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

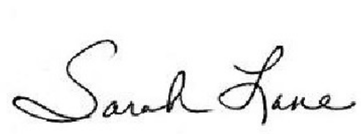
INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245225	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLEEPY EYE REHABILITATI CENTER	1105 3RD AVENUE SOUTHWEST , SLEEPY EYE, Minnesota, 56085

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 7/15/25, 7/16/25, and 7/17/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed:H52258009C (MN00114110) with deficiencies issued at: F880 and F684. 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 regulations has been attained.	F0000		08/20/2025
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to comprehensively assess and monitor non-pressure related skin impairments for 1 of 3 residents (R1) reviewed for skin integrity. In addition, based on interview and document review the facility failed to comprehensively assess and monitor for change in condition for 1 of 1 resident (R1) who	F0684	R1 no longer resides at the facility. The nurse leadership reviewed the company policy and procedures related to skin assessments and change of resident health status or a change of condition. A house wide audit was conducted to review for baseline and updated skin assessments. Those requiring an update were completed. Resident change of condition is reviewed during the weekday morning IDT meeting or PRN. A new section of our morning meeting has been added for resident change of condition. The nursing department has been educated on resident skin assessments and change of resident health status or a change of condition. DON conducted a pericare training and testing nursing department. Staff have been completing daily skin audits and returning them to the DON. The DON is running weekly reports to ensure completion. During the daily huddle between shifts, both skin concerns and change of condition are reviewed for necessary action.	09/03/2025

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

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

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F0684 SS = D	Continued from page 1 had a change of condition and was admitted to the hospital with sepsis. Findings include: R1's face sheet dated 7/16/25, identified R1 admitted 6/2025, with diagnoses of fracture of neck of left femur (broken hip), hypertension (high blood pressure), malnutrition (not consuming enough food/fluids), gastrointestinal stromal tumor of large intestine (GIST) (rare cancerous tumor in digestive system), colon cancer (cancer that begins in the large intestine). R1's discharge Minimum Data Set (MDS) dated 6/20/25, identified short term memory issues and moderately impaired decision making. R1 was independent with eating, supervision/touching assistance required for oral hygiene, personal hygiene, and upper body dressing. Moderate assistance required for toileting hygiene, showering, lower body dressing, footwear. R1 required moderate assistance with sitting, lying, standing, toilet and tub transfers. R1 was able to walk 10 feet with supervision/touch assistance. R1 was frequently incontinent of bowel and bladder. R1 was five feet tall and weighed 113 pounds. R1 did not have any skin conditions. R1 did not receive oral chemotherapy. R1's impaired skin integrity R1's hospital discharge summary dated 6/5/25, identified R1 admitted to hospital from a fall that resulted in left femoral neck hip fracture and underwent surgical repair of the hip. A hydrocolloid dressing was placed on the surgical incision and not to be removed until seven days after the surgery date. R1's admission assessment dated 6/6/25, identified R1 had frequent pain in the left hip area. Skin assessment identified intact abrasions to right and left scapula and upper-mid vertebrae-not measured; skin tear to left elbow; left hip surgical incision; bruising on palms of right and left hands, left upper extremity, and right upper extremity; right eye was blood shot and puffy. Surgical dressing on left hip was to stay in place for seven days post-surgery. Multiple scattered purple to maroon bruises on bilateral upper extremities and hands, the skin tear has a mepilex in place. The abrasions on left and right scapula are intact and square shaped most likely from hospital electrodes. The blood shot right eye had puffiness noted on the top of the right eyelid and has been present for a while.	F0684	Continued from page 1 The DON or designee will conduct weekly audits on the completion of the skin assessments and any necessary follow up actions and audits on resident vitals and progress notes for changes of condition for 3 weeks and monthly for 3 months and results will be reviewed by QAPI for any further action. Date Certain 9/3/25	

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F0684 SS = D	Continued from page 2 The skin assessment did not include any further descriptions or characteristics of the bruising such as exact locations, measurements, and pain nor identify the skin integrity around the occlusive bandage such as redness, tenderness, swelling, shadowing, and pain. R1's care plan dated 6/7/25, identified alteration in elimination with interventions to assist with toileting, provide assistance with peri-cares morning, evening, and as needed. R1's care plan dated 6/7/25, identified alteration in skin integrity related to mobility, fragile skin, and occasional incontinence. Interventions included leave dressing in place until 6/13/25, monitor skin integrity daily during cares, weekly skin inspection by nurse, monitor for skin breakdown for signs/symptoms of infection, report signs/symptoms to medical doctor or physician assistant, document on skin condition and keep doctor informed of changes, treatment/dressing orders for the left femur/hip incision and left elbow skin tear. Additionally, the care plan directed staff to bath R1 on Saturday evenings, showers only, assist of one with personal hygiene and dressing. R1's Braden Scale for Predicting Pressure Score Risk dated 6/12/25, identified no sensory impairment, occasionally moist skin, walks frequently, slightly limited mobility, adequate nutrition, potential problem with friction and shear. R1 scored 19 which did not indicate a risk. R1's physician order dated 6/5/25, identified a weekly skin inspection by licensed nursing staff every Saturday. R1's Treatment Administration Record (TAR) dated 6/2025, identified weekly skin inspection by licensed nurse every Tuesday beginning 6/17/25. Prior order was for weekly skin inspection every Saturday and was discontinued on 6/12/25. No skin assessment was assigned for 6/10/25. R1's Weekly Skin Inspection dated 6/7/25, Skin Summary identified R1 refused bath. A correlating skin check was not completed. R1's daily skilled progress notes from 6/6/25-6/13/25 identified wound to left hip was unable to be visualized due to non-removable dressing in place. R1's daily skilled progress note dated 6/14/25, identified left hip no open wounds noted, treatment provided as ordered, no drainage, peri-wound intact.	F0684		

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F0684 SS = D	Continued from page 3 R1's daily skilled progress note dated 6/15/25, surgical incision was open to air. At 9:35 p.m., unable to visualize wound due to unremovable dressing (even though surgical dressing was documented as removed earlier the same day). R1's daily skilled progress note dated 6/16/25, identified no open wounds noted, dressing to wound remains clean, dry and intact, wound not visualized. R1's daily skilled progress note dated 6/17/25, identified dressing to wound remains clean, dry and intact, wound not visualized. R1's daily skilled progress note dated 6/19/25, identified no open wound noted, treatment to wound performed on shift as ordered. No drainage noted. Peri-wound skin is intact. R1's oncology visit note dated 6/9/25, identified her Positron Emission Tomography (PET) scan was showing more activity in the small intestine and activity in the rectal area. These areas are concerning for new cancer in the rectal area and/or worsening of GIST. Doctors' communication handwritten included reports of pain 8/10 in the left hip. PET scan showing more cancer in the intestines, rectal area, and a mass in the left intergluteal cleft (vertical partition that separates buttocks). The note did not indicate if the mass that was identified in the left intergluteal cleft was palatable. R1's Point of Care (POC) response history dated 6/19/25 identified R1 had a shower. Review of R1's record between 6/6/25 through 6/20/25 did not identify or include comprehensive skin assessments or monitoring of the impaired skin integrity that was identified on the 6/6/25 assessments which included intact abrasions to right and left scapula and upper-mid vertebrae-not measured; skin tear to left elbow; left hip surgical incision; bruising on palms of right and left hands, left upper extremity, and right upper extremity. Additionally, after the surgical dressing was removed the record did include a comprehensive assessment of the surgical line that would include measurements, integrity of sutures/staples/surgical glue, wound edge proximity, and signs/symptoms of infection. R1's hospital Wound evaluation and treatment note dated 6/20/25, R1 came to emergency room for weakness, fever, low blood pressure, and tachycardia. When rolling R1 it	F0684		

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F0684 SS = D	Continued from page 4 was discovered that she had a pressure area that was tunneling and draining on her left ischial tuberosity. Redness is extended to the front including left labia and most of left buttock. It is also indurated. Facility just noticed it today before she came to the emergency room. Assessment included pressure injury-community acquired, full thickness, wound base covered in slough, around wound had edema, redness, indurated (abnormal hardened tissue), was intact and warm to the touch. Measurements: length 1.4 cm, width 0.6 cm, depth 0.9 cm. Tunneling 0.8 cm at 12 o'clock, 1.0 cm at 3 o'clock, 1.9 cm at 5 o'clock, and 0.9 cm at 9 o'clock. Moderate amount of yellow/gold malodorous foul drainage. Pain 7/10 when touching area. R1 stated "I just want to die, I don't want to deal with this." During an interview on 7/16/25 at 9:45 a.m., nursing assistant (NA)-A stated R1 had a little redness in her peri area, but no open sores. NA-A recalled that R1 had special precautions for chemotherapy and a lot of loose bowel movements from that. NA-A could not recall specific dates when she assisted R1. During an interview on 7/16/25 at 9:59 a.m., NA-B stated she worked with R1 primarily the first two weeks that she was at the facility. NA-B walked with a walker, went to meals, had some loose stools but did not notice redness in her peri area. During an interview on 7/17/25 at 9:19 a.m., NA-C stated she thought she last assisted with toileting R1 about four days prior to 6/20/25. At that time, R1 was not red or irritated in the peri area but did complain that it hurt when NA-C completed peri-care. NA-C asked if she had pushed too hard during peri-care, R1 replied, maybe. At that time, nothing looked concerning that she would notify the nurse about. During a phone interview on 7/17/25 at 3:50 p.m., nurse practitioner (NP)-A stated upon review of hospital documentation it appeared they were questioning an internal abscess. If the abscess was internal the facility would not have seen it until it opened. Potentially, it could have not been able to be visualized and not unheard of that it was not noticed until it opened, and it could have opened when the staff was wiping R1. During a phone interview on 7/17/25 at 11:05 a.m., medical doctor (MD)-A stated R1 did not have a pressure ulcer when she was sent to the facility from the hospital on 6/6/25. Pressure wounds happen when people are sitting to much, not eating or drinking, and not mobile. Pressure wounds do not happen overnight. R1 was	F0684		

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F0684 SS = D	Continued from page 5 already very weak and frail, not very mobile and was not motivated. Upon assessment the wound looked very consistent with a pressure ulcer and would be visible to see if R1 was on the toilet or being rolled side to side. During an interview on 7/17/25 at 2:13 p.m., Administrator and director of nursing (DON) were present. DON stated the expectation was that all skin issues were identified on the weekly skin assessments along with descriptions of skin impairments including required measurements. Change in Condition R1’s hospital discharge orders dated 6/6/25, identified an order for atenolol 50 milligrams daily for hypertension. R1’s physician order dated 6/6/25, identified weekly vital sign monitoring. Review of R1’s vital signs identified between 6/6/25 through 6/18/25, identified ranges for blood pressures of 156/67 to 102/51; HR 84-99; oxygen saturations (O2) 97%-95%. The vital sign record identified a decrease in systolic pressure that started on 6/16/25 with an increase in HR. R1's identified blood pressure readings from 6/16/25-6/18/25 were: -6/6/25: 120/51, and 156/67 -6/7/25: 142/76, 136/88, and 143/72 -6/8/25: 139/80 -6/10/25: 130/54 -6/12/25: 145/64 -6/14/25: 140/60 -6/16/25: 102/51 -6/17/25: 118/60 -6/18/25: 104/50 R1’s Occupational Therapy notes dated 6/8/25-6/20/25, identified on 6/17/25, care conference was held and discussed R1 complaining of nausea during sessions and it is impacting her performance. R1’s Occupational	F0684		

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F0684 SS = D	Continued from page 6 Therapy note on 6/18/25, R1 was in recliner and refusing therapy, stating she would not get up today. No nausea but pain in left hip and back area, however, R1 has only been lying in recliner for the past three days and only occasionally moving to the bed. In review of R1's record there was no indication vital signs were re-assessed and/or increased monitoring nor the physician notified of the change in BP and/or HR in conjunction with in R1's refusals of therapy and "lying in recliner for the past three days" R1's hospital discharge summary dated 7/17/25, identified R1 was hospitalized from 6/20/25 to 6/25/25 for diagnoses that included severe sepsis secondary to buttock abscess and cellulitis. During a phone interview on 7/17/25 at 4:17 p.m., registered nurse (RN)-B stated R1 was always tired, ate in her room, and stayed in her room. Review of R1's blood pressure of 90/43 and pulse of 100 on 6/19/25, RN-B stated normally she would recheck a blood pressure with that reading and was unsure why she did not. If that was R1's baseline it would not have been a trigger for her to recheck it. RN-B was not aware of R1 having any emesis or loose stool on 6/19/25. RN-B stated with sepsis a resident would have a higher temperature, elevated heart rate and low blood pressure. RN-B did not notify the medical doctor of the low blood pressure or high pulse and did not articulate a reason why she did not. During a phone interview on 7/16/25 at 1:43 p.m., nursing assistant (NA)-D stated he worked with R1 on 6/20/25. R1 was very tired and was not good at holding a conversation which was not R1's typical behavior. During an interview on 7/16/25 at 10:16 a.m., LPN-A stated she had not seen R1's skin prior to the hospital transfer. R1 had a skin assessment done by LPN-A on 6/7/25, and that was the only one she could see in the chart. R1 would only allow staff to look at her peri area on bath day. LPN-A stated R1 had supervision assistance with toileting and was able to wipe herself after using the toilet as R1 was working hard to get back to an independent status. LPN-A was not aware of a low blood pressure reading on 6/19/25 and recalled her vitals were within normal limits when she took them the morning of 6/20/25 (not documented). On 6/20/25, LPN-B went with LPN-A to assess R1's vital signs. R1's temperature was elevated. LPN-A stated she was suspicious of R1 having a urinary tract infection and an ambulance was called. R1 was on the cot for the ambulance transfer and LPN-A and LPN-B had performed	F0684		

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F0684 SS = D	Continued from page 7 peri cares on her and that was when they noticed she had a tunneling wound that was opened on her left inner thigh, LPN-A described the area as the size of a pencil eraser head and the location was the inner thigh where the skin connects to the thigh. During a follow-up interview on 7/17/25 at 5:12 p.m., LPN-A stated R1 was tired and had room trays on 6/20/25 but did not want her daughters called. LPN-A stated she assumed R1 was calling them herself as she had a personal cell phone. During an interview on 7/16/25 at 10:45 a.m., LPN-B stated she did not recall what prompted her to check R1's VS on 6/20/25, but R1's cheeks were flushed and she was laid back in her chair, which was out of baseline for R1. LPN-B was unsure when R1's VS had been taken and completed a set. LPN-B noted an increased temperature when she took VS and had R1 sent to the emergency department for evaluation. During a phone interview on 7/17/25 at 3:50 p.m., nurse practitioner (NP)-A stated would not have gotten too excited if she had been informed of R1's low blood pressure and high pulse on 6/19/25 as R1 had a higher blood pressure and pulse when she was seen on 6/11/25 and was a frail person. NP-A did not mention what R1's blood pressure or pulse were on 6/11/25, or when she would become concerned with them. During an interview on 7/17/25 at 2:13 p.m., Administer and director of nursing (DON) were present. DON stated if she had done a blood pressure and it was low, she would re-check but on the opposite arm, review the other vital signs including pulse and temperature, document and notify the physician of the changes. DON would also continue to monitor throughout the shift and document any changes and alert on-coming staff of findings. The blood pressure should have been retaken, the pulse was 100 and that is not flagged on our computer as a high pulse, so that would not have been an alarming vital sign. The expectation was to document findings, monitor, and notify physician of changes identified. The facility Skin Assessment and Wound Management policy dated 2/2025, identified staff will perform routine skin inspections with daily care, nurses to be notified if skin changes identified, and a weekly skin inspection will be completed by licensed staff. When a pressure ulcer is identified the following actions will be taken: notify provider/treatment ordered, notify resident representative, complete education with resident/resident representative including risks and benefits, notify nurse manager, referral to dietary and therapies if appropriate, review and update care plan	F0684		

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F0684 SS = D	Continued from page 8 including interventions, update resident care lists, update care plan to identify risk of skin breakdown, follow ongoing treatments per order, updated provider and resident representative as needed. The facility Notification of Changes policy dated 3/2024, identified nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the residents physician, to ensure the best outcomes of care for the resident	F0684		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F0880	R4's care plan has been reviewed and assessed for enhanced barrier precautions. Staff have been educated regarding enhanced barrier precautions for the resident. A house wide audit has been conducted to review other residents for the need of EBP and updated their care plan appropriately. Training has been assigned to staff that are required to use EBP when caring for a resident. The DON or designee will conduct weekly audits for 3 weeks and monthly for 3 months and results will be reviewed by QAPI for any further action.	09/03/2025

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F0880 SS = D	Continued from page 9 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to apply enhanced barrier precautions (EBP) while performing cares on 1 of 3 residents (R4). Findings include: Enhanced Barrier Precautions are a set of guidelines aimed at preventing the spread of infections caused by multidrug-resistant organisms (MDROs). These precautions are particularly important in skilled nursing facilities where the risk of transmission is high due to close contact among residents and	F0880		

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F0880 SS = D	Continued from page 10 healthcare providers. R4's face sheet dated 7/16/25, identified diagnoses of acute pyelonephritis (kidney infection) and malignant neoplasm of endometrium (uterine cancer). R4's comprehensive Minimum Data Set (MDS) dated 5/7/25, identified R4 had an indwelling catheter. R4's care plan dated 5/2/25, identified R4 was on EBP related to a chronic foley catheter. Interventions included to follow EBP, use appropriate communication to follow EBP, explain reason for use of EBP, and staff to don/doff (put on and take off) EBP when providing high contact cares. During an observation on 7/17/25 at 8:35 a.m., nursing assistant (NA)-C entered R4's room without donning EBP, a sign directing the use of EBP was on the door with a cart outside the room with gown, gloves, and masks in it. nursing assistant (NA)-C filled a wash basin with water, donned gloves, washed R4's hands, under her arms, and peri-area including catheter tubing then dried the areas. NA-C removed large urinary collection drainage bag and attached a smaller, more discreet urinary collection bag to R4's leg without using an alcohol wipe to sanitize the connection between the inserted catheter and the urinary drainage bag. Licensed practical nurse (LPN)-B entered room and did not have EBP on. LPN-B pushed on R4's feet and ankles to check for edema. When R4 stood up, LPN-B had gloves on and removed dressing on R4's coccyx, assessed, and put a new dressing on, LPN-B changed gloves and sanitized hands in between touching dirty and clean products. LPN-B listened to R4's lungs. LPN-B requested registered nurse (RN)-A come to room and assess lung sounds on R4. RN-A entered room and assessed lung sounds without applying EBP. During an interview on 7/17/25 at 9:19 a.m., NA-C stated she should have worn EBP when performing cares on R4 because she had a catheter. During an interview on 7/17/25 at 9:25 a.m., RN-A stated EBP should have been worn in R4's room. During an interview on 7/17/25 at 9:26 a.m., LPN-B stated she would not have to wear EBP while caring for R4 because she was not performing any cares with the catheter and the area on her coccyx was not an open wound, it was just a dressing for protection. Director of nursing (DON) came to the cart and verified that LPN-B would have to wear EBP because she was providing cares to a resident with a catheter.	F0880		

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F0880 SS = D	Continued from page 11 During an interview on 7/17/25 at 2:13 p.m., DON stated R4 was on EBP, and it is the expectation that staff wear EBP when providing cares to any resident on EBP. The Enhanced Barrier Precautions policy dated 4/1/24, identified staff should utilize gown and gloves for high contact resident care activities for residents known to be colonized or infected with multi-drug-resistant organisms (MDRO) as well as those at an increased risk of MDRO acquisition such as residents with wounds or indwelling medical devices. Implement EBP for indwelling catheters.	F0880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 12, 2025

Administrator
SLEEPY EYE REHABILITATI CENTER
1105 3RD AVENUE SOUTHWEST
SLEEPY EYE, MN 56085

Re: State Nursing Home Licensing Orders
Event ID: 872L11

Dear Administrator:

The above facility was surveyed on July 17, 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.

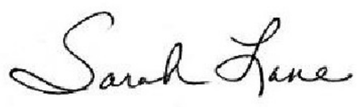
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/17/2025**

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20000	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 7/15/25, 7/16/25, and 7/17/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		08/20/2025

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed: H52258009C (MN00114110) with licensing order issued at: 0875. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	20000		
20875	Adequate and Proper Nursing Care; Monitor TPR CFR(s): MN Rule 4658.0520 Subp. 2 l Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: l. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	20875	Corrected	09/03/2025

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20875	Continued from page 2 Based on interview and document review the facility failed to comprehensively assess and monitor non-pressure related skin impairments for 1 of 3 residents (R1) reviewed for skin integrity. In addition, based on interview and document review the facility failed to comprehensively assess and monitor for change in condition for 1 of 1 resident (R1) who had a change of condition and was admitted to the hospital with sepsis. Findings include: R1's face sheet dated 7/16/25, identified R1 admitted 6/2025, with diagnoses of fracture of neck of left femur (broken hip), hypertension (high blood pressure), malnutrition (not consuming enough food/fluids), gastrointestinal stromal tumor of large intestine (GIST) (rare cancerous tumor in digestive system), colon cancer (cancer that begins in the large intestine). R1's discharge Minimum Data Set (MDS) dated 6/20/25, identified short term memory issues and moderately impaired decision making. R1 was independent with eating, supervision/touching assistance required for oral hygiene, personal hygiene, and upper body dressing. Moderate assistance required for toileting hygiene, showering, lower body dressing, footwear. R1 required moderate assistance with sitting, lying, standing, toilet and tub transfers. R1 was able to walk 10 feet with supervision/touch assistance. R1 was frequently incontinent of bowel and bladder. R1 was five feet tall and weighed 113 pounds. R1 did not have any skin conditions. R1 did not receive oral chemotherapy. R1's impaired skin integrity R1's hospital discharge summary dated 6/5/25, identified R1 admitted to hospital from a fall that resulted in left femoral neck hip fracture and underwent surgical repair of the hip. A hydrocolloid dressing was placed on the surgical incision and not to be removed until seven days after the surgery date. R1's admission assessment dated 6/6/25, identified R1 had frequent pain in the left hip area. Skin assessment identified intact abrasions to right and left scapula and upper-mid vertebrae-not measured; skin tear to left elbow; left hip surgical incision; bruising on palms of right and left hands, left upper extremity, and right upper extremity; right eye was blood shot and puffy. Surgical dressing on left hip was to stay in place for	20875		

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20875	Continued from page 3 seven days post-surgery. Multiple scattered purple to maroon bruises on bilateral upper extremities and hands, the skin tear has a mepilex in place. The abrasions on left and right scapula are intact and square shaped most likely from hospital electrodes. The blood shot right eye had puffiness noted on the top of the right eyelid and has been present for a while. The skin assessment did not include any further descriptions or characteristics of the bruising such as exact locations, measurements, and pain nor identify the skin integrity around the occlusive bandage such as redness, tenderness, swelling, shadowing, and pain. R1’s care plan dated 6/7/25, identified alteration in elimination with interventions to assist with toileting, provide assistance with peri-cares morning, evening, and as needed. R1’s care plan dated 6/7/25, identified alteration in skin integrity related to mobility, fragile skin, and occasional incontinence. Interventions included leave dressing in place until 6/13/25, monitor skin integrity daily during cares, weekly skin inspection by nurse, monitor for skin breakdown for signs/symptoms of infection, report signs/symptoms to medical doctor or physician assistant, document on skin condition and keep doctor informed of changes, treatment/dressing orders for the left femur/hip incision and left elbow skin tear. Additionally, the care plan directed staff to bath R1 on Saturday evenings, showers only, assist of one with personal hygiene and dressing. R1’s Braden Scale for Predicting Pressure Score Risk dated 6/12/25, identified no sensory impairment, occasionally moist skin, walks frequently, slightly limited mobility, adequate nutrition, potential problem with friction and shear. R1 scored 19 which did not indicate a risk. R1's physician order dated 6/5/25, identified a weekly skin inspection by licensed nursing staff every Saturday. R1’s Treatment Administration Record (TAR) dated 6/2025, identified weekly skin inspection by licensed nurse every Tuesday beginning 6/17/25. Prior order was for weekly skin inspection every Saturday and was discontinued on 6/12/25. No skin assessment was assigned for 6/10/25. R1’s Weekly Skin Inspection dated 6/7/25, Skin Summary identified R1 refused bath. A correlating skin check was not completed.	20875		

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20875	Continued from page 4 R1's daily skilled progress notes from 6/6/25-6/13/25 identified wound to left hip was unable to be visualized due to non-removable dressing in place. R1's daily skilled progress note dated 6/14/25, identified left hip no open wounds noted, treatment provided as ordered, no drainage, peri-wound intact. R1's daily skilled progress note dated 6/15/25, surgical incision was open to air. At 9:35 p.m., unable to visualize wound due to unremovable dressing (even though surgical dressing was documented as removed earlier the same day). R1's daily skilled progress note dated 6/16/25, identified no open wounds noted, dressing to wound remains clean, dry and intact, wound not visualized. R1's daily skilled progress note dated 6/17/25, identified dressing to wound remains clean, dry and intact, wound not visualized. R1's daily skilled progress note dated 6/19/25, identified no open wound noted, treatment to wound performed on shift as ordered. No drainage noted. Peri-wound skin is intact. R1's oncology visit note dated 6/9/25, identified her Positron Emission Tomography (PET) scan was showing more activity in the small intestine and activity in the rectal area. These areas are concerning for new cancer in the rectal area and/or worsening of GIST. Doctors' communication handwritten included reports of pain 8/10 in the left hip. PET scan showing more cancer in the intestines, rectal area, and a mass in the left intergluteal cleft (vertical partition that separates buttocks). The note did not indicate if the mass that was identified in the left intergluteal cleft was palatable. R1's Point of Care (POC) response history dated 6/19/25 identified R1 had a shower. Review of R1's record between 6/6/25 through 6/20/25 did not identify or include comprehensive skin assessments or monitoring of the impaired skin integrity that was identified on the 6/6/25 assessments which included intact abrasions to right and left scapula and upper-mid vertebrae-not measured; skin tear to left elbow; left hip surgical incision; bruising on palms of right and left hands, left upper extremity, and right upper extremity. Additionally, after the surgical dressing was removed the record did include a	20875		

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20875	Continued from page 5 comprehensive assessment of the surgical line that would include measurements, integrity of sutures/staples/surgical glue, wound edge proximity, and signs/symptoms of infection. R1's hospital Wound evaluation and treatment note dated 6/20/25, R1 came to emergency room for weakness, fever, low blood pressure, and tachycardia. When rolling R1 it was discovered that she had a pressure area that was tunneling and draining on her left ischial tuberosity. Redness is extended to the front including left labia and most of left buttock. It is also indurated. Facility just noticed it today before she came to the emergency room. Assessment included pressure injury-community acquired, full thickness, wound base covered in slough, around wound had edema, redness, indurated (abnormal hardened tissue), was intact and warm to the touch. Measurements: length 1.4 cm, width 0.6 cm, depth 0.9 cm. Tunneling 0.8 cm at 12 o'clock, 1.0 cm at 3 o'clock, 1.9 cm at 5 o'clock, and 0.9 cm at 9 o'clock. Moderate amount of yellow/gold malodorous foul drainage. Pain 7/10 when touching area. R1 stated "I just want to die, I don't want to deal with this." During an interview on 7/16/25 at 9:45 a.m., nursing assistant (NA)-A stated R1 had a little redness in her peri area, but no open sores. NA-A recalled that R1 had special precautions for chemotherapy and a lot of loose bowel movements from that. NA-A could not recall specific dates when she assisted R1. During an interview on 7/16/25 at 9:59 a.m., NA-B stated she worked with R1 primarily the first two weeks that she was at the facility. NA-B walked with a walker, went to meals, had some loose stools but did not notice redness in her peri area. During an interview on 7/17/25 at 9:19 a.m., NA-C stated she thought she last assisted with toileting R1 about four days prior to 6/20/25. At that time, R1 was not red or irritated in the peri area but did complain that it hurt when NA-C completed peri-care. NA-C asked if she had pushed too hard during peri-care, R1 replied, maybe. At that time, nothing looked concerning that she would notify the nurse about. During a phone interview on 7/17/25 at 3:50 p.m., nurse practitioner (NP)-A stated upon review of hospital documentation it appeared they were questioning an internal abscess. If the abscess was internal the facility would not have seen it until it opened. Potentially, it could have not been able to be visualized and not unheard of that it was not noticed until it opened, and it could have opened when the	20875		

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20875	Continued from page 6 staff was wiping R1. During a phone interview on 7/17/25 at 11:05 a.m., medical doctor (MD)-A stated R1 did not have a pressure ulcer when she was sent to the facility from the hospital on 6/6/25. Pressure wounds happen when people are sitting to much, not eating or drinking, and not mobile. Pressure wounds do not happen overnight. R1 was already very weak and frail, not very mobile and was not motivated. Upon assessment the wound looked very consistent with a pressure ulcer and would be visible to see if R1 was on the toilet or being rolled side to side. During an interview on 7/17/25 at 2:13 p.m., Administrator and director of nursing (DON) were present. DON stated the expectation was that all skin issues were identified on the weekly skin assessments along with descriptions of skin impairments including required measurements. Change in Condition R1’s hospital discharge orders dated 6/6/25, identified an order for atenolol 50 milligrams daily for hypertension. R1’s physician order dated 6/6/25, identified weekly vital sign monitoring. Review of R1’s vital signs identified between 6/6/25 through 6/18/25, identified ranges for blood pressures of 156/67 to 102/51; HR 84-99; oxygen saturations (O2) 97%-95%. The vital sign record identified a decrease in systolic pressure that started on 6/16/25 with an increase in HR. R1's identified blood pressure readings from 6/16/25-6/18/25 were: -6/6/25: 120/51, and 156/67 -6/7/25: 142/76, 136/88, and 143/72 -6/8/25: 139/80 -6/10/25: 130/54 -6/12/25: 145/64 -6/14/25: 140/60 -6/16/25: 102/51	20875		

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20875	Continued from page 7 -6/17/25: 118/60 -6/18/25: 104/50 R1’s Occupational Therapy notes dated 6/8/25-6/20/25, identified on 6/17/25, care conference was held and discussed R1 complaining of nausea during sessions and it is impacting her performance. R1’s Occupational Therapy note on 6/18/25, R1 was in recliner and refusing therapy, stating she would not get up today. No nausea but pain in left hip and back area, however, R1 has only been lying in recliner for the past three days and only occasionally moving to the bed. In review of R1's record there was no indication vital signs were re-assessed and/or increased monitoring nor the physician notified of the change in BP and/or HR in conjunction with in R1's refusals of therapy and "lying in recliner for the past three days" R1’s hospital discharge summary dated 7/17/25, identified R1 was hospitalized from 6/20/25 to 6/25/25 for diagnoses that included severe sepsis secondary to buttock abscess and cellulitis. During a phone interview on 7/17/25 at 4:17 p.m., registered nurse (RN)-B stated R1 was always tired, ate in her room, and stayed in her room. Review of R1's blood pressure of 90/43 and pulse of 100 on 6/19/25, RN-B stated normally she would recheck a blood pressure with that reading and was unsure why she did not. If that was R1's baseline it would not have been a trigger for her to recheck it. RN-B was not aware of R1 having any emesis or loose stool on 6/19/25. RN-B stated with sepsis a resident would have a higher temperature, elevated heart rate and low blood pressure. RN-B did not notify the medical doctor of the low blood pressure or high pulse and did not articulate a reason why she did not. During a phone interview on 7/16/25 at 1:43 p.m., nursing assistant (NA)-D stated he worked with R1 on 6/20/25. R1 was very tired and was not good at holding a conversation which was not R1's typical behavior. During an interview on 7/16/25 at 10:16 a.m., LPN-A stated she had not seen R1’s skin prior to the hospital transfer. R1 had a skin assessment done by LPN-A on 6/7/25, and that was the only one she could see in the chart. R1 would only allow staff to look at her peri area on bath day. LPN-A stated R1 had supervision assistance with toileting and was able to wipe herself after using the toilet as R1 was working hard to get back to an independent status. LPN-A was not aware of a	20875		

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20875	Continued from page 8 low blood pressure reading on 6/19/25 and recalled her vitals were within normal limits when she took them the morning of 6/20/25 (not documented). On 6/20/25, LPN-B went with LPN-A to assess R1's vital signs. R1's temperature was elevated. LPN-A stated she was suspicious of R1 having a urinary tract infection and an ambulance was called. R1 was on the cot for the ambulance transfer and LPN-A and LPN-B had performed peri cares on her and that was when they noticed she had a tunneling wound that was opened on her left inner thigh, LPN-A described the area as the size of a pencil eraser head and the location was the inner thigh where the skin connects to the thigh. During a follow-up interview on 7/17/25 at 5:12 p.m., LPN-A stated R1 was tired and had room trays on 6/20/25 but did not want her daughters called. LPN-A stated she assumed R1 was calling them herself as she had a personal cell phone. During an interview on 7/16/25 at 10:45 a.m., LPN-B stated she did not recall what prompted her to check R1's VS on 6/20/25, but R1's cheeks were flushed and she was laid back in her chair, which was out of baseline for R1. LPN-B was unsure when R1's VS had been taken and completed a set. LPN-B noted an increased temperature when she took VS and had R1 sent to the emergency department for evaluation. During a phone interview on 7/17/25 at 3:50 p.m., nurse practitioner (NP)-A stated would not have gotten too excited if she had been informed of R1's low blood pressure and high pulse on 6/19/25 as R1 had a higher blood pressure and pulse when she was seen on 6/11/25 and was a frail person. NP-A did not mention what R1's blood pressure or pulse were on 6/11/25, or when she would become concerned with them. During an interview on 7/17/25 at 2:13 p.m., Administer and director of nursing (DON) were present. DON stated if she had done a blood pressure and it was low, she would re-check but on the opposite arm, review the other vital signs including pulse and temperature, document and notify the physician of the changes. DON would also continue to monitor throughout the shift and document any changes and alert on-coming staff of findings. The blood pressure should have been retaken, the pulse was 100 and that is not flagged on our computer as a high pulse, so that would not have been an alarming vital sign. The expectation was to document findings, monitor, and notify physician of changes identified. The facility Skin Assessment and Wound Management policy dated 2/2025, identified staff will perform routine skin inspections with daily care, nurses to be	20875		

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20875	Continued from page 9 notified if skin changes identified, and a weekly skin inspection will be completed by licensed staff. When a pressure ulcer is identified the following actions will be taken: notify provider/treatment ordered, notify resident representative, complete education with resident/resident representative including risks and benefits, notify nurse manager, referral to dietary and therapies if appropriate, review and update care plan including interventions, update resident care lists, update care plan to identify risk of skin breakdown, follow ongoing treatments per order, updated provider and resident representative as needed. The facility Notification of Changes policy dated 3/2024, identified nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the residents physician, to ensure the best outcomes of care for the resident SUGGESTED METHOD OF CORRECTION: The facility should review and/or revise policies and procedures related to notification of change in resident health status or a change of condition. The Director of Nursing (DON) or designee should educate nursing staff to the policies and procedures and conduct measurable audits, to verify notification to appropriate parties occurred relate to a change in health status or condition. The DON or designee should bring the results of those audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD TO CORRECT: Twenty-one (21) days.	20875		