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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 19VM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00650

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245482**

2.STATE VENDOR OR MEDICAID NO.
(L2) **122343700**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRAIRIE MANOR CARE CENTER**
(L4) **220 THIRD STREET NORTHWEST**
(L5) **BLOOMING PRAIRIE, MN** (L6) **55917**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/12/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 06/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/20/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/07/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN-24-5482

Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on May 12, 2014. Refer to CMS form 2567B.

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245482

June 20, 2014

Mr. Delbert Clark, Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, Minnesota 55917

Dear Mr. Clark:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 10, 2014 the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds located in rooms .

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

June 3, 2014

Mr. Delbert Clark, Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, MN 55917

RE: Project Number S5482024

Dear Mr. Clark:

On April 7, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 27, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 12, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 29, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 27, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 27, 2014, effective May 10, 2014 and therefore remedies outlined in our letter to you dated April 7, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245482	A. Building B. Wing	5/12/2014

Name of Facility	Street Address, City, State, Zip Code
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **04/25/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/25/2014**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **04/25/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/25/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	06/03/2014	10160	05/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/27/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245482	01 - MAIN BUILDING 01	5/29/2014

Name of Facility	Street Address, City, State, Zip Code
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0038	04/30/2014	ID Prefix Reg. # NFPA 101 LSC K0054	05/10/2014	ID Prefix Reg. # NFPA 101 LSC K0144	04/30/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GN/kfd	06/03/2014	10160	05/29/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/27/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245482	A. Building 02 - CHAPEL B. Wing	5/29/2014

Name of Facility	Street Address, City, State, Zip Code
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0054	05/10/2014	ID Prefix Reg. # NFPA 101 LSC K0144	04/30/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** GN/kfd	**Date:** 06/03/2014	**Signature of Surveyor:** 10160	**Date:** 05/29/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 3/27/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**		**YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 19VM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00650

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245482**
2.STATE VENDOR OR MEDICAID NO.
(L2) **122343700**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRAIRIE MANOR CARE CENTER**
(L4) **220 THIRD STREET NORTHWEST**
(L5) **BLOOMING PRAIRIE, MN** (L6) **55917**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/27/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NE II 04/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/02/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-24-5482-

On March 27, 2014 a standard survey was completed at the facility by the Minnesota Departments of Health and Public Safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4813

April 7, 2014

Mr. James Broich, Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, Minnesota 55917

RE: Project Number S5482024

Dear Mr. Broich:

On March 27, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 6, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 6, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 June 27, 2014 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 27, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections, State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program, Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING _____ APR 18 2014 B. WING _____ MN Dept of Health Rochester	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280 04/21/14 GPN	See ATTACHED PLAN of CORRECTION	4-25-14

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

Allison Henrichsen — ACTING ADMINISTRATOR — 4/16/14

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

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F 280	Continued From page 1 by: Based on observation, interview and document review, the facility failed to ensure specific resident centered pain management was included in the comprhensive care plan for 1 of 3 residents (R16) reviewed for unecessary medications. Findings include: R16 lacked revision of the care plan to include individualized interventions for pain. R16 was observed on 3/24/14 through 3/27/14. On 3/24/14 at 3:57 p.m. R16 was observed in bed and not at an activity program with the boy scouts. At 4:55 p.m. R16 was observed being removed from the dining room at his request and again at 7:15 p.m. was lying in bed. On 3/25/14 R16 was observed from 8:54 a.m. to 1:15 p.m. With each observation, R16 was noted to be in bed, TV on, and sleeping. On 3/26/14 at 10:30 a.m. R16 was observed in bed and not at brunch. And again from 1:00 p.m. to 3:30 p.m. R16 was noted to be in bed sleeping. The quarterly Minimum Data Sets (MDS) dated 8/29/13, 11/21/13, and 2/13/14 indicated R16 had no difficulty sleeping, staying a sleep or sleeping too much. The quarterly MDS of 11/21/13 and 2/13/14 indicated R16 had frequent mild pain. Review the physician orders indicated R16 received Trazodone (an antidepressant used for sleep) since 9/25/13 and morphine as needed for pain since 11/25/13. The care plan with a review date of 2/20/14 indicated a focus/problem of pain related to arthritis. The problem had interventions of	F 280		

F280

1. Resident R16 Care Plan has been updated to include non-pharmalogical interventions for pain as well as parameters for the use of PRN Tylenol and PRN Morphine as of 3/27/14.
2. All MARs and Care Plans for residents that have more than one PRN pain medication ordered will be reviewed to include parameters for when to use each medication. All Care Plans will have individualized interventions for pain included.
3. All licensed nursing staff will be reeducated on the Pain Medication Policy and on revising resident Care Plans when indicated by April 24th 2014.
4. Audits of Care Plans and MARs will be completed for the next quarter. Don/Designee will be responsible to complete and review audits to ensure compliance. The random audits and this deficiency will be reviewed at the next regular QA meeting.
5. Date of completion is April 25th, 2014

Pain Management Policy

Basic Responsibility

Licensed Nurses

Purpose

It is a policy of Prairie Manor Care Center to ensure residents experiencing pain will have a comprehensive assessment of that pain and will have an established plan to treat that pain.

Procedure

- A pain assessment will be completed, using an appropriate pain scale to describe pain, on admission, readmission, quarterly, after a fall, and for new onset of pain. Pain Assessments will be documented. Obtain information directly from the resident whenever possible. If resident is unable to participate, obtain information from caregivers and family members.
- Pain assessments will be evaluated by licensed nursing staff and physicians will be notified if pain is not adequately controlled. Orders will be obtained, by a physician, for medications and treatment to relieve pain.
- Resident will be monitored for pain after medications and treatments for pain are ordered for effectiveness and for possible side effects.
- If pain medication/treatment is not adequate to relieve resident's pain, the physician will be notified and medication/treatment will be changed. Resident will be monitored again for effectiveness. This process will continue until adequate pain management is achieved.
- Documentation regarding pain management process will be completed in the Nurses Notes and family/responsible party will be informed of resident's progress and medication/treatment changes.
- Each resident will have pain addressed in their care plan. Care plans will include individualized interventions for pain as well as non-pharmalogical interventions for pain.
- Each resident that has more than one PRN pain medication ordered will have parameters in the MAR and Care Plan to identify when to give which PRN pain medication.

Signature Allison Henrud RN DON

Updated: April 9, 2014
Department: Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 2 administer pain medication and monitor effectiveness, encourage verbalization of pain and monitor for non-verbal signs of discomfort, and pain assessment quarterly and as needed. The care plan did not identify individualized interventions specific for R16 that would help him to manage the pain. The care plan did not identify the use of the as needed medication of Tylenol or morphine or identify when to give which medication. During an interview on 3/26/14 at 10:40 a.m., the director of nursing indicated care plan should include individual specific non-pharmacological interventions for pain.	F 280		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329	See ATTACHED PLAN of CORRECTION	4-25-14

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F 329	Continued From page 3 drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement parameters for use of as needed Haldol (antipsychotic medications) and Morphine (pain medication), evaluate and assess for sleep and develop a plan to assist the resident to manage insomnia without an increase in the Trazodone (antidepressant and hypnotic) and failed to monitor the behaviors after the initiate of Seroquel to determine effectiveness of the medication for 1 of 5 residents (R16) reviewed for unnecessary medications. Findings include: R16 was observed on 3/24/14 at 3:57 p.m. in bed and not at an activity program with the boy scouts. At 4:55 p.m. R16 was observed being assisted from the dining room at his request and again at 7:15 p.m. was lying in bed. On 3/25/14 R16 was observed from 8:54 a.m. to 1:15 p.m. With each observation, R16 was noted to be in bed, TV on, and sleeping. On 3/26/14 at 10:30 a.m. R16 was observed in bed and not at brunch. And again from 1:00 p.m. to 3:30 p.m. R16 was noted to be in bed sleeping. The quarterly Minimum Data Sets (MDS) dated 8/29/13, 11/21/13, and 2/13/14 indicated R16 had no difficulty sleeping, staying at sleep or sleeping too much. The quarterly MDS of 11/21/13 and	F 329		

F329

1. PRN Haldol has been discontinued for resident R16. Resident R16 Care Plan has been updated to include non-pharmalogical interventions for sleep as well as parameters for the use of PRN Morphine as of 3/27/14. Sleep tracking and monitoring of R16 sleep will be completed, reviewed with MD, and added to Care Plan. Behaviors will be assessed and reported to MD for possible trial dose reduction of Seroquel.
2. A new "Guideline for Administration of PRN Antipsychotic Medication" sheet will be implemented for all residents with orders for PRN antipsychotic medications. All MARs and Care Plans for residents that have PRN pain and PRN antipsychotic medications will include parameters on when to use. Sleep tracking will be completed for all residents using a Hypnotic medication or an Antidepressant medication for sleep and an assessment completed per facility policy. All resident behaviors will be monitored and reviewed for unnecessary medications and to determine effectiveness when an Antipsychotic medication is initiated, increased, decreased, or discontinued per facility policy. Psychotropic Medication Policy was reviewed and updated.
3. All licensed nursing staff will be reeducated on the Psychotropic Medication Policy, the Guidelines for PRN Antipsychotic Use, and the Pain Medication Policy by April 24th 2014.
4. Audits of care plans and psychotropic medication monitoring will be completed for the next quarter. Don/Designee will complete or review audits to ensure compliance. Random audits and this deficiency will be reviewed at the next regular scheduled QA meeting.
5. Date of completion will be April 25th, 2014.

Guidelines for Administration of PRN Antipsychotic Medication

Resident Name_____Date_____

Medication Order_____

May be administered after meeting the following guidelines for use.

Guidelines:

- **Pain** has been assessed and treated or ruled out as a contributing factor.
- **Personal Needs** have been assessed: Offer/Assist with toileting, hydration, food, position change, etc.
- **Unable to Redirect or Calm** resident with music, back rub, conversation, one-on-one, quiet environment, or other diversional activities.
- **Behavior(s) Unchanged** in _____minutes after attempts to meet personal needs, calm, redirect resident.

Target Behaviors for this resident are defined as:

_____Prolonged yelling/swearing at staff and/or other residents

_____Physical abuse toward staff and/or other residents i.e., hitting, kicking, Scratching, biting

_____Verbalization of anxiety/distress with observable physical symptoms

specify:_____

_____Resisting cares that are necessary to meet basic needs

_____Other_____

Updated: April 9, 2014

Department: Nursing

PSYCHOTROPIC DRUG USE POLICY

Purpose:

Prairie Manor Care Center assures that each resident's drug regime is free from unnecessary drugs. Resident's receiving psychotropic medication are monitored for: excessive doses, excessive duration, adequate indications, presence of adverse side effects, and target behaviors in accordance with Federal Tag 329.

POLICY

It is the policy of Prairie Manor Care Center to monitor all resident's experiencing behavioral symptoms and that are taking psychotropic medications (or any other drugs outside of their intended use) for management of mood/behaviors.

PROCEDURE

1. Psychotropic Behavior Management Nurses/Nurse Managers will track all psychotropic medication changes; medication initiations/discontinuations and dose reductions/increases on resident's individual psychotropic chronological along with the indications.
2. Informed consent for all psychotropic medications will be obtained before residents start on a new medication and the consent form will be placed in resident's chart under "psychotropics" once signed.
3. Resident's started on any psychotropic medication will be triggered under "communications" for daily charting x's 4 weeks for target behaviors, or if dose is increased or decreased or the medication is discontinued, charting will be triggered for daily charting x's 4 weeks, then charting will be done quarterly in a "RN Behavior Note" and as needed.
4. All psychtropic medications will be reviewed during each resident's quarterly pre-care conference/IDT meetings, during quarterly care conferences, routinely on certification visits with the physician, and as needed.
5. Behavior Management Nurses will review resident's use of antipsychotic medications monthly at IDT/behavior management meeting, during quarterly care conferences, routinely on certification visits with the physician, and as needed.
6. Resident's taking antipsychotics will be monitored every shift, by nurses and R.N.A.'s, for target behaviors using a behavior flow sheet tool that will be placed in R.N.A.'s wing workbook. This sheet will be filled out indicating what interventions were used and if the interventions worked. RNAs will also report any behaviors to the nurse and the behavioral episodes will be documented in the nurse's notes under "mood and behavior," in the computer, to reflect the specifics of each episode.
7. A Behavior Care Plan will be developed for residents that have behaviors and those with orders for antipsychotic medications (Seroquel, Haldol, Risperidone…). All target behaviors and non-pharmalogical interventions will be included.
8. The mood state, functional abilities and behavioral symptoms of resident's taking **cholinesterase inhibitors** (Aricept, Razadyne, Exelon, Namenda…) will be

reviewed with physician on certification visits (and as needed), and quarterly at care conference with IDT, resident and family. A Care Plan will be developed.

9. A sleep disruption Care Plan will be developed for residents with orders for hypnotic/sedative medications (Ambien, Trazodone…). Non-pharmalogical interventions will also be included. Sleep tracking will be completed before routine certification physician visits for review.
10. A Psychotropic Care Plan will be developed for residents with orders for antidepressants and antianxiety medications (Ativan, Remeron, Celexa, Zoloft…). All target behaviors and interventions will be included.
11. Care Plans will be reviewed and revised quarterly and as needed.
12. Resident's with orders for PRN antipsychotics, antianxiety and hypnotic will be assessed using the Guidelines for Administration worksheet prior to giving this PRN medication and effectiveness will be documented after given.
13. A DISCUS Assessment will be completed on every resident on Admission for a baseline and then every 6 months for any resident that takes an antipsychotic medication.
14. The consulting pharmacist will conduct a drug review monthly and will identify and report irregularities to the Attending Physician and the Director of Nursing.

SIGNATURE Allison Henshaw RN DON

Revised: 3/28/14
Department: Nursing

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F 329	Continued From page 4 2/13/14 indicated R16 had frequent mild pain. The quarterly MDS of 8/29/13, 11/21/13, and 2/13/14 indicated R16 displayed no verbal or physical behaviors toward others or self, displayed no refusal of cares, and displayed wandering behaviors. The quarterly MDS dated 2/13/14 indicated R16 had a brief interview of mental status score of 8 or moderate cognitive impairment. The registered nurse (RN) Behavior Note of 11/24/13 listed diagnoses of "Alcoholism, depression, history of repeated poor choices with at risk behavior requiring 24-our supervision to maintain sobriety and safety ..." The physician orders signed 3/10/14 also listed additional diagnoses of chronic pain, chronic kidney disease, dementia with behavioral disturbances. R16 lacked parameters for use of as needed Haldol (antipsychotic) and as needed Morphine (pain): On 10/28/13 the physician ordered 1 mg Haldol every 8 hours as needed for severe agitation. The medication administration record indicated the resident received the as needed Haldol 3 times in October, 3 times in November 2013. There was no Haldol given as needed for December 2013, January and February 2014, or the first two weeks of March 2014. The physician's order did not include parameters for use of the as needed Haldol (i.e. what behaviors the medication was to be given for, what non-pharmacological interventions should be used first, or if any other assessment and medication should be attempted.) R16 ' s care plan dated of 2/20/14 had a problem/focus related to behaviors identified.	F 329		

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F 329	Continued From page 5 The care plan had an intervention of give medications as prescribed by physician i.e. Haldol, Zoloft, and Seroquel but did not identify parameters for use of the Haldol. During an interview on 3/26/14 at 11:00 a.m. director of nursing (DON) stated guidelines/parameters for the use of the as needed Haldol had not been developed for R16 and should have been. On 11/25/13 the physician order increased the Morphine to 2 mg every 4 hours as needed. The medication administration record indicated R16 received morphine 13 times in October, once in November 2013, and once in March 2014. In addition R16 had a physician's order for as needed Tylenol dated 5/31/13 and received the Tylenol once in October 2013. However, neither the Tylenol nor Morphine had parameters as to when the medication is to be used and which one for what pain level/intensity. R16 ' s care plan dated 2/20/14 had a plan that indicated pain related to arthritis but did not identify the use of the as needed medication of Tylenol or Morphine or identify when to give which medication and for what type or intensity of pain. During an interview on 3/26/14 at 9:10 a.m. the case manager-registered nurse (RN)-B stated staff should give the Tylenol first for mild pain and then morphine, but stated the facility had not developed parameters for the use of the Tylenol or Morphine for R16. During an interview on 3/27/14 at 9:10 a.m. the DON indicated the facility had not listed parameters for use of the pain medications on the care plan. R16 had an increase in Trazodone used for sleep	F 329		

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F 329	Continued From page 6 however, the effectiveness of the increased medication was not determined. Nor were non-pharmacological interventions attempted prior to the use of the sleeping medication: Physician orders dated 9/25/13 indicated R16 was to receive Trazodone 25 mg for sleep. The orders directed the Trazodone be increased to 50 mg after 1 day and to 100 mg on 10/7/13. The quarterly sedative/hypnotic assessment was reviewed for 12/13/13 and 2/22/14. The assessments noted a sleep tracking and mood monitoring had been completed. The assessment stated R16 was receiving Trazodone for depression and insomnia, but no evaluations of the residents sleep/awake cycle or hours of sleep was found or documented. R16 ' s care plan dated 2/20/14 indicated a focus/problem of history of insomnia. The interventions had not listed the factors that may facilitate or interfere with normal sleep patterns and did not identify specific interventions (non-pharmacological) to assist the resident to sleep. During an interview on 3/26/14 at 9:10 a.m., RN-A and RN-B indicated the sleep tracking should be done prior to the physician visit, but the sleep tracking for R16 had not been done. RN-B indicated the sleep tracking would cover the time period from 6 p.m. to 9 a.m. and did not monitor sleep during the day. During an interview on 3/26/14 at 10:20 a.m. the DON stated the Sedative/Hypnotic Assessment was to be completed quarterly and should include non-pharmacological interventions and added that sleep tracking was to be completed. DON stated R16 would go through periods of sleep and then awake for a couple days.	F 329		

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F 329	Continued From page 7 R16 lacked monitoring of Seroquel to determine if it is affective to treat symptoms: Physician orders for R16 revealed an order dated 10/18/13 that the physician ordered Seroquel 25 mg twice a day. The quarterly RN Behavior Note of 11/24/13 indicated R16 was currently taking Seroquel. The RN quarterly Behavior Note did not identify the type or frequency of behaviors or if the use of non-pharmacological interventions were effective. During an interview on 3/26/14 at 9:10 a.m., RN-A, RN-B indicated R16 ' s behaviors were long standing. RN-B stated the documentation was generally found in the nursing notes, because the nursing assistants would tell the nurse about the behavior. Regarding the behavior monitoring, RN-B stated had discussed the need for quantitative monitoring, but that the facility was not doing it. During an interview on 3/26/14 at 10:20 a.m. DON stated the quarterly RN Behavior summary was to include a review of the medications, review of the gradual dose reductions, review of the behaviors and interventions. The licensed social work (LSW)-A was interviewed on 3/27/14 at 8:45 a.m. LSW-A noted that in October 2014 R16 ' s behaviors could have been related to the change from having a private room to a double room (companion) and also the resident's brother had died in October 2013. LSW-A indicated that she had noticed behaviors would occur each time an attempt was made to provide a roommate in the past.	F 329		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS	F 412	See ATTACHED PLAN of CORRECTION	4-25-14

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F 412	Continued From page 8 The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate dental services were provided or offered related to broken and missing teeth for 1 of 1 resident (R57) reviewed for dental services. Findings include: R57 was observed on 3/25/14, at 9:15 a.m. to have multiple upper and lower missing teeth, and both lower front teeth broken off. R57's admission note dated 7/12/13, indicated R57 had her own teeth with some missing, last dental appointment had been more than one year prior to admission. The care plan with a review date of 1/15/14, was reviewed and included diagnosis of depression, cerebrovascular accident (CVA) with right sided hemiparesis and aphasia. The care plan did not identify R57 had any dental issues. R57's admission Minimum Data Set (MDS) dated 7/19/13, did not identify R57 had any dental issues or problems with teeth. The MDS indicated	F 412		

F412

1. Resident R57 has been offered a dental appointment and the Care Plan has been updated with current dental status as of 4/1/14.
2. All resident Care Plans will be reviewed and updated to ensure that they have been offered a dental appointment. If they have not been offered a dental appointment they will be asked if they would like one. This will be documented in all resident Care Plans. This will also be covered in future care conferences on a routine basis for all residents.
3. All licensed nursing staff will be reeducated on the new Oral Assessment Policy by April 24th 2014. A thorough oral assessment will be completed on Admission, Re-Admission, whenever there is a reported dental concern, and quarterly during the MDS assessment period. Each resident and/or family representative will be offered assistance to make arrangements for a dental appointment within 90 days of admission and then on a yearly basis at the minimum.
4. Audits of all new admission assessments and Care Plans will be completed for the next quarter. Don/Designee will be responsible to complete and review audits to ensure compliance. This deficiency and audits will be reviewed at the next regular scheduled QA meeting.
5. Completion date will be April 25th 2014.

ORAL ASSESSMENT POLICY

Basic Responsibility

Licensed Nursing Staff

Purpose

It is the policy of Prairie Manor Care Center to ensure each resident has access to dental services to ensure proper dental care, and to promote the highest possible quality of life.

Procedure

- A thorough oral assessment will be completed and documented on Admission, Re-Admission, whenever there is a reported dental concern, and quarterly during MDS assessment period. This information will be documented in the progress notes. Information will also be documented in the Nursing Admission Assessment on Admission/Re-Admission.
- Arrangements will be made during the admission process for dentures to be marked within 7 days of admission.
- Each resident and/or family representative will be offered assistance to make arrangements for a dental appointment within 90 days of admission and then on a yearly basis at the minimum.
- Each resident will be encouraged to utilize the services of his/her own dentist. If one has not been designated by the resident or his/her family, nursing will assist them in securing the services of a local dentist. A list of local dentists is furnished on Admission. The resident/family will be allowed to select their own dental care.
- When a resident complains of any mouth problems such as broken dentures, rough edges, sores in their mouth, discomfort when chewing etc., Nursing staff will assess and arrange for the resident's dental appointment at the first available time and convenience to the resident. Transportation to and from the appointment will also be arranged.
- All efforts regarding a resident's dental care will be documented in the resident's progress notes.
- Resident's dental status will be addressed in their care plan.

Signature Allison Henstrud RN DON

Updated: March 26, 2014

Department: Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING _____ APR 18 2014 B. WING _____ MN Dept of Health Rochester	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

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F 412	Continued From page 9 R57 had moderate cognitive impairment and required extensive assistance of staff with personal hygiene. Registered dietitian note dated 10/23/13, identified R57 was independent with eating a regular diet, and had an unplanned weight loss. Care conference progress notes were reviewed between 7/31/13, and 1/9/14. There was no evidence of dental services offered or discussion with R57 or family regarding the need for dental services. On 3/26/14, at 11:58 a.m. R57 indicated dental services had not been offered however she would go if offered. On 3/26/14, at 12:25 p.m. the director of nursing (DON) confirmed R57's dental status had not been assessed and stated she would expect missing and broken teeth be identified on the comprehensive admission assessment. DON indicated dental services should have been offered during admission. DON verified R57's record lacked documentation dental services had been offered and stated, "[R57] should have been offered dental services since she has had a weight loss." A policy was requested however not provided.	F 412		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	See ATTACHED PLAN of CORRECTION	4-25-14

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F 428	Continued From page 10	F 428		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to ensure the consulting pharmacist identified irregularities and reported them to the director of nursing and physician for 1 of 5 residents (R16) reviewed for unnecessary medications.

Findings include:

R16 was observed on 3/24/14 at 3:57 p.m. in bed and not at an activity program with the boy scouts. At 4:55 p.m. R16 was observed being assisted from the dining room at his request and again at 7:15 p.m. was lying in bed. On 3/25/14 R16 was observed from 8:54 a.m. to 1:15 p.m. With each observation, R16 was noted to be in bed, TV on, and sleeping. On 3/26/14 at 10:30 a.m. R16 was observed in bed and not at brunch. And again from 1:00 p.m. to 3:30 p.m. R16 was noted to be in bed sleeping.

The quarterly Minimum Data Sets (MDS) dated 8/29/13, 11/21/13, and 2/13/14 indicated R16 had no difficulty sleeping, staying at sleep or sleeping too much. The quarterly MDS of 11/21/13 and 2/13/14 indicated R16 had frequent mild pain. The quarterly MDS of 8/29/13, 11/21/13, and 2/13/14 indicated R16 displayed no verbal or physical behaviors toward others or self, displayed no refusal of cares, and displayed wandering behaviors. The quarterly MDS dated 2/13/14 indicated R16 had a brief interview of

F428

1. Consulting Pharmacist reviewed resident R16 medications for unnecessary medications on 3/28/14. PRN Haldol has been discontinued. Behaviors and Sleep tracking will be assessed and reported to MD for possible trial dose reduction of Seroquel.
2. Consulting Pharmacist will review all Sedative/Hypnotic and RN Behavior assessments to ensure that drug irregularities are identified, there are appropriate indications for the use of the psychotropic medications, and to ensure that there is appropriate monitoring for effectiveness and side effects. A new "Guideline for Administration of PRN Antipsychotic Medication" sheet will be implemented for all residents with orders for PRN antipsychotic medications. Parameters for all PRN pain and antipsychotic medications will be Care Planned in any pertinent resident's plan of care. Sleep tracking will be completed for all residents using a Hypnotic medication or an Antidepressant medication for sleep and an assessment completed per facility policy. All resident behaviors will be monitored and reviewed for unnecessary medications and to determine effectiveness when an Antipsychotic medication is initiated, increased, decreased, or discontinued per facility policy. Psychotropic Medication Policy was reviewed and updated.
3. Consulting Pharmacist and DON reviewed and revised the Pharmacy, Medication Irregularities Policy. All licensed nursing staff will be re-educated on Policy by April 24th 2014.
4. DON and Consulting Pharmacist will be responsible to conduct audits on Sedative/Hypnotic and RN Behavior assessments/monitoring for the next quarter. This deficiency and the audits will be reviewed at the next regular scheduled QA meeting.
5. Completion date will be April 25th, 2014.

Pharmacy, Medication Irregularities Policy

POLICY:

It is the policy of Prairie Manor Care Center to prevent any medication irregularities and to prevent the use of unnecessary drugs in our resident population.

PROCEDURE:

1. A pharmacist will review medications on admission, re-admission, and at time of emergency medication use from the in-house Emergency Drug Box, which they supply.
2. The Consulting Pharmacist will conduct a monthly medication review on all residents noting the medications, doses, length of time the medication has been given, and also noting drugs for compatibility or antagonistic effects.
3. The Consulting Pharmacist will review all medications to ensure drug irregularities are identified, that there are appropriate indications for the use of psychotropic medications, and that the appropriate monitoring for effectiveness and side effects is completed to ensure there is no unnecessary drug use.
4. The Consulting Pharmacist will make written recommendations with needed corrections and/or approval of each resident to the Medical Director and Director of Nursing as needed.
5. The Consulting Pharmacist documentation will be completed in the Point Click progress notes under "Consulting Pharmacist".

Signature Allison Hemsued RN DON

Department: Nursing

Updated: 4/10/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 11 mental status score of 8 or moderate cognitive impairment. The registered nurse (RN) Behavior Note of 11/24/13 listed diagnoses of "Alcoholism, depression, history of repeated poor choices with at risk behavior requiring 24-our supervision to maintain sobriety and safety ..." The physician orders signed 3/10/14 also listed additional diagnoses of chronic pain, chronic kidney disease, dementia with behavioral disturbances. R16 lacked parameters for use of as needed Haldol (antipsychotic) and as needed Morphine (pain): On 10/28/13 the physician ordered 1 mg Haldol every 8 hours as needed for severe agitation. The medication administration record indicated the resident received the as needed Haldol 3 times in October, 3 times in November 2013. There was no Haldol given as needed for December 2013, January and February 2014, or the first two weeks of March 2014. The physician's order did not include parameters for use of the as needed Haldol (i.e. what behaviors the medication was to be given for, what non-pharmacological interventions should be used first, or if any other assessment and medication should be attempted.) R16's care plan dated of 2/20/14 had a problem/focus related to behaviors identified. The care plan had an intervention of give medications as prescribed by physician i.e. Haldol, Zoloft, and Seroquel but did not identify parameters for use of the Haldol. During an interview on 3/26/14 at 11:00 a.m. director of nursing (DON) stated	F 428		

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MN Dept of Health Address

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F 428	Continued From page 12 guidelines/parameters for the use of the as needed Haldol had not been developed for R16 and should have been. On 11/25/13 the physician order increased the Morphine to 2 mg every 4 hours as needed. The medication administration record indicated R16 received morphine 13 times in October, once in November 2013, and once in March 2014. In addition R16 had a physician's order for as needed Tylenol dated 5/31/13 and received the Tylenol once in October 2013. However, neither the Tylenol nor Morphine had parameters as to when the medication is to be used and which one for what pain level/intensity. R16's care plan dated 2/20/14 had a plan that indicated pain related to arthritis but did not identify the use of the as needed medication of Tylenol or Morphine or identify when to give which medication and for what type or intensity of pain. During an interview on 3/26/14 at 9:10 a.m. the case manager-registered nurse (RN)-B stated staff should give the Tylenol first for mild pain and then morphine, but stated the facility had not developed parameters for the use of the Tylenol or Morphine for R16. During an interview on 3/27/14 at 9:10 a.m. the DON indicated the facility had not listed parameters for use of the pain medications on the care plan. R16 had an increase in Trazodone used for sleep however, the effectiveness of the increased medication was not determined. Nor were non-pharmacological interventions attempted prior to the use of the sleeping medication: Physician orders dated 9/25/13 indicated R16 was to receive Trazodone 25 mg for sleep. The orders directed the Trazodone be increased to 50	F 428		

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F 428	Continued From page 13 mg after 1 day and to 100 mg on 10/7/13. The quarterly sedative/hypnotic assessment was reviewed for 12/13/13 and 2/22/14. The assessments noted a sleep tracking and mood monitoring had been completed. The assessment stated R16 was receiving Trazodone for depression and insomnia, but no evaluations of the residents sleep/awake cycle or hours of sleep was found or documented. R16's care plan dated 2/20/14 indicated a focus/problem of history of insomnia. The interventions had not listed the factors that may facilitate or interfere with normal sleep patterns and did not identify specific interventions (non-pharmacological) to assist the resident to sleep. During an interview on 3/26/14 at 9:10 a.m., RN-A and RN-B indicated the sleep tracking should be done prior to the physician visit, but the sleep tracking for R16 had not been done. RN-B indicated the sleep tracking would cover the time period from 6 p.m. to 9 a.m. and did not monitor sleep during the day. During an interview on 3/26/14 at 10:20 a.m. the DON stated the Sedative/Hypnotic Assessment was to be completed quarterly and should include non-pharmacological interventions and added that sleep tracking was to be completed. DON stated R16 would go through periods of sleep and then awake for a couple days. R16 lacked monitoring of Seroquel to determine if it is affective to treat symptoms: Physician orders for R16 revealed an order dated 10/18/13 that the physician ordered Seroquel 25 mg twice a day. The quarterly RN Behavior Note of 11/24/13 indicated R16 was currently taking Seroquel. The	F 428		

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F 428	Continued From page 14 RN quarterly Behavior Note did not identify the type or frequency of behaviors or if the use of non-pharmacological interventions were effective. During an interview on 3/26/14 at 9:10 a.m., RN-A, RN-B indicated R16 ' s behaviors were long standing. RN-B stated the documentation was generally found in the nursing notes, because the nursing assistants would tell the nurse about the behavior. Regarding the behavior monitoring, RN-B stated had discussed the need for quantitative monitoring, but that the facility was not doing it. During an interview on 3/26/14 at 10:20 a.m. DON stated the quarterly RN Behavior summary was to include a review of the medications, review of the gradual dose reductions, review of the behaviors and interventions. The licensed social work (LSW)-A was interviewed on 3/27/14 at 8:45 a.m. LSW-A noted that in October 2014 R16's behaviors could have been related to the change from having a private room to a double room (companion) and also the resident's brother had died in October 2013. LSW-A indicated that she had noticed behaviors would occur each time an attempt was made to provide a roommate in the past. The consultant pharmacist was interviewed on 3/28/14 at 10:00 a.m. via telephone. She indicated she would expect the facility to monitor sleep and do quantitative behavior monitoring for the Seroquel. The consultant pharmacist stated she had sent a note to nursing on 11/25/13 referencing the need for sleep monitoring. She stated she would expect a nurse assessment be documented for the use of as needed Haldol or Morphine. The consultant pharmacist stated she had reviewed the facility and physician	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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APR 18 2014
MN Dept of Health
Rochester

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F 428	Continued From page 15 documentation, but was unaware that the behavior monitoring, sleep monitoring, and parameters for use of as needed medication was not completed.	F 428		

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	245482	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/27/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Prairie Manor Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	POC rk 4-21-14 RECEIVED APR 17 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DOC: 5-6-14
EXIT: 3-27-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Allison Henrrud	Acting Administrator	4/16/14

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Prairie Manor Care Center is a 1-story building. The original building was constructed in 1970 and was determined to be of Type II(111) construction, with a partial basement. In 1984, addition was constructed and was determined to be of Type II(111) construction. The facility is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 48 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038	See Attached Plan of Correction	4-30-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 038 SS=D	Continued From page 2 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2., 7.1.6.2 and 7.2.1.4.5. The deficient practice could affect all 13 out 48 residents. Findings include: On facility tour between 9:00 AM and 12 noon on 03/27/2014, observation revealed, that the Left wing exit discharge has a change in elevation of more than 1/2 inch, between concrete sidewalk panels (2 inches) NOTE: Check ALL paths to public way for this deficiency This deficient practice was confirmed by the facility Maintenance Director (SB) at the time of discovery.	K 038		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	K 054	See Attached Plan of Correction	5-10-14

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PRAIRIE MANOR CARE CENTER	**220 THIRD STREET NORTHWEST** **BLOOMING PRAIRIE, MN 55917**

(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
K 054	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 2000 NFPA 101, 9.6.1.4 and 1999 NFPA 72, Sections 7-1.1.1. The deficient practice could affect all 48 residents. Findings include: On facility tour between 9:00 AM and 12 noon on 03/27/2014, observation of the Fire Alarm Control Panel (FACP) showed the FACP was in trouble. The trouble was a "Battery Charging Fault". Maintenance Director indicated this has been in trouble for the last 6 months. This deficient practice was confirmed by the facility Maintenance Director (SB) at the time of discovery.	K 054		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency	K 144	See Attached Plan of Correction	4-30-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/27/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	**220 THIRD STREET NORTHWEST** **BLOOMING PRAIRIE, MN 55917**

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K 144	Continued From page 4 generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 48 residents. Findings include: On facility tour between 9:00 AM and 12 noon on 03/27/2014, documentation review of the monthly emergency generator testing log (April 2013 to March 2014), revealed that the monthly test have been done, but indicated that the natural gas emergency generator was not being tested under load of 30 percent. There was no other documentation stating that the emergency generator was tested by one of the following means: 1. Loading that maintains the minimum water temperatures as recommended by the manufacturer or 2. under load of 30 percent or more of the nameplate rating of generator or 3. 2 hour load bank test This deficient practice was confirmed by the facility Maintenance Director (SB) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/27/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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PRAIRIE MANOR CARE CENTER

PLANS OF CORRECTION

MAIN BUILDING 1

K 038 The left wing exit discharge will be repaired to bring the concrete sidewalk to the correct elevation. We will inspect all the other exit paths to public way and bring those to the correct elevation if any are out of compliance. The completion date will be April 30, 2014. The facility Maintenance Director will be responsible for this correction and to monitor the exit paths in the future in order to prevent a reoccurrence of this deficiency.

K 054 A new fire panel has been ordered and will be installed by Trans Alarm Company. The completion date will be May 10, 2014. The Maintenance Director will be responsible for this correction and to monitor the new fire panel in the future to ensure that the trouble "Battery Charging Fault" does not appear.

K 144 The generator will be repaired by Generator Systems Services. They will replace the necessary parts so that the generator can be run under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. and in accordance with the requirements of 2000 NFPA 101 – 9.1.3 and 1999 NFPA 110 6-4.2 (A) & (B) AND 6-4.2.2. Generator System Services will test and run the generator under full load for 30 minutes after the repairs are completed. The completion date for these repairs is April 30, 3014. The Maintenance Director will be responsible for overseeing that this deficiency is corrected and testing of the generator under load for 30 minutes in the future and to document the testing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING **02 - CHAPEL** B. WING _____	**03/27/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	**220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917**

(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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Prairie Manor Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	Pack 4-21-14 RECEIVED APR 17 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

Allison Henriud | Acting Administrator | 4/16/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING **02 - CHAPEL** B. WING _____	**03/27/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Prairie Manor Care Center 1991 chapel addition is a 1-story building with no basement. The 1991 chapel addition was determined to be of Type V (111) construction. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 48 at the time of the survey.	K 000		
K 054 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance	K 054	See ATTACHED Plan of CORRECTION	05-10-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING **02 - CHAPEL** B. WING _____	**03/27/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 054	Continued From page 2 with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 2000 NFPA 101, 9.6.1.4 and 1999 NFPA 72, Sections 7-1.1.1. The deficient practice could affect all 48 residents. Findings include: On facility tour between 9:00 AM and 12 noon on 03/27/2014, observation of the Fire Alarm Control Panel (FACP) showed the FACP was in trouble. The trouble was a "Battery Charging Fault". Maintenance Director indicated this has been in trouble for the last 6 months. This deficient practice was confirmed by the facility Maintenance Director (SB) at the time of discovery.	K 054		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by:	K 144	See Attached Plan of Correction	4-30-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING **02 - CHAPEL** B. WING _____	**03/27/2014**

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K 144	Continued From page 3 Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 48 residents. Findings include: On facility tour between 9:00 AM and 12 noon on 03/27/2014, documentation review of the monthly emergency generator testing log (April 2013 to March 2014), revealed that the monthly test have been done, but indicated that the natural gas emergency generator was not being tested under load of 30 percent. There was no other documentation stating that the emergency generator was tested by one of the following means: 1. Loading that maintains the minimum water temperatures as recommended by the manufacturer or 2. under load of 30 percent or more of the nameplate rating of generator or 3. 2 hour load bank test This deficient practice was confirmed by the facility Maintenance Director (SB) at the time of discovery.	K 144		

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K 144	Continued From page 4 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		

PRAIRIE MANOR CARE CENTER

PLANS OF CORRECTION

CHAPEL – BUILDING 02

K 054 A new fire panel has been ordered and will be installed by Trans Alarm Company. The completion date will be May 10, 2014. The Maintenance Director will be responsible for this correction and to monitor the new fire panel in the future to ensure that the trouble "Battery Charging Fault" does not appear.

K 144 The generator will be repaired by Generator Systems Services. They will replace the necessary parts so that the generator can be run under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. and in accordance with the requirements of 2000 NFPA 101 – 9.1.3 and 1999 NFPA 110 6-4.2 (A) & (B) AND 6-4.2.2. Generator System Services will test and run the generator under full load for 30 minutes after the repairs are completed. The completion date for these repairs is April 30, 3014. The Maintenance Director will be responsible for overseeing that this deficiency is corrected and testing of the generator under load for 30 minutes in the future and to document the testing.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4813

April 4, 2014

Mr. James Broich, Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, Minnesota 55917

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5482024

Dear Mr. Broich:

The above facility was surveyed on March 24, 2014 through March 27, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 me.

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00650	A. BUILDING: _____ B. WING _____	03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

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2 000	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 March 24, 25, 26 and 27, 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature."	2 000 04/21/14 GPN	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.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Allison Henrud	Acting Administrator	4/16/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00650	A. BUILDING: _____ B. WING _____	03/27/2014

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2 000	Continued From page 1 Make a copy of these orders for your records and return the original to the address below: Minnesota Department of Health 18 Wood Lake Drive SE, Rochester, MN 55904 c/o Gary Nederhoff, Unit Supervisor 507-206-2731 Office	2 000	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 surveyors findings are the Suggested Method of Correction and 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.	
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 570	Continued From page 2 by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure specific resident centered pain management was included in the comprhensive care plan for 1 of 3 residents (R16) reviewed for unecessary medications. Findings include: R16 lacked revision of the care plan to include individualized interventions for pain. R16 was observed on 3/24/14 through 3/27/14. On 3/24/14 at 3:57 p.m. R16 was observed in bed and not at an activity program with the boy scouts. At 4:55 p.m. R16 was observed being removed from the dining room at his request and again at 7:15 p.m. was lying in bed. On 3/25/14 R16 was observed from 8:54 a.m. to 1:15 p.m. With each observation, R16 was noted to be in bed, TV on, and sleeping. On 3/26/14 at 10:30 a.m. R16 was observed in bed and not at brunch. And again from 1:00 p.m. to 3:30 p.m. R16 was noted to be in bed sleeping. The quarterly Minimum Data Sets (MDS) dated 8/29/13, 11/21/13, and 2/13/14 indicated R16 had no difficulty sleeping, staying a sleep or sleeping too much. The quarterly MDS of 11/21/13 and 2/13/14 indicated R16 had frequent mild pain. Review the physician orders indicated R16 received Trazodone (an antidepressant used for sleep) since 9/25/13 and morphine as needed for pain since 11/25/13.	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 570	Continued From page 3 The care plan with a review date of 2/20/14 indicated a focus/problem of pain related to arthritis. The problem had interventions of administer pain medication and monitor effectiveness, encourage verbalization of pain and monitor for non-verbal signs of discomfort, and pain assessment quarterly and as needed. The care plan did not identify individualized interventions specific for R16 that would help him to manage the pain. The care plan did not identify the use of the as needed medication of Tylenol or morphine or identify when to give which medication. During an interview on 3/26/14 at 10:40 a.m., the director of nursing indicated care plan should include individual specific non-pharmacological interventions for pain. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could ensure nursing staff revise resident care plans when indicated and in a timely manner. Audits could be preformed to ensure staff were in compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		
21330	MN Rule 4658.0725 Subp. 2 A&B Providing Routine & Emergency Oral Health Ser Subp. 2. Annual dental visit. A. Within 90 days after admission, a resident must be referred for an initial dental examination unless the resident has received a dental examination within the six months before admission. B. After the initial dental examination, a nursing home must ask the resident if the	21330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21330	Continued From page 4 resident wants to see a dentist and then provide any necessary help to make the appointment, on at least an annual basis. This opportunity for an annual dental checkup must be provided within one year from the date of the initial dental examination or within one year from the date of the examination done within the six months before admission. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate dental services were provided or offered related to broken and missing teeth for 1 of 1 resident (R57) reviewed for dental services. Findings include: R57 was observed on 3/25/14, at 9:15 a.m. to have multiple upper and lower missing teeth, and both lower front teeth broken off. R57's admission note dated 7/12/13, indicated R57 had her own teeth with some missing, last dental appointment had been more than one year prior to admission. The care plan with a review date of 1/15/14, was reviewed and included diagnosis of depression, cerebrovascular accident (CVA) with right sided hemiparesis and aphasia. The care plan did not identify R57 had any dental issues. R57's admission Minimum Data Set (MDS) dated 7/19/13, did not identify R57 had any dental issues or problems with teeth. The MDS indicated R57 had moderate cognitive impairment and required extensive assistance of staff with	21330		

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21330	Continued From page 5	21330		

personal hygiene. Registered dietitian note dated 10/23/13, identified R57 was independent with eating a regular diet, and had an unplanned weight loss. Care conference progress notes were reviewed between 7/31/13, and 1/9/14. There was no evidence of dental services offered or discussion with R57 or family regarding the need for dental services.

On 3/26/14, at 11:58 a.m. R57 indicated dental services had not been offered however she would go if offered.

On 3/26/14, at 12:25 p.m. the director of nursing (DON) confirmed R57's dental status had not been assessed and stated she would expect missing and broken teeth be identified on the comprehensive admission assessment. DON indicated dental services should have been offered during admission. DON verified R57's record lacked documentation dental services had been offered and stated, "[R57] should have been offered dental services since she has had a weight loss."

A policy was requested however not provided.

Suggested Method of Correction: The director of nursing (DON) or designee could develop/review policies and procedures and provide staff training to ensure residents are receiving necessary dental care and services. The DON or designee could monitor to ensure policies and procedures are being followed.

Time Period for Correction: Twenty-one (21) days.

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21530	Continued From page 6	21530		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality	21530		

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21530	Continued From page 7 assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the consulting pharmacist identified irregularities and reported them to the director of nursing and physician for 1 of 5 residents (R16) reviewed for unnecessary medications. Findings include: R16 was observed on 3/24/14 at 3:57 p.m. in bed and not at an activity program with the boy scouts. At 4:55 p.m. R16 was observed being assisted from the dining room at his request and again at 7:15 p.m. was lying in bed. On 3/25/14 R16 was observed from 8:54 a.m. to 1:15 p.m. With each observation, R16 was noted to be in bed, TV on, and sleeping. On 3/26/14 at 10:30 a.m. R16 was observed in bed and not at brunch. And again from 1:00 p.m. to 3:30 p.m. R16 was noted to be in bed sleeping. The quarterly Minimum Data Sets (MDS) dated 8/29/13, 11/21/13, and 2/13/14 indicated R16 had no difficulty sleeping, staying at sleep or sleeping too much. The quarterly MDS of 11/21/13 and 2/13/14 indicated R16 had frequent mild pain. The quarterly MDS of 8/29/13, 11/21/13, and 2/13/14 indicated R16 displayed no verbal or physical behaviors toward others or self, displayed no refusal of cares, and displayed wandering behaviors. The quarterly MDS dated 2/13/14 indicated R16 had a brief interview of mental status score of 8 or moderate cognitive impairment.	21530		

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21530	Continued From page 8 The registered nurse (RN) Behavior Note of 11/24/13 listed diagnoses of "Alcoholism, depression, history of repeated poor choices with at risk behavior requiring 24-our supervision to maintain sobriety and safety ..." The physician orders signed 3/10/14 also listed additional diagnoses of chronic pain, chronic kidney disease, dementia with behavioral disturbances. R16 lacked parameters for use of as needed Haldol (antipsychotic) and as needed Morphine (pain): On 10/28/13 the physician ordered 1 mg Haldol every 8 hours as needed for severe agitation. The medication administration record indicated the resident received the as needed Haldol 3 times in October, 3 times in November 2013. There was no Haldol given as needed for December 2013, January and February 2014, or the first two weeks of March 2014. The physician's order did not include parameters for use of the as needed Haldol (i.e. what behaviors the medication was to be given for, what non-pharmacological interventions should be used first, or if any other assessment and medication should be attempted.) R16 ' s care plan dated of 2/20/14 had a problem/focus related to behaviors identified. The care plan had an intervention of give medications as prescribed by physician i.e. Haldol, Zoloft, and Seroquel but did not identify parameters for use of the Haldol. During an interview on 3/26/14 at 11:00 a.m. director of nursing (DON) stated guidelines/parameters for the use of the as needed Haldol had not been developed for R16 and should have been.	21530		

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21530	Continued From page 9 On 11/25/13 the physician order increased the Morphine to 2 mg every 4 hours as needed. The medication administration record indicated R16 received morphine 13 times in October, once in November 2013, and once in March 2014. In addition R16 had a physician's order for as needed Tylenol dated 5/31/13 and received the Tylenol once in October 2013. However, neither the Tylenol nor Morphine had parameters as to when the medication is to be used and which one for what pain level/intensity. R16 ' s care plan dated 2/20/14 had a plan that indicated pain related to arthritis but did not identify the use of the as needed medication of Tylenol or Morphine or identify when to give which medication and for what type or intensity of pain. During an interview on 3/26/14 at 9:10 a.m. the case manager-registered nurse (RN)-B stated staff should give the Tylenol first for mild pain and then morphine, but stated the facility had not developed parameters for the use of the Tylenol or Morphine for R16. During an interview on 3/27/14 at 9:10 a.m. the DON indicated the facility had not listed parameters for use of the pain medications on the care plan. R16 had an increase in Trazodone used for sleep however, the effectiveness of the increased medication was not determined. Nor were non-pharmacological interventions attempted prior to the use of the sleeping medication: Physician orders dated 9/25/13 indicated R16 was to receive Trazodone 25 mg for sleep. The orders directed the Trazodone be increased to 50 mg after 1 day and to 100 mg on 10/7/13. The quarterly sedative/hypnotic assessment was reviewed for 12/13/13 and 2/22/14. The assessments noted a sleep tracking and mood	21530		

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monitoring had been completed. The assessment stated R16 was receiving Trazodone for depression and insomnia, but no evaluations of the residents sleep/awake cycle or hours of sleep was found or documented.

R16 ' s care plan dated 2/20/14 indicated a focus/problem of history of insomnia. The interventions had not listed the factors that may facilitate or interfere with normal sleep patterns and did not identify specific interventions (non-pharmacological) to assist the resident to sleep.
During an interview on 3/26/14 at 9:10 a.m., RN-A and RN-B indicated the sleep tracking should be done prior to the physician visit, but the sleep tracking for R16 had not been done. RN-B indicated the sleep tracking would cover the time period from 6 p.m. to 9 a.m. and did not monitor sleep during the day. During an interview on 3/26/14 at 10:20 a.m. the DON stated the Sedative/Hypnotic Assessment was to be completed quarterly and should include non-pharmacological interventions and added that sleep tracking was to be completed. DON stated R16 would go through periods of sleep and then awake for a couple days.
R16 lacked monitoring of Seroquel to determine if it is affective to treat symptoms:
Physician orders for R16 revealed an order dated 10/18/13 that the physician ordered Seroquel 25 mg twice a day.
The quarterly RN Behavior Note of 11/24/13 indicated R16 was currently taking Seroquel. The RN quarterly Behavior Note did not identify the type or frequency of behaviors or if the use of non-pharmacological interventions were effective.
During an interview on 3/26/14 at 9:10 a.m., RN-A, RN-B indicated R16 ' s behaviors were long standing. RN-B stated the documentation

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was generally found in the nursing notes, because the nursing assistants would tell the nurse about the behavior. Regarding the behavior monitoring, RN-B stated had discussed the need for quantitative monitoring, but that the facility was not doing it.
During an interview on 3/26/14 at 10:20 a.m. DON stated the quarterly RN Behavior summary was to include a review of the medications, review of the gradual dose reductions, review of the behaviors and interventions.

The licensed social work (LSW)-A was interviewed on 3/27/14 at 8:45 a.m. LSW-A noted that in October 2014 R16 ' s behaviors could have been related to the change from having a private room to a double room (companion) and also the resident's brother had died in October 2013. LSW-A indicated that she had noticed behaviors would occur each time an attempt was made to provide a roommate in the past.

The consultant pharmacist was interviewed on 3/28/14 at 10:00 a.m. via telephone. She indicated she would expect the facility to monitor sleep and do quantitative behavior monitoring for the Seroquel. The consultant pharmacist stated she had sent a note to nursing on 11/25/13 referencing the need for sleep monitoring. She stated she would expect a nurse assessment be documented for the use of as needed Haldol or Morphine. The consultant pharmacist stated she had reviewed the facility and physician documentation, but was unaware that the behavior monitoring, sleep monitoring, and parameters for use of as needed medication was not completed.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could

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21530	Continued From page 12 develop, review, and/or revise policies and procedures to ensure the consultant pharmacist identifies drug irregularities including appropriate indications for use of psychotropic medications and appropriate monitoring for efficacy and side effects of medications. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director,	21540		

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21540	Continued From page 13 the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement parameters for use of as needed Haldol (antipsychotic medications) and Morphine (pain medication), evaluate and assess for sleep and develop a plan to assist the resident to manage insomnia without an increase in the Trazodone (antidepressant and hypnotic) and failed to monitor the behaviors after the initiate of Seroquel to determine effectiveness of the medication for 1 of 5 residents (R16) reviewed for unnecessary medications. Findings include: R16 was observed on 3/24/14 at 3:57 p.m. in bed and not at an activity program with the boy scouts. At 4:55 p.m. R16 was observed being assisted from the dining room at his request and again at 7:15 p.m. was lying in bed. On 3/25/14 R16 was observed from 8:54 a.m. to 1:15 p.m. With each observation, R16 was noted to be in bed, TV on, and sleeping. On 3/26/14 at 10:30 a.m. R16 was observed in bed and not at brunch. And again from 1:00 p.m. to 3:30 p.m. R16 was noted to be in bed sleeping. The quarterly Minimum Data Sets (MDS) dated 8/29/13, 11/21/13, and 2/13/14 indicated R16 had no difficulty sleeping, staying at sleep or sleeping too much. The quarterly MDS of 11/21/13 and 2/13/14 indicated R16 had frequent mild pain. The quarterly MDS of 8/29/13, 11/21/13, and 2/13/14 indicated R16 displayed no verbal or	21540		

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21540	Continued From page 14 physical behaviors toward others or self, displayed no refusal of cares, and displayed wandering behaviors. The quarterly MDS dated 2/13/14 indicated R16 had a brief interview of mental status score of 8 or moderate cognitive impairment. The registered nurse (RN) Behavior Note of 11/24/13 listed diagnoses of "Alcoholism, depression, history of repeated poor choices with at risk behavior requiring 24-our supervision to maintain sobriety and safety ..." The physician orders signed 3/10/14 also listed additional diagnoses of chronic pain, chronic kidney disease, dementia with behavioral disturbances. R16 lacked parameters for use of as needed Haldol (antipsychotic) and as needed Morphine (pain): On 10/28/13 the physician ordered 1 mg Haldol every 8 hours as needed for severe agitation. The medication administration record indicated the resident received the as needed Haldol 3 times in October, 3 times in November 2013. There was no Haldol given as needed for December 2013, January and February 2014, or the first two weeks of March 2014. The physician's order did not include parameters for use of the as needed Haldol (i.e. what behaviors the medication was to be given for, what non-pharmacological interventions should be used first, or if any other assessment and medication should be attempted.) R16 ' s care plan dated of 2/20/14 had a problem/focus related to behaviors identified. The care plan had an intervention of give medications as prescribed by physician i.e. Haldol, Zoloft, and Seroquel but did not identify parameters for use of the Haldol.	21540		

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21540	Continued From page 15 During an interview on 3/26/14 at 11:00 a.m. director of nursing (DON) stated guidelines/parameters for the use of the as needed Haldol had not been developed for R16 and should have been. On 11/25/13 the physician order increased the Morphine to 2 mg every 4 hours as needed. The medication administration record indicated R16 received morphine 13 times in October, once in November 2013, and once in March 2014. In addition R16 had a physician's order for as needed Tylenol dated 5/31/13 and received the Tylenol once in October 2013. However, neither the Tylenol nor Morphine had parameters as to when the medication is to be used and which one for what pain level/intensity. R16 ' s care plan dated 2/20/14 had a plan that indicated pain related to arthritis but did not identify the use of the as needed medication of Tylenol or Morphine or identify when to give which medication and for what type or intensity of pain. During an interview on 3/26/14 at 9:10 a.m. the case manager-registered nurse (RN)-B stated staff should give the Tylenol first for mild pain and then morphine, but stated the facility had not developed parameters for the use of the Tylenol or Morphine for R16. During an interview on 3/27/14 at 9:10 a.m. the DON indicated the facility had not listed parameters for use of the pain medications on the care plan. R16 had an increase in Trazodone used for sleep however, the effectiveness of the increased medication was not determined. Nor were non-pharmacological interventions attempted prior to the use of the sleeping medication: Physician orders dated 9/25/13 indicated R16	21540		

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21540	Continued From page 16 was to receive Trazodone 25 mg for sleep. The orders directed the Trazodone be increased to 50 mg after 1 day and to 100 mg on 10/7/13. The quarterly sedative/hypnotic assessment was reviewed for 12/13/13 and 2/22/14. The assessments noted a sleep tracking and mood monitoring had been completed. The assessment stated R16 was receiving Trazodone for depression and insomnia, but no evaluations of the residents sleep/awake cycle or hours of sleep was found or documented. R16 ' s care plan dated 2/20/14 indicated a focus/problem of history of insomnia. The interventions had not listed the factors that may facilitate or interfere with normal sleep patterns and did not identify specific interventions (non-pharmacological) to assist the resident to sleep. During an interview on 3/26/14 at 9:10 a.m., RN-A and RN-B indicated the sleep tracking should be done prior to the physician visit, but the sleep tracking for R16 had not been done. RN-B indicated the sleep tracking would cover the time period from 6 p.m. to 9 a.m. and did not monitor sleep during the day. During an interview on 3/26/14 at 10:20 a.m. the DON stated the Sedative/Hypnotic Assessment was to be completed quarterly and should include non-pharmacological interventions and added that sleep tracking was to be completed. DON stated R16 would go through periods of sleep and then awake for a couple days. R16 lacked monitoring of Seroquel to determine if it is affective to treat symptoms: Physician orders for R16 revealed an order dated 10/18/13 that the physician ordered Seroquel 25 mg twice a day. The quarterly RN Behavior Note of 11/24/13	21540		

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(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) COMPLETE DATE
21540	Continued From page 17 indicated R16 was currently taking Seroquel. The RN quarterly Behavior Note did not identify the type or frequency of behaviors or if the use of non-pharmacological interventions were effective. During an interview on 3/26/14 at 9:10 a.m., RN-A, RN-B indicated R16 ' s behaviors were long standing. RN-B stated the documentation was generally found in the nursing notes, because the nursing assistants would tell the nurse about the behavior. Regarding the behavior monitoring, RN-B stated had discussed the need for quantitative monitoring, but that the facility was not doing it. During an interview on 3/26/14 at 10:20 a.m. DON stated the quarterly RN Behavior summary was to include a review of the medications, review of the gradual dose reductions, review of the behaviors and interventions. The licensed social work (LSW)-A was interviewed on 3/27/14 at 8:45 a.m. LSW-A noted that in October 2014 R16 ' s behaviors could have been related to the change from having a private room to a double room (companion) and also the resident's brother had died in October 2013. LSW-A indicated that she had noticed behaviors would occur each time an attempt was made to provide a roommate in the past. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure that policies and procedures are updated and that staff training has been completed to assure each resident's drug regimen is monitored and that residents are not taking unnecessary drugs. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00650	A. BUILDING: _____ B. WING _____	03/27/2014

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