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	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Providence Community Home	700 Third Avenue Northwest Sleepy Eye, MN 56085

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and document review, the facility failed to ensure data submitted to the QAPI committee for 4 of 4 quarters submitted and reviewed, was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 47 residents. Refer to F657 and F880. Findings include: Review of the QAPI meeting minutes submitted for review identified for review of the past 4 Quarters of QAPI meeting minutes identified review of each quarter is as follows: Quarter 1 (April 2025): Attendees included the medical director, DON, RN staff development coordinator (RN-A), the pharmacist, dietary manager, facility director, vice president, maintenance supervisor, the administrator, and social services attended. Data submitted included:Falls: 4 with minor injury, none with major injury.Infections: 18. 15 were urinary tract infections (UTI), and 3 were skin.Medication errors: 3Elopements: 0Skin tears: 3Bruises: 12Abrasions/scrapes/lacerations: 1Admissions 13Discharges: 12. 8 residents went home and 4 were deaths.Social services: to review VA reportsEthics committee was to review any ethical concerns Pharmacy was to review pharmacy/trends or concernsPerformance Improvement projects were to be discussed. Social services documented 5 VA reports submitted to MDH and law enforcement. 2 residents had missing money. Residents were encouraged to use a lock drawer. There was no evidence of what was investigated, if the investigations were completed timely, or all staff/residents pertinent had been interviewed. 1 residents' money was found but details were not included. 2 residents were noted to have slapped one another. 1 resident's (unknown) care plan was updated, and medication was reviewed. A 2nd resident identified an (unknown) male resident touched a female resident (unknown) over their clothes inappropriately. QAPI documented there was a medication review to prevent similar incidents, and the resident was discharged to another facility. Neither resident was reported to be affected emotionally or physically. There was no indication QAPI reviewed if all the elements had been investigated thoroughly or if other residents with similar behaviors were reviewed. Bowel incontinence and medication error reductions were the PIP projects reviewed during that meeting. Analysis was occurring on PIP projects. The DON reviewed fall and infection statistics. QAPI noted the IDT team would continue to review falls weekly and interventions, however there was no indication of a comprehensive review by QAPI occurred of any benchmarks, goals or analysis of IDT data. There was also no indication employee surveillance was being reviewed or discussed. Survey results and updated policies were noted to have been reviewed and shared with the medical director. There was no indication what policies were reviewed, who reviewed the policies, or if the QAPI committee as a whole ensured those policies were appropriate and based on current standards of practice. The Pharmacist was noted to not have any trends to review at that time, however, there was no evidence the 3 medication errors noted above were discussed to identify what the benchmarks and goals were, if there were commonalities with the errors, or if they were significant to resident health. Although dietary, maintenance, and the RN staff development coordinator had attended, there was no indication that those departments nor others such as activities had data brought forth for review and analysis, to ensure all areas affecting patient care were being monitored. Quarter 2 (July 2025): Attendees included the medical director, DON, RN staff development coordinator (RN-A), the pharmacist, facility director, the administrator, the vice (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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	president, and social services attended. Those areas included:Social services documented no VA reported were submitted. Administration discusses PIP projects which included benchmarks, goals and analysis.Falls were again submitted by the DON. There were 46 falls (8 minor injuries and no major injuries were noted). The IDT once again was to continue to review falls weekly and discuss strategies at that time. There was no evidence QAPI had ensured a comprehensive review of each resident's fall had occurred, what the benchmarks and goals were, or that analysis of IDT team findings and interventions had occurred. There was also no evidence QAPI had discussed or recognized the dramatic spike from the previous quarter as an area of high concern.Resident infection data was documented as reviewed. There were 18 total infections, with 9being UTI, 3 skin infections, and 6 respiratory infections. Staff were encouraged to utilize McGeer's criteria and follow antibiotic stewardship, however no benchmarks or goals were discussed, and no analysis of data was documented to have occurred to identify trends, or if tracking was occurring appropriately, if transmission-based precautions were needed or implemented timely etc. There was also no employee surveillance reviewed.Skin tears, bruises medication errors, elopements and discharges were documented as reviewed, however there was no documentation to support QAPI had provided appropriate oversight and monitoring.Pharmacy had no trends to review at that time, however, there were concerns brought forth of no open or expiration dates on insulin, expired medications, and missing signatures were noted in the narcotic book in her review. There was no indication QAPI had discussed these events reported to determine what were the underlying causes or had recommended actions to correct deficient practice. Quarter 3 (October 2025): Attendees included the medical director, DON, RN staff development coordinator (RN-A), the pharmacist, facility director, the vice president, the administrator and social services attended. Those areas included:Social services documented 2 VA reports were submitted, 1 for an unwitnessed fall resulting in fracture, and another involving transferring a resident with an EZ stand. In that instance, QAPI documented the resident's (unknown) knees gave out resulting in bruising. No fracture was noted, and it was reported that resident was switched to a total body lift to prevent similar incidents. There was no indication QAPI had reviewed data surrounding the incidents to ensure appropriate monitoring occurred. Administration discusses PIP projects which included benchmarks, goals and analysis.Falls were again submitted by the DON. There were 20 falls (5 with minor injuries and 1 with major injuries). The IDT once again was reported to be reviewing falls weekly. There was no evidence QAPI had ensured a comprehensive review of each resident's fall had occurred, what the benchmarks and goals were, or that analysis of IDT team findings and interventions had occurred.Resident infection data was reviewed. 13 in total with 7 UTI, 4 were skin, and 2 respiratory. Again, McGeer's and antibiotic stewardship were encouraged, however there remained no evidence analysis or oversight by QAPI was occurring.Skin tears, bruises medication errors, elopements and discharges were documented as reviewed, however there was no documentation to support QAPI had provided appropriate oversight and monitoring.There were no concerns brought forth from pharmacy, however in the medication room review document submitted from pharmacy, there was a notation a cart was observed unlocked, the last shift of controlled drug count with dual signatures was on 8/11/25. This was not discussed or brought forth by pharmacy as a concern staff were not reconciling controlled meds appropriately. Open dates were still noted to be a continued concern. Quarter 4 (January 2026): Attendees included the medical director, director of nursing (DON), social services, the administrator, the Minimum Data Set (MDS) nurse, and pharmacist. No other departments were noted to have attended. Topics discussed were:UTI (urinary tract infections) (PIP): started on 7/1/25, which was noted to be in the implementation phase, whose purpose was to reduce UTI. Measures were Q1 9 UTI. Status was listed as increased testing. Changes initiated for actions identified were staff education, to improve resident hydration, add cranberry supplements, and ensure staff perform a clean catch (urinary collection to ensure no contamination occurred giving false results). A root cause analysis was completed, barrier identified, and specific education noted. Estimated completion dates were given. Other members (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	weighed in such as pharmacist and infection preventionist, etc. Walking (PIP): a thorough analysis was completed and was similar to the above UTI section.VA (vulnerable adult) reports: staff noted they had no submissions for the previous quarter.Falls were notes as discussed. 38 for last quarter (9 with minor injuries and 0 major injuries). The interdisciplinary team (IDT) was noted to review falls weekly and discussed interventions and strategies. However, in the QAPI review, no residents were specifically discussed to ensure IDT was doing analysis of data behind falls. It was also not clear if this is a continued concern, th numbers were better or worse, what goals were, or if there was any analysis of data by QAPI to ensure IDT was reviewing their data appropriately.Resident infections were discussed in numbers but no there was no data documented as being reviewed, there were no benchmarks or goals, and no analysis identified. There was also no mention employee surveillance having been discussed. 6. Medication errors were noted as reviewed. 4 errors occurred. There was no documentation to support what the errors were, what the facility's benchmarks and goals were, or analysis of data. The QAPI committee notes documented There were no pharmacy trends to review at this time. There was no evidence to suggest the facility addressed and included all systems of care, such as dietary or maintenance, actual and/or potential staffing issues, or that other areas that would impact resident care were reviewed. There was also no evidence of a thorough review of data if the area was not part of a performance improvement project (PIP). Interview and document review on 4/15/26 at 3:45 p.m., with the administrator identified she was in charge of PIP and the director of nursing (DON) was in charge of the rest of discussion and documentation of QAPI. The administrator noted that whatever the DON documented in the QAPI meeting minutes was all they had. In review of the QAPI minutes provided, it was discussed with the administrator there was no evidence of oversight of analysis evident as only data brought forward with a brief overview of areas that weren't a PIP project. The administrator agreed there was a need for all data to have benchmarks, goals, actions, interventions and analysis of how well the plans worked and to ensure oversight was provided. The administrator agreed the QAPI committee needed more information to show those topics discussed were monitored appropriately to identify compliance or the need for further monitoring. Survey findings were discussed, specifically that one resident (R4) who was reviewed for falls failed to have their care plan revised after new interventions were identified to be implemented and would have been identified had the QAPI committee reviewed specifics around IDT review for falls and appropriate oversight would have occurred. The administrator agreed with that discussion and understood need for documenting the oversight. Review of the February 2026, Quality Assurance/Assessment and Performance Improvement Plan identified QAPI would make quality improvement decisions based on data analysis with input from residents, families, staff and the community. QAPI was to set goals for performance and measures progress toward those goals. The committee was to include representatives from all departments including nursing, food and nutrition, laundry, housekeeping, maintenance, health information technology, therapeutic recreation, therapy, business office and administration.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and document review, the facility failed to have a system for employee surveillance based on national standards or identify specific criteria used in determining staff return to work (RTW) for 3 of 5 sampled staff (nurse aide (NA)-A, NA-B, and trained medication aide (TMA)-A).Findings include: Interview, employee surveillance review, and staff timecard punch review on 4/15/26 at 12:18 p.m., with registered nurse (RN)-A identified she is the interim infection preventionist (IP) while the IP was on vacation. When staff called in sick, facility process only dictated a return to work that was 3 days or longer required a physician Return to Work (RTW) note. They used no criteria to identify when staff would be able to safely RTW using national and State guidelines to ensure the safety of all residents and other staff in transmission prevention of potentially infectious disease. With the 3 sampled staff:Nurse aide (NA)-B called in ill on 2/8/26, 2/9/26, 2/13/26, 2/23/26 and 2/26/26. RN-A was allowed to return to work as soon as the next day. It was later discovered after 2/26/26 NA-B was pregnant and that was the cause of her vomiting, however it was unknown at the time of illness. NA-A called in on 3/31/26 with a sore throat and runny nose. It was not documented with a presence or absence of fever. NA-A RTW on 4/1/26. NA-A was known to call-in multiple times for illness. RN-A was unaware if NA-A had tested for COVID and was not cleared for potential respiratory infectious disease following CDC guidance of symptoms improving and fever free for at least 24 hours prior to RTW. Trained medication aide (TMA)-A left her shift on 4/2/26. TMA-A was seen by a physician and had a RTW clearance date of 4/6/26. The documented reason was RSV. On 4/6/26, TMA-A called in with continued symptoms of RSV. Timecards identified she had RTW on 4/7/26. There was no evidence that staff had ensured TMA-A was fever free or had improved symptoms for 24 hours before her return.RN-A stated she agreed there should be a system to vet staff prior to returning based off national guidelines and was unaware staff with unknown gastro-intestinal (GI) illness were to be kept off work for 48 hours after cessation of all symptoms per CDC and minimum 72 hours per State standards of the MDH to prevent highly potentially contagious GI illness such as Norovirus. Interview on 4/15/26 at 2:50 p.m. with the administrator identified the lack of employee surveillance was discussed. The administrator was unaware of staff needing to be vetted prior to returning to work to show national and/or state standards were followed, and employees were deemed appropriate to RTW as not to potentially expose other residents and/or staff to infectious disease. The documentation above showed no evidence of that occurring. Although she thought the DON may have screened employees prior to RTW, she agreed there was no evidence appropriate employee surveillance that had occurred. The administrator agreed with the findings and on the need to improve the surveillance and RTW vetting process and ensure documentation occurred. The administrator was unaware employee surveillance was not being discussed in QAPI. Review of the January 2026, Staff with Signs and Symptoms of Infectious Disease policy identified staff assessment protocols were to have been established in order for the facility to be notified if a staff member had symptoms of an infectious disease and must stay out of the facility. The goal was to prevent residents from contracting communicable disease and prevent an outbreak. Staff exhibiting any of the symptoms below need to call into DPCH and report the symptoms they are having. The staff member receiving the call were to document the employee's signs and symptoms such as: VomitingDiarrheaGeneralized body achesCoughRunny and or stuffy noseHeadachesChillsFatigueTemperature Sore Throat Once a staff's temperature had been normal for 24 hours without taking fever reducing drugs and other symptoms were absent, the employee was allowed to return to work, depending on the infection (testing may be requested). There was no indication the policy followed national standards of practice and/ or State guidelines, depending upon the symptoms. There was also no mention of how the process was to occur or that staff who were taking the call-ins had been appropriately trained per national and state standards for vetting employees in order to safely RTW. The policy did note staff were to be trained upon hire and annually on signs and symptoms of infectious disease.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was attempted for 2 of 5 sampled residents' (R3 and R8) on psychotropic medications. Findings include: R8's 3/27/26, accepted quarterly Minimum Data Set (MDS) assessment identified R8's cognition was severely impaired. R8 had inattention that fluctuated. R8 took scheduled pain, antianxiety, and antidepressant medication. R8's diagnoses list identified unspecified psychosis, depression, restlessness and agitation. R8's physician orders identified Zoloft 25 milligrams (mg) by mouth daily in the evening for depression with a start date of 6/6/23. Review of R8's GDR information provided by the facility identified on: 12/4/23, a fax to the provider by registered nurse (RN)-C that read, Resident was due for a 6-month review of psychotropic medications. She was currently taking Ativan, Lyrica and Zoloft. She has not had any adverse reactions to the medication. Okay to continue for another 6 months? The medical doctor responded ON 12/5/23, Patient is stable on above medications.will not change. 7/2/24, the medical provider notes identified an assessment and plan for cognitive decline was to continue sertraline (Zoloft). R8 had no behavior issues. Staff were to encourage participation with facility activities for increased engagement and interaction. 6/22/25, a fax to the provider by RN-C that read, Resident was due for a 6-month review of scheduled psychotropic medications. The resident has orders for Zoloft 25 mg daily in evening. The medication is effective and well tolerated. May we have orders to continue for another 6 months? She also has Ativan 0.5 mg daily in evening. This medication is effective and well tolerated. May we have orders to continue for another 6 months? The medical doctor responded on 2/24/25 with yes. 3/3/26, medical provider note identified the assessment and plan for cognitive was to continue sertraline (Zoloft). R8 had no behavior issues. Staff were to encourage participation with facility activities for increased engagement and interaction. 12/27/25, a fax to the provider by RN-C read, Resident was due for a 6-month review of scheduled psychotropic medications. The resident has orders for Zoloft 25 mg daily in evening. The medication is effective and well tolerated. May we have orders to continue for another 6 months? She also has Ativan 0.5 mg daily in evening. This medication is effective and well tolerated. May we have orders to continue for another 6 months? The medical doctor responded on 2/24/25, with yes. R8's pharmacy reviews for October, November, and December of 2025 and January, February, and March of 2026 had no mention of psychoactive medication review or a GDR recommendation. R8's undated, current care plan identified R8 had the potential to feel anxious, angry, sad, confused or forgetful, and have episodes of depression. Staff were to evaluate situational stressors and re-orient (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8 unless it makes her agitated. Offer her choices and relaxation techniques. Interview on 4/15/26 at 4:14 p.m., with the administrator identified she would expect the regulations would be followed and gradual dose reductions (GDR) would be attempted as required. R3's comprehensive MDS assessment, accepted on 9/11/25 identified she was admitted to the facility in August 2025. R3 had diagnoses of depression, restlessness and agitation, unspecified dementia without behavioral or psychotic disturbance. She had moderate cognitive impairment, and her Patient Health Questionnaire-9 (PHQ-9) score was 1, indicating little to no depressive symptoms with no behaviors noted during the lookback period. R3's last physician's orders in September 2025, identified she received: Sertraline HCL (anti-depressant) 50 milligrams (mg), 1.5 tablets daily. Seroquel (antipsychotic) 12.5 mg in the a.m., and 25 mg in the evening. R3's pharmacy recommendations identified on: 9/26/25, pharmacist (RPh)-A made recommendations for lab tests. 10/27/25 and 11/24/25, RPh-A noted no problems with medications were identified. 12/11/25, review of allergy medication and cholesterol medications were reviewed and recommended to be discontinued. 1/23/26, Tylenol was recommended for a dose reduction from polypharmacy (multiple-like) medications. Seroquel 12.5 mg dose was as needed (prn) at that time and RPh-A recommended it to be discontinued as it was overdue for a 14 day face to face review. The physician was encouraged to discontinue that prn dose at that time. 2/19/26, and again on 3/19/26, RPh-A indicated no problems were identified. There was no indication RPh-A recommended a GDR attempt within her 1st 6 months of admission. R3's nursing progress notes identified on 12/1/26, staff noted R3 was due for 6 month scheduled psychotropic medication evaluation upcoming on 5/30/26 for her Seroquel. There was no indication nursing staff identified R3 should have had a GDR attempt requested within 6 months of admission. Interview on 4/11/26 at 3:22 p.m., with registered nurse (RN)-B identified nursing listed the medications for physicians when completing rounds and only asked if they would like to continue them. They made no mention to the physician if a resident was due for a GDR to be attempted. Interview on 4/15/26 at 10:15 a.m., with RPH-A identified GDR are listed in her notes as a review of medications. She does not specifically recommend GDR's. RPh-A identified she had recommended a review of medication in May 2026, as she made an error as she thought R3 had been admitted in January. She felt the nursing staff were to inquire about GDR's. RPh-A thought R8 had a GDR done and would check. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/15/26 at 12:18 p.m., with RN-A identified she was under the understanding the RPH would ask about GDR in their medication reviews and was unsure if GDR's were discussed or mentioned at that time. Interview on 415/26 at 2:50 p.m., with the administrator identified she was unaware GDR were not being performed and/or documented for R3 or R8, only mediation reviews were being requested to either continue or discontinue the medication. The administrator agreed GDR must be requested and attempted as required. If the request from the physician was denied, a rational for the denial was required and must be documented. Review of the December 2022, Pharmaceutical Services, Psychotropic Drugs policy identified residents who use psychotropic drugs were to receive GDR's unless contraindicated in an effort to discontinue the drug. Review of the undated, Psychotropic Medication policy, identified a psychotropic drug review would be completed by the consulting pharmacist with a collaborated goal of reduction or discontinuation of psychotropic medication. The purpose of the gradual dose reduction was to find an optimal dose or to determine if the continued use of the medication was beneficial to the residents. Accepted standards of practice for GDR were within the first year of a resident admission on a psychotropic medication or after the start of a psychotropic medication the facility must attempt a GDR in two separate quarters with at least one month between the attempts, unless clinically contraindicated. After the first year a GDR must be attempted annually, unless clinically contraindicated.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and document review, the facility failed to ensure care plans were appropriately developed for 1 of 5 sampled residents (R3) who received anticoagulant therapy.Findings include: R3's comprehensive MDS assessment, accepted on 9/11/25 identified she was admitted to the facility in August 2025. R3 had moderate cognitive impairment, with diagnoses of heart disease, cardiovascular and coagulation treatment, atrial fibrillation (heart's inability to appropriately contract, causing potential blood clots), and a history of heart attack. R3 required staff assistance with Activities of Daily Living (ADL) such as bathing, dressing and toileting. R3 used a walker, wheelchair, and cane or crutch for mobility and had a physical impairment on one side of her body. R3's current Medication Administration Record (MAR) indicated R3 received Xarelto, 15 milligrams (mg) daily related to their diagnosis of atrial fibrillation. R3's current, undated care plan identified R3 was at risk for falls as she was weaker and was known to be more fatigued than normal and may not remember to call staff for assistance. R3 had dementia and was known to be confused. R3 had muscle weakness and unsteadiness. R3's goal was to stay safe while out or moving about, transferring, and to avoid injury. There was no mention on the care plan R3 was at increased risk of bleeding and there were no bleeding precautions noted. Interview and care plan review on 4/15/26 at 12:18 p.m., with registered nurse (RN)-A identified she agreed there were no bleeding precautions listed on the care plan to alert staff what to monitor for since R3 was on an anti-coagulant. We probably haven't thought of that. RN-A agreed residents on anticoagulants should have increased monitoring related to increased risk of bleeding. Interview on 4/15/26 at 2:50 p.m. with the administrator identified she was unaware R3's care plan did not have any bleeding precautions. The administrator was unaware if any residents on anti-coagulants had interventions as they were at high risk for bleeding. The administrator agreed care plans needed to be developed as appropriate. Review of the current, undated Xaralto (anti-coagulant) patient safety information, located at: https://www.xarelto-us.com/what-is-xarelto/?utm_source=bing&utm_medium=cpc&utm_campaign=EG-DTCB- identified Xarelto was a blood thinner that treats and helps prevent blood clots that are related to certain conditions involving the heart and blood vessels. Anticoagulants lower your blood's ability to clot by stopping specific proteins and enzymes, also known as clotting factors, from doing their job to help blood clots form. Side effects of Xarelto included increased risk of bleeding. Patients were likely to bruise more easily, and it may take longer for bleeding to stop which can be serious and may lead to death. Patients were to notify a physician or receive medical attention if a patient developed signs or symptoms of bleeding such as:Unexpected bleeding or bleeding that lasts a long time, such as:Nosebleeds that happen often.Unusual bleeding from gums.Menstrual bleeding that is heavier than normal, or vaginal bleeding.Bleeding that is severe or you cannot control.Red, pink, or brown urine.Bright red or black stools (looks like tar).Cough up blood or blood clots.Vomit blood or your vomit looks like coffee grounds.Headaches, feeling dizzy or weak.Pain, swelling, or new drainage at wound sites.Left upper belly (abdominal) pain, pain below the left rib cage or at the tip of your left shoulder or diffuse abdominal discomfort (these may be symptoms of the rupture of the spleen). Review of the National Library of Medicine (NLM) article located at: https://pmc.ncbi.nlm.nih.gov/articles/PMC12284669/, To anti-coagulate or not to anti-coagulate-that is the question in patients with fall risks, identified falls were associated with an increased risk of traumatic bleeding events and death. Another NLM article located at: https://pmc.ncbi.nlm.nih.gov/articles/PMC11242576/, Traumatic Brain Injury in Patients under Anticoagulant Therapy: Review of Management in Emergency Department identified the National Institute for Health Care Excellence (NICE) suggested considering conducting a head CT scan for people who have sustained a traumatic brain injury (TBI) [ex: hitting their head from a fall] and have no other indications for a head CT scan, except being on anticoagulant therapy. There was no policy related to anti-coagulation monitoring provided by the end of survey.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and document review, the facility failed to revise the care plan for 1 of 1 sampled resident (R4) reviewed for falls.Findings include: R4's 4/2/26, accepted admission Minimum Data Set (MDS) assessment identified R4's cognition was severely impaired. R4 required substantial assistance from staff for activities of daily living (ADL's) and was incontinent of bowel and bladder. R4 had a history of falls prior to admission, had 2 falls since admission (1 with minor injury and 1 with major injury). R4 was identified to have delirium, inattention, disorganized thinking, and altered mental status that fluctuated. R4 took scheduled pain, antipsychotic, antianxiety, antidepressant, diuretic, and opioid medication. She was also noted during the assessment period to take an antibiotic. R4 was receiving occupational and physical therapy. R4's diagnoses list identified dementia with psychotic disturbance, anxiety, cardia arrhythmia, high blood pressure, depression, osteoporosis, weakness and malnutrition. R4's fall reports identified on:2/17/26, R4 had an unwitnessed fall in her room, and was found next to the chair. R4 was assessed and assisted in her chair and then toileted. She reported she thought she bumped her head when she tried to walk. The call light was not on at time of fall. The Corrective action/solution was to place alarm on her bed, chair, and wheelchair.2/22/26, R4 had an unwitnessed fall in the facility living room and was found next to a recliner leaning on her right side. Her glasses were broken, and she had a laceration (cut) near her left eye. Prior to her fall R4 had been sitting on a chair near the window in the living room. At time of fall there were no staff in the area due to residents finishing up lunch and transporting residents out of the dining room. R4 had tried to walk and fell. The Corrective action/solution was to make sure she was sitting on her chair alarm, to not take her out of dining room until staff were around the living room area and have a staff member be in dining area when she was in dining area. Review of 3/10/26, interdisciplinary team (IDT) meeting note identified the IDT did a review of R4's 2/22/26 fall on 2/24/26 with a new identified intervention of having R4 in the living room area for supervision as much as able, and to continue with her therapy treatments. R4's current, undated care plan, identified R4 required 2 staff to assist with transfers and toileting. R4 did not understand instructions and was not able express her needs. R4 had a wander guard on her wheelchair. R4 could not safely transfer without assistance and had a bed and chair sensor alarm in place that connected to and turned on the call light and/or pager. The care plan lacked identification that R4 should remain in the dining room until staff were around the living room area and to ensure staff were in the dining room area while R4 was there or that R4 should be in the living room area as much as possible for supervision. Interview and care plan review on 4/15/26 at 2:17 p.m., with registered nurse (RN)-A identified R4 had been admitted to the facility for failure to thrive and dementia. R4 had 2 falls since admission in February 2026. RN-A identified the only intervention on her care plan was to have a bed and chair alarm. RN-A confirmed the interventions that had been identified on the 2/22/26, fall report had not been added to the care plan following R4's second fall that resulted in a fractured of her pelvis. RN-A identified when a fall occurred, that the charge nurse would complete a fall report and that person was to update the care plan with the new interventions. Then the IDT meets weekly and reviews any falls and would review interventions. The IDT also should update the care plan if the intervention was changed after review. RN-A stated the care plan should be updated any time care needs change for a resident. Interview on 4/15/26 at 4:14 p.m., with the administrator identified she would expect that R4's care plan would reflect her current care needs including identified fall interventions. Any time a new intervention or care need was identified to care for a resident that the care plan would be updated. Review of undated Fall and Post-Fall Assessment identified that following a fall the nurse would assess the resident and provide necessary medical attention. The environment would be evaluated for possible causes and necessary action would be taken to correct as needed. The family and medical doctor would be updated and notified of new interventions. Interventions would be added to the care plan and communicated to the staff.

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	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Divine Providence Community Home	700 Third Avenue Northwest Sleepy Eye, MN 56085

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and document review the facility failed to weekly assess and measure a pressure ulcer for 1 of 2 sampled residents (R5). Findings include: R5's 4/2/26, accepted quarterly Minimum Data Set (MDS) assessment identified R5 had severe cognitive impairment. R5 required partial assistance with activities of daily living (ADL). R5 had 1 unhealed stage 3 pressure ulcer (full thickness tissue loss subcutaneous fat may be visible, but bone, tendon or muscle are not exposed) that was not present on admission and had moisture associated skin damage. R5 had a pressure relieving device on her bed and in her wheelchair. She took daily antidepressant and pain medication. R5's 4/14/26, diagnoses list identified dementia with anxiety, panic disorder, major depressive disorder, legal blindness, osteoarthritis, disorder of skin and subcutaneous tissue right buttocks cheek, and mixed incontinence of bladder. R5's 12/10/25, fax to physician identified communication that R5 had a pressure area measuring 3 centimeters (cm) x 3 cm on her right buttock with treatment set up to apply Mepilex every 3 days, and a note from staff asking if the physician would like to provide any further orders. R5's 12/23/25, provider communication identified staff were to report if R5's wound worsened or failed to resolve. R5's 4/14/26, printed care plan identified the nurse was to assist to reduce pressure and friction between R5 and her bed or chair. R5 had a pressure reducing mattress and cushions in her wheelchair and recliner. The nurse was to provide wound care to her right buttock and assess and measure the wound weekly. R5 would be monitored for nutrition and hydrating intake. Staff were to help R5 stay clean and dry and use a thin layer of barrier cream on red areas or previous problem areas. Staff were to report any redness to the nurse. Observation on 4/14/26 at 10:17 a.m., with registered nurse (RN)-A of R5's right buttocks wound identified RN-A prepped the supplies, washed her hands and donned gloves. RN-A removed the dressing and washed the wound. Observation of the wound identified a small open area with a pink wound bed. RN-A described the wound as stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed) with a thin layer of skin missing and measured the wound. RN-A identified interventions noted were for staff to promote healing and prevent further breakdowns including pressure relieving mattress and ensure a cushion was in her wheelchair and recliner. Interview on 4/14/26 at 12:07 p.m., with RN-A identified R5 had a treatment order to measure R5's wound every Monday. She revealed according to the documentation for February, March, and April of 2026 a measurement had only been completed on 3/9/26 and also what she had done earlier in the day. She confirmed the nurses had been charting that they had held the treatment and did not perform the task on all other Mondays. The nurse was to complete an assessment of the wound and measure every Monday until healed. R5's treatment administration record (TAR) identified an order to measure right buttocks open area one time a week on Monday until healed, start date of 2/2/26. Apply an Allevyn dressing and change every 3 days until healed, start date 2/7/26. Review of February, March, and April 2026 identified the following charting:2/2/26, was documented as held and not performed2/9/26, there was no documentation that the measurement was completed or not completed2/16/26, was documented as held and not performed2/23/26, was documented as held and not performed3/2/26, was documented as held and not performed3/9/26, was documented as completed3/16/26, was documented as held and not performed3/23/26, was documented as held and not performed3/30/26, was documented as held and not performed 4/6/26, was documented as held and not performed 4/13/26, was documented as held and not performed 4/14/26, documented as completed R5's wound assessment for February, March, and April 2026 identified the following documentation:2/2/26, R5's Allevyn (absorbent foam dressing) was intact on R5's right buttock.2/9/26, R5's Allevyn dressing was intact on R5's right buttock.2/16/26, R5's Allevyn dressing was as intact on R5's right buttock. R5's left buttock was noted, however, staff failed to document concerns with the left buttock.2/23/26, R5's Mepilex (absorbent silicone foam dressing) was intact on R5's right buttock.3/2/26, R5's Allevyn dressing was intact on R5's right (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	buttock.3/9/26, R5 had 2 open areas measuring 0.5 cm around. The areas were cleaned and Allevyn dressings were applied.3/16/26, R5's Allevyn dressing was identified as intact on R5's right buttock.3/23/26, R5s right buttock was as opened and cleaned with an Allevyn dressing applied.3/30/26, R5's right buttock was not open however, an Allevyn dressing was applied4/5/26, R5's right buttock was opened and cleaned with an Allevyn dressing applied 4/6/26, R5's Allevyn dressing was intact on R5's right buttock 4/13/26, R5's Allevyn dressing was identified as intact on R5's right buttock 4/14/26, R5's right buttock had a stage 2 pressure ulcer with the wound tissue being pink and surrounding tissue identified as dark discolored. The right buttock wound measured 1 cm x 0.7 cm, the area was cleaned, and an Allevyn dressing was applied.Prior to the surveyor's observation of the wound and treatment with the RN-A on 4/14/26, there was no evidence to support the nurse appropriately assessed and measured R5's wound weekly to monitor for worsening, remaining the same, or if they showed improvement. Interview on 4/14/26 at 12:21 p.m., with RN-B confirmed the nurse should be following the treatment orders to assess and measure R5's wound weekly. She was unsure why this was not being completed. Interview on 4/15/26 at 4:14 p.m., with administrator identified she would expect the licensed nurses would follow the facility policy on wound monitoring and measuring. Review of April 2017, Pressure Ulcer Assessment policy identified pressure ulcers would be evaluated, measured and characteristics of the wound would be documented weekly to determine worsening or improvement.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview, and document review, the Quality Assurance (QA) committee failed to ensure they received reports from the infection preventionist relating to employee surveillance for 4 of 4 quarters reviewed. Refer to F865 and F880Findings include: Review of the QAPI meeting minutes submitted for review identified for review of the past 4 Quarters of QAPI meeting minutes identified review of each quarter is as follows: Quarter 1 (April 2025): Attendees included the medical director, DON, RN staff development coordinator (RN-A), the pharmacist, dietary manager, facility director, vice president, maintenance supervisor, the administrator, and social services attended. Data submitted included:Infections: 18. 15 were urinary tract infections (UTI), and 3 were skin. The DON reviewed infection statistics. QAPI noted the IDT team would continue to review falls weekly and interventions, however there was no indication of a comprehensive review by QAPI occurred of any benchmarks, goals or analysis of IDT data. There was also no indication employee surveillance was being reviewed or discussed. Quarter 2 (July 2025): Attendees included the medical director, DON, RN staff development coordinator (RN-A), the pharmacist, facility director, the administrator, the vice president, and social services attended. Those areas included:Resident infection data was documented as reviewed. There were 18 total infections, with 9being UTI, 3 skin infections, and 6 respiratory infections. Staff were encouraged to utilize McGeer's criteria and follow antibiotic stewardship, however no benchmarks or goals were discussed, and no analysis of data was documented to have occurred to identify trends, or if tracking was occurring appropriately, if transmission-based precautions were needed or implemented timely etc. There was also no employee surveillance reviewed. Quarter 3 (October 2025): Attendees included the medical director, DON, RN staff development coordinator (RN-A), the pharmacist, facility director, the vice president, the administrator and social services attended. Those areas included:Resident infection data was reviewed. 13 in total with 7 UTI, 4 were skin, and 2 respiratory. Again, no employee surveillance was included. Quarter 4 (January 2026): Attendees included the medical director, director of nursing (DON), social services, the administrator, the Minimum Data Set (MDS) nurse, and pharmacist. No other departments were noted to have attended. Topics discussed were:Resident infections were discussed in numbers but no there was no data documented as being reviewed, there were no benchmarks or goals, and no analysis identified. There was also no mention employee surveillance having been discussed. Interview and document review on 4/15/26 at 3:45 p.m., with the administrator identified she was in charge of PIP and the director of nursing (DON) was in charge of the rest of discussion and documentation of QAPI. There was no evidence to support the IP had brought employee surveillance to QAPI for oversight. The administrator agreed with that discussion and understood need for documenting the oversight. Review of the February 2026, Quality Assurance/Assessment and Performance Improvement Plan identified QAPI would make quality improvement decisions based on data analysis with input from residents, families, staff and the community. QAPI was to set goals for performance and measures progress toward those goals. The committee was to include representatives from all departments including nursing, food and nutrition, laundry, housekeeping, maintenance, health information technology, therapeutic recreation, therapy, business office and administration. There was no specific mention to the IP bringing all surveillance data to QAPI for review. Review of the January 2026, Infection Control Coordinator policy, identified the infection control coordinator was to report information related to compliance to Administrator and Quality Assurance and Assessment Committee. The IP was to collect, analyze, and investigate data and trends to nursing staff and health practitioners; maintain infection logs for staff and residents; consult on strategies for infection prevention; and implement evidence-based control practices. Infection logs -summaries of infections.