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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sleepy Eye Rehabilitati Center	1105 3rd Avenue Southwest Sleepy Eye, MN 56085

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 ([NAME]) (rare cancerous tumor in digestive system), colon cancer (cancer that begins in the large intestine).R1's discharge Minimum Data Set (MDS) dated [DATE], 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 integrityR1's hospital Discharge summary dated [DATE], 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 [DATE], 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. 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.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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE], 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.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.