

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245225	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Sleepy Eye Rehabilitati Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>44630</p> <p>Based on observation, interview and document review, the facility failed to ensure most recent survey results were readily accessible for residents or visitors to view. This had the potential to affect all 53 residents who resided in the facility and visitors.</p> <p>Findings include:</p> <p>On 2/24/25 at 12:55 p.m., the hallway leading to the chapel across from the vending machines a three-ring binder labeled Survey Results was located in a acrylic wall mount. The survey results in the binder were dated 4/20/23. The results of the most recent federal recertification survey dated 5/15/24, were not included. There was no posted information indicating any other results were available.</p> <p>On 02/25/25 at 10:53 a.m., the administrator stated he was responsible to place the most recent survey results in the binder and confirmed the most recent survey results from 5/15/24, were not located in the binder as expected.</p> <p>No policy regarding posting of survey results was provided.</p>		

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073</p> <p>Based on observation, interview and document review, the facility failed to ensure an oxygen tank was handled safely for 1 of 1 resident (R54) reviewed for safety hazards.</p> <p>Findings include:</p> <p>R54's facesheet printed on 2/25/25, indicated R54 had been admitted on [DATE], with a diagnosis of acute exacerbation of chronic obstructive pulmonary disease (COPD) (inflammation of the airway causing difficulty breathing).</p> <p>R54's physician orders dated 2/24/25, included oxygen delivery system via nasal cannula 3-4 LPM (liter per minute) every shift.</p> <p>During an observation on 2/24/25 at 5:14 p.m., observed licensed practical nurse (LPN)-A, carry an E-sized metal oxygen tank, holding it to her chest with both arms wrapped around it, down hallway three. LPN-A walked from the oxygen storage room at the beginning of hallway three to the last room on hallway three.</p> <p>During an interview on 2/24/25 at 5:19 p.m., LPN-A stated she did not know an oxygen tank should not be carried. LPN-A was able to verbalize if dropped, an oxygen tank could explode or become a projectile injuring residents and staff. Together with LPN-A, went to the oxygen storage room where there were three empty oxygen tank hand carts available for use.</p> <p>During an interview on 2/25/25 at 1:23 p.m., nursing assistant (NA)-A stated, you don't carry an oxygen tank, you put it on a wheelie, adding, she didn't want to get blown to pieces if she dropped it. NA-A stated she knew this because she had training.</p> <p>During an interview on 2/25/25 at 2:07 p.m., the director of nursing (DON) stated LPN-A informed her she had carried an oxygen tank to a resident's room because she didn't know she shouldn't. The DON stated staff should not travel with an oxygen tank as it was a safety risk.</p> <p>Skills training that occurred in July 2024, indicated LPN-A received training on oxygen use. The training did not specifically identify safe handling of an oxygen tank.</p> <p>A policy on safe handling of oxygen tanks was requested and a competency titled Oxygen Administration dated 2/14, was received indicating oxygen tanks must be transported in oxygen cart or immediately placed in approved holder on a wheelchair.</p>		