### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

					AND TRANSMITTAL FE SURVEY AGENCY	ID: 19VM Facility ID: 00650
1. MEDICARE/MEDICAID PROVID (L1) 245482 2.STATE VENDOR OR MEDICAID (L2) 122343700	(L3) <b>PRAIRIE M</b> (L4) <b>220 THIRD</b>	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	
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 05/1  8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	<b>2/2014</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds  14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 52 (L37) (L38)  16. STATE SURVEY AGENCY REM See Attached Remarks	52 (L18) 52 (L17)  DWN  19 SNF  (L39)	Complianc1. A B. Not in Con Requirem  ICF  (L42)	nce With equirements e Based On: cceptable POC apliance with Progents and/or Appli  IID  (L43)	gram ed Waivers:	2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural S) 5. Life Safety Code	7. Medical Director
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL Date:
Gary Nederhoff, Unit Su	pervisor	0	06/03/2014	(L19)	Kamala Fiske-Downing	, Enforcement Specialist <sub>06/20/2014</sub> (L20
PA	RT II - TO BE (	COMPLETED I	BY HCFA RE	EGIONAL	L OFFICE OR SINGLE S	STATE AGENCY
19. DETERMINATION OF ELIGIBLE  _X	Participate		IPLIANCE WITH	H CIVIL		uncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e:
22. ORIGINAL DATE OF PARTICIPATION 05/01/1987	23. LTC AGREEN BEGINNING		4. LTC AGREEN ENDING DA		26. TERMINATION ACTION  VOLUNTARY  01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	TC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS  A. Suspension of Admissions: (L44)			02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active		
28. TERMINATION DATE:	29	. INTERMEDIARY/	(L45) (CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	(L32)	. DETERMINATION <b>05/07/2014</b>	I OF APPROVAL	L DATE (L33)	DETERMINATION APP	ROVAL

DETERMINATION APPROVAL

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00650

C&T REMARKS - CMS 1539 FORM

CCN-24-5482

STATE AGENCY REMARKS



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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

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

cc: Licensing and Certification File



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, Program Specialist

Licensing and Certification Program

Kumalu Fishe Downing

Division of Compliance Monitoring

Minnesota Department of Health

Prairie Manor Care Center June 3, 2014 Page 2

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

Enclosure

cc: Licensing and Certification File

## 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 245482	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/12/2014
Name of Facility		Street Address, City, State, Zip Code	
PRAIRIE MANOR CARE CENTER		220 THIRD STREET NORTHWI	

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
		C	Correction				Correction					Correction
ID Prefix	F0280		Completed 14/25/2014	ID Prefix	F0329		Completed <b>04/25/2014</b>		ID Prefix	F0412		Completed <b>04/25/2014</b>
	483.20(d)(3), 483.10				483.25(I)		- 0 1/20/20 1 1			483.55(b)		
	403.20(u)(3), 403.10				403.23(1)					403.33(b)		<u> </u>
			Correction				Correction					Correction
ID Prefix	F0428		Completed 4/25/2014	ID Prefix			Completed		ID Prefix			Completed
Reg. #	483.60(c)			Reg. #			-		Reg. #			_
LSC				LSC			-		LSC			_ 
		_	Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			,	ID Prefix					ID Prefix			_
Reg. #				Reg. #			-		Reg. #			
LSC				LSC					LSC			=
		C	Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix				ID Prefix			-					<u>—</u>
Reg. # LSC				Reg. # LSC			-		Reg. #			_
												_
		C	Correction				Correction					Correction
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Reg. #				Reg. #			=		Reg. #			_
							-		LSC	·		<del>_</del> _
Reviewed I	By Revie	wed E	Зу	Date:	Signature	of Su	veyor:				Date:	
State Agen	cy GN	N/KFI	D	06/03/201	14			1016	50		0	05/12/2014
Reviewed I	By Revie	wed E	Зу	Date:	Signature	of Su	veyor:				Date:	
CMS RO												
Followup t	to Survey Complete				Check for any					Summary of the Facility?		
	3/27/2014			1	Onconecte	a Delik	VIO) COIDIO	25	o. , oeni lo	and racinty:	YES	NO

## Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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(Y1) Provider / Supplier / CLIA / Identification Number 245482	(Y2) Multiple Con A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 5/29/2014	
Name of Facility		Street Address, City, State, Zip Code		
PRAIRIE MANOR CARE CENTER		220 THIRD STREET NORTHWI BLOOMING PRAIRIE, MN 5591		

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		Correction Completed 04/30/2014	ID Prefix		(	Correction Completed 05/10/2014		ID Prefix			Correction Completed 04/30/2014
Reg. #	NFPA 101		Reg. #	NFPA 101				Reg. #	NFPA 101		
LSC	K0038		LSC	K0054				LSC	K0144		_
		Correction			C	Correction					Correction
		Completed	15.5 (		(	Completed					Completed
	-										
Reg. # LSC			Reg. # LSC					Reg. # LSC			
		Correction			(	Correction					Correction
		Completed				Completed					Completed
ID Prefix	-		ID Prefix					ID Prefix			_
Reg. #			Reg. #	-				Reg. #			
			LSC				<u> </u>	LSC			<u> </u>
		Correction			C	Correction					Correction
ID Prefix		Completed	ID Profix		(	Completed		ID Profix			Completed
Reg. # LSC			Reg. # LSC					Reg. # LSC			<u> </u>
		Correction			(	Correction					Correction
		Completed				Completed					Completed
	-										
Reg. # LSC			Reg. # LSC					Reg. # LSC			
Reviewed I	Зу Re	viewed By	Date:	Signature	of Surv	eyor:				Date:	
State Agen	су	GN/kfd	06/03/20	014		10	160				05/29/2014
Reviewed I	Ву Re	viewed By	Date:	Signature	of Surv	eyor:				Date:	
CMS RO											
Followup t	o Survey Compl			Check for any							
	3/27/20	14		uncorrecte	eu petici	encies (CIV	J-256	or) sent to	the Facility?	YES	NO

Form CMS - 2567B (9-92) Page 1 of 1 Event ID: 19VM22

## 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 245482	(Y2) Multiple Cons A. Building B. Wing	(Y3) Date of Revisit 5/29/2014	
Name of Facility		Street Address, City, State, Zip Code	
PRAIRIE MANOR CARE CENTER		220 THIRD STREET NORTHWE BLOOMING PRAIRIE, MN 5591	

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		Correction Completed 05/10/2014	ID Prefix		Correction Completed 04/30/2014	ID Prefix	Correction Completed
Reg. #	NFPA 101			NFPA 101		Reg. #	
LSC	K0054		LSC	K0144		LSC	
		Correction			Correction		Correction
		Completed	15.5 (		Completed	15.5 %	Completed
Reg. # LSC			Reg. # LSC			Reg. #	
		Correction			Correction		Correction
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		Correction			Correction		Correction
		Completed			Completed		Completed
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Reg. # LSC			Reg. # LSC			Reg. # LSC	
Reviewed I	By Re	eviewed By	Date:	Signature	of Surveyor:		Date:
State Agen	су	GN/kfd	06/03/20	014	10	160	05/29/2014
Reviewed I	Ву Re	eviewed By	Date:		of Surveyor:		Date:
CMS RO							
Followup t	o Survey Comp				Uncorrected Defi		
	3/27/20	)14		Uncorrected	Deficiencies (CN	15-256/) Sent to	the Facility? YES NO

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

ID: 19VM

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00650 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (L8) (L3) PRAIRIE MANOR CARE CENTER (L1)245482 1. Initial 2. Recertification (L4) 220 THIRD STREET NORTHWEST 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) **55917** 122343700 (L2)(L5) BLOOMING PRAIRIE, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 8. Full Survey After Complaint (L9) 05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 03/27/2014 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC (L10) 12 RHC 16 HOSPICE 09/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN \_\_\_7. Medical Director 12. Total Facility Beds \_1. Acceptable POC 4. 7-Day RN (Rural SNF) 8. Patient Room Size (L18)56 5. Life Safety Code \_\_\_ 9. Beds/Room X B. Not in Compliance with Program (L17) 13. Total Certified Beds 56 Requirements and/or Applied Waivers: **R**\* (L12)\* Code: 15. FACILITY MEETS 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)56 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): See Attached Remarks 17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date: 04/21/2014 Gail Sorensen, HFE NE II Kamala Fiske-Downing, Enforcement Specialist 05/02/2014 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 21. 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) Facility is Eligible to Participate 3. Both of the Above: 2. Facility is not Eligible (L21) 22. ORIGINAL DATE 23 LTC AGREEMENT 24 LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE **VOLUNTARY** INVOLUNTARY 05/01/1987 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (1.24)(L25) 03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS OTHER 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (1.44)(1.27)B. Rescind Suspension Date: (1.45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (L31)32. DETERMINATION OF APPROVAL DATE 31. RO RECEIPT OF CMS-1539

(L33)

DETERMINATION APPROVAL

(L32)

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00650

**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.



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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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, Program Specialist

Licensing and Certification Program, Division of Compliance Monitoring

Minnesota Department of Health

Kumalu Fiske Downing

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

Enclosure

cc: Licensing and Certification File

PRINTED: 04/04/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION APR 18 2014	(X3) DATE SURVEY COMPLETED	
		245482	B. WING	MN Dept of Health Rochester	03/27/2014	
NAME OF PROVIDER OR SUPPLIER  PRAIRIE MANOR CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  220 THIRD STREET NORTHWEST  BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLETION	
F 000	INITIAL COMMEN	TS	FC	000	1.1 · · · · · · · · · · · · · · · · · ·	
F 280 SS=D	as your allegation of Department's acceleration of the first ple used as verificated. Upon receipt of an revisit of your facility validate that substant regulations has be your verification.	of correction (POC) will serve of compliance upon the eptance. Your signature at the page of the CMS-2567 form will tion of compliance.  acceptable POC an on-site ty may be conducted to ential compliance with the en attained in accordance with 10(k)(2) RIGHT TO ANNING CARE-REVISE CP	F 2	280 See ATTACHED PLAN O	F 4-25-14	
99=D	The resident has the incompetent or oth incapacitated under	ne right, unless adjudged erwise found to be er the laws of the State, to ning care and treatment or		See ATTACHED PLAN OF CORRECTION		
	within 7 days after comprehensive as interdisciplinary tea physician, a register for the resident, ar disciplines as dete and, to the extent the resident, the relegal representative and revised by a teach assessment.		04/21 61PN			
	This REQUIREME	NT is not met as evidenced			0/0 - 1	
LABORATOR	V DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE	

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.

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPI ING	LE CONSTRUC <b>APR 1 8 2014</b> MN Dept of Health Rochester		TE SURVEY MPLETED
		245482	B. WING			03	/27/2014
	PROVIDER OR SUPPLIER  MANOR CARE CENT	'ER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
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F 280	by: Based on observat review, the facility fa resident centered p in the comprhensive residents (R16) revi medications.  Findings include: R16 lacked revision	ion, interview and document ailed to ensure specific ain management was included a care plan for 1 of 3 iewed for unecessary	F 2	80			
	On 3/24/14 at 3:57 and not at an activit scouts. At 4:55 p.m removed from the dagain at 7:15 p.m. wR16 was observed With each observatibed, TV on, and slea.m. R16 was observed a.m. R16 was observed.	on 3/24/14 through 3/27/14. p.m. R16 was observed in bed y program with the boy n. R16 was observed being ining room at his request and was lying in bed. On 3/25/14 from 8:54 a.m. to 1:15 p.m. ion, R16 was noted to be in eping. On 3/26/14 at 10:30 rved in bed and not at brunch. 0 p.m. to 3:30 p.m. R16 was					
	8/29/13, 11/21/13, a no difficulty sleeping too much. The qual 2/13/14 indicated R Review the physicia received Trazodone sleep) since 9/25/13 pain since 11/25/13.						
	indicated a focus/pro	review date of 2/20/14 oblem of pain related to m had interventions of					

MN Dept of Health Rochester

- 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 24<sup>th</sup> 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 25<sup>th</sup>, 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 Cllvm Hennuden Don

Updated: April 9, 2014 Department: Nursing

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G APR 18 2014		(X3) DATE SURVEY COMPLETED	
		245482	B. WING _	MN Dept of Health	03/	27/2014	
NAME OF PROVIDER OR SUPPLIER  PRAIRIE MANOR CARE CENTER				STREET ADDRESS, CITY, STARE, PARCODE  220 THIRD STREET NORTHWEST  BLOOMING PRAIRIE, MN 55917			
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F 280	administer pain me effectiveness, enco and monitor for nor and pain assessme The care plan did n interventions specif to manage the pain identify the use of the Tylenol or morphine medication.  During an interview director of nursing i include individual spinterventions for pa	dication and monitor urage verbalization of pain averbal signs of discomfort, ant quarterly and as needed. ot identify individualized ic for R16 that would help him The care plan did not ne as needed medication of or identify when to give which on 3/26/14 at 10:40 a.m., the indicated care plan should becific non-pharmacological	F 28				
SS=D	unnecessary drugs. drug when used in a duplicate therapy); o without adequate m indications for its us adverse consequen should be reduced o combinations of the  Based on a compre resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and d record; and residen drugs receive gradu behavioral intervent	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or onitoring; or without adequate se; or in the presence of ces which indicate the dose or discontinued; or any		See ATTACHED PLAN OF CORRECTION		4-25-14	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			E SURVEY
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F 329	Continued From padrugs.	age 3	F;	329			
	by: Based on observareview, the facility fimplement parame Haldol (antipsychot (pain medication), and develop a plan	NT is not met as evidenced tion, interview and document ailed to develop and ters for use of as needed ic medications) and Morphine evaluate and assess for sleep to assist the resident to					
	Trazodone (antidep failed to monitor the Seroquel to determ medication for 1 of unnecessary medic	without an increase in the pressant and hypnotic) and the behaviors after the initiate of the ine effectiveness of the 5 residents (R16) reviewed for eations.					- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
	and not at an activity scouts. At 4:55 p.m assisted from the dagain at 7:15 p.m. or R16 was observed With each observed bed, TV on, and slea.m. R16 was obse	on 3/24/14 at 3:57 p.m. in bed by program with the boy h. R16 was observed being ining room at his request and was lying in bed. On 3/25/14 from 8:54 a.m. to 1:15 p.m. being. On 3/26/14 at 10:30 rved in bed and not at brunch. O p.m. to 3:30 p.m. R16 was sleeping.					
	8/29/13, 11/21/13, a no difficulty sleeping	num Data Sets (MDS) dated and 2/13/14 indicated R16 had g, staying at sleep or sleeping rterly MDS of 11/21/13 and					

- 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 24<sup>th</sup> 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 25<sup>th</sup>, 2014.

## **Guidelines for Administration of PRN Antipsychotic Medication**

Resident Name	Date
Medication Order	
May be administered after meetin	
Guidelines:	
<ul> <li>Personal Needs have been a food, position change, etc.</li> <li>Unable to Redirect or Calm one-on-one, quiet environment</li> </ul>	treated or ruled out as a contributing factor. ssessed: Offer/Assist with toileting, hydration, resident with music, back rub, conversation, ent, or other diversional activitiesminutes after attempts to redirect resident.
Target Behaviors for this resident a	re defined as:
Prolonged yelling/swearing	ng at staff and/or other residents
Physical abuse toward sta	iff and/or other residents i.e., hitting, kicking,
Verbalization of anxiety/d	listress with observable physical symptoms
Resisting cares that are ne	ecessary to meet basic needs

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 precare 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 Henspud PN DON

Revised: 3/28/14 Department: Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		ONSTRUCTION APR 1 8 2014	(X3) DATE SURVE COMPLETED		
		245482	B. WING		MN Dept of Health Rochester	03	3/27/2014	
	PROVIDER OR SUPPLIER  MANOR CARE CEN		STREET ADDRESS, CITY, STATE, ZIP CODE  220 THIRD STREET NORTHWEST  BLOOMING PRAIRIE, MN 55917					
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F 329	2/13/14 indicated F The quarterly MDS 2/13/14 indicated F physical behaviors displayed no refusa wandering behavio 2/13/14 indicated F mental status score impairment.  The registered nure 11/24/13 listed diag depression, history at risk behavior rec maintain sobriety a orders signed 3/10 diagnoses of chron	age 4 R16 had frequent mild pain. For 8/29/13, 11/21/13, and R16 displayed no verbal or toward others or self, Fal of cares, and displayed From The quarterly MDS dated R16 had a brief interview of For of 8 or moderate cognitive  See (RN) Behavior Note of Groses of "Alcoholism, For epeated poor choices with Full ring 24-our supervision to Find safety" The physician Find 14 also listed additional Find pain, chronic kidney Find Service of R16 had a disturbances.	F3	329				
	Haldol (antipsychologiain): On 10/28/13 the prevery 8 hours as not the resident receive times in October, 3 There was no Hald December 2013, Jathe first two weeks physician's order diuse of the as neede the medication was non-pharmacologic used first, or if any medication should let R16's care plan date.	eters for use of as needed ic) and as needed Morphine a sysician ordered 1 mg Haldol eeded for severe agitation. In ministration record indicated ed the as needed Haldol 3 times in November 2013. For anuary and February 2014, or of March 2014. The d not include parameters for ed Haldol (i.e. what behaviors to be given for, what al interventions should be other assessment and be attempted.)  Setted of 2/20/14 had a led to behaviors identified.					10A	

		IDENTIFICATION NUMBER:	A. BUILD		COMPLETED			
		245482	B. WING		MN Dept of Health	03	/27/2014	
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F 329	The care plan had medications as pre Haldol, Zoloft, and parameters for use During an interview director of nursing guidelines/parameters needed Haldol had and should have be On 11/25/13 the ph Morphine to 2 mg emedication administration administration addition R16 had a needed Tylenol data Tylenol once in October 19 the Tylenol nor Mowhen the medication data for what pain level/	an intervention of give escribed by physician i.e. Seroquel but did not identify of the Haldol.  You on 3/26/14 at 11:00 a.m. (DON) stated ters for the use of the as not been developed for R16 een.  Pysician order increased the every 4 hours as needed. The stration record indicated R16 13 times in October, once in and once in March 2014. In physician's order for as eed 5/31/13 and received the tober 2013. However, neither rephine had parameters as to on is to be used and which one	F3	29	DEFICIENCY)			
	identify the use of t Tylenol or Morphine medication and for During an interview case manager-regi staff should give th then morphine, but developed parame or Morphine for R1 3/27/14 at 9:10 a.m had not listed paramedications on the	he as needed medication of e or identify when to give which what type or intensity of pain. on 3/26/14 at 9:10 a.m. the stered nurse (RN)-B stated e Tylenol first for mild pain and stated the facility had not ters for the use of the Tylenol 6. During an interview on the DON indicated the facility meters for use of the pain						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	APR 18 2014	COMPLETED			
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F 329	however, the effect medication was not non-pharmacologic prior to the use of the Physician orders downs to receive Trazorders directed the mg after 1 day and The quarterly sedar reviewed for 12/13/20 assessments noted monitoring had been assessment stated for depression and of the residents slessleep was found or R16 's care plan downstead for depression and of the residents slessleep was found or R16 's care plan downstead for depression and of the residents slessleep was found or R16 's care plan downstead for did not identify (non-pharmacologisteep. During an interview and RN-B indicated the physical for R16 has indicated the sleep period from 6 p.m. sleep during the da 3/26/14 at 10:20 a. Sedative/Hypnotic /completed quarterly	iveness of the increased to determined. Nor were sal interventions attempted the sleeping medication: ated 9/25/13 indicated R16 todone 25 mg for sleep. The Trazodone be increased to 50 to 100 mg on 10/7/13.  Itive/hypnotic assessment was 13 and 2/22/14. The dia sleep tracking and mood on completed. The R16 was receiving Trazodone insomnia, but no evaluations ep/awake cycle or hours of	F3	329				
		was to be completed. DON to through periods of sleep and buple days.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245482		(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED		
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F 329	R16 lacked monitor it is affective to trea Physician orders fo 10/18/13 that the pl mg twice a day. The quarterly RN B indicated R16 was RN quarterly Behav type or frequency o non-pharmacologic During an interview RN-A, RN-B indicat long standing. RN-was generally found because the nursing nurse about the bel monitoring, RN-B st	ring of Seroquel to determine if	F 32	29		1 1.41 1 1.42 1 1.42 1 1.43 1
F 412 SS=D	DON stated the quawas to include a reversity of the graduate the behaviors and in the behaviors and interviewed on 3/27 that in October 2014 have been related the private room to a dealso the resident's the 2013. LSW-A indicate behaviors would occurate to provide a resident of the provide a resident of the provide a resident occurate the provide and the provide a resident of the provide and the provide a resident of the provide and the provide a resident of the provide and th		F 41	2 See ATTACHED PLAN OF CORRECTION		4-25-14

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245482		A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  PRAIRIE MANOR CARE CENTER				2	TREET ADDRESS, CITY, STATE, ZIE DE 120 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MINS 195917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 412	The nursing facility an outside resource §483.75(h) of this p covered under the S dental services to m resident; must, if ne making appointmen transportation to an must promptly refer damaged dentures.  This REQUIREMEN by:	must provide or obtain from e, in accordance with art, routine (to the extent State plan); and emergency neet the needs of each ecessary, assist the resident in its; and by arranging for d from the dentist's office; and residents with lost or	F4	12			
	review, the facility fadental services were to broken and missi (R57) reviewed for continuous include:  R57 was observed of	ailed to ensure appropriate eprovided or offered related ng teeth for 1 of 1 resident dental services.  on 3/25/14, at 9:15 a.m. to and lower missing teeth, and		Translation of the state of the			
	R57 had her own teddental appointment prior to admission. Tdate of 1/15/14, was diagnosis of depress accident (CVA) with aphasia. The care pany dental issues.  R57's admission Mir	te dated 7/12/13, indicated eth with some missing, last had been more than one year he care plan with a review reviewed and included sion, cerebrovascular right sided hemiparesis and lan did not identify R57 had					
		tify R57 had any dental with teeth. The MDS indicated					

- 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 24<sup>th</sup> 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 25<sup>th</sup> 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<sup>®</sup>

- 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 (Illian Henry RN DOW)

Updated: March 26, 2014

Department: Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	riple construction apr 1 8 2014	(X3) DATE SURVEY COMPLETED					
		245482	B. WING _	MN Dept of Health Rochester	03/27/2014				
NAME OF PROVIDER OR SUPPLIER  PRAIRIE MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  220 THIRD STREET NORTHWEST  BLOOMING PRAIRIE, MN 55917						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION				
F 412	R57 had moderate required extensive personal hygiene. 10/23/13, identified eating a regular disweight loss. Care were reviewed bet There was no evid or discussion with need for dental se	e cognitive impairment and assistance of staff with Registered dietitian note dated R57 was independent with et, and had an unplanned conference progress notes ween 7/31/13, and 1/9/14. Hence of dental services offered R57 or family regarding the	F 4	12					
- 4 <u>1,178.</u>	(DON) confirmed been assessed an missing and broke comprehensive ac indicated dental se offered during admirecord lacked doc been offered and second	25 p.m. the director of nursing R57's dental status had not a stated she would expect in teeth be identified on the amission assessment. DON ervices should have been mission. DON verified R57's umentation dental services had stated, "[R57] should have been vices since she has had a							
F 428 SS=D	483.60(c) DRUG I IRREGULAR, AC	ested however not provided. REGIMEN REVIEW, REPORT T ON  of each resident must be once a month by a licensed	F 4	28 See ATTACHED PLAN OF CORRECTION	4-25-14				
	the attending phys	nust report any irregularities to sician, and the director of e reports must be acted upon.							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONST ING		IPR 1 8 2014		(X3) DATE SURVEY COMPLETED	
		245482	B. WING			MN Dept of Health	03	3/27/2014	
NAME OF PROVIDER OR SUPPLIER  PRAIRIE MANOR CARE CENTER				220 THIRD	STREET ADDRESS, CITY, STATE, ZIP CODE  220 THIRD STREET NORTHWEST  BLOOMING PRAIRIE, MN 55917			1) 11 (1) 12 (1) 12 (1) 14	
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F 428	Continued From pa	nge 10	F 4	28					
	by: Based on interview facility failed to ens identified irregularit director of nursing a	NT is not met as evidenced and document review the ure the consulting pharmacist ies and reported them to the and physician for 1 of 5 iewed for unnecessary							
	and not at an activity scouts. At 4:55 p.n assisted from the dagain at 7:15 p.m. NR16 was observed With each observed bed, TV on, and slea.m. R16 was obse	on 3/24/14 at 3:57 p.m. in bed ty program with the boy n. R16 was observed being ining room at his request and was lying in bed. On 3/25/14 from 8:54 a.m. to 1:15 p.m. tion, R16 was noted to be in reping. On 3/26/14 at 10:30 rved in bed and not at brunch. 0 p.m. to 3:30 p.m. R16 was sleeping.							
	8/29/13, 11/21/13, a no difficulty sleeping too much. The qua 2/13/14 indicated R The quarterly MDS 2/13/14 indicated R physical behaviors displayed no refusa wandering behavior	num Data Sets (MDS) dated and 2/13/14 indicated R16 had g, staying at sleep or sleeping arterly MDS of 11/21/13 and 16 had frequent mild pain. of 8/29/13, 11/21/13, and 16 displayed no verbal or toward others or self, all of cares, and displayed rs. The quarterly MDS dated 16 had a brief interview of							

- 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.
- Consulting Pharmacist and DON reviewed and revised the Pharmacy, Medication Irregularities Policy. All licensed nursing staff will be reeducated on Policy by April 24<sup>th</sup> 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 25<sup>th</sup>, 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:

- 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 allein Henruel RNDON

Department: Nursing

Updated: 4/10/14

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIPL ING .	APR 18 2014		TE SURVEY MPLETED
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F 428	mental status score impairment.	of 8 or moderate cognitive	F∠	128			
	11/24/13 listed diag depression, history at risk behavior requalitation and a signed 3/10/diagnoses of chronical diagnoses of chronical d	se (RN) Behavior Note of noses of "Alcoholism, of repeated poor choices with uiring 24-our supervision to not safety" The physician 14 also listed additional c pain, chronic kidney with behavioral disturbances.					
	Haldol (antipsychoti (pain): On 10/28/13 the phyevery 8 hours as ne The medication adn the resident receive times in October, 3. There was no Haldo December 2013, Ja the first two weeks ophysician's order did use of the as neede the medication was non-pharmacological.	ters for use of as needed c) and as needed Morphine visician ordered 1 mg Haldol eded for severe agitation. Ininistration record indicated d the as needed Haldol 3 times in November 2013. Digiven as needed for nuary and February 2014, or of March 2014. The d not include parameters for d Haldol (i.e. what behaviors to be given for, what all interventions should be other assessment and the attempted.)					
	The care plan had a medications as pres	ed to behaviors identified. n intervention of give cribed by physician i.e. Seroquel but did not identify					
	During an interview director of pursing (	on 3/26/14 at 11:00 a.m.					4.5 m

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER  MANOR CARE CENT	ER		STREET ADDRESS, CITY DEPT OF HERE  220 THIRD STREET NOTATION STATE  BLOOMING PRAIRIE, MN 55917		
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F 428	Continued From pa	ge 12	F 42	28		
		ers for the use of the as not been developed for R16 een.				<b>w</b>
	Morphine to 2 mg e medication adminis received morphine November 2013, ar addition R16 had a needed Tylenol date Tylenol once in Oct the Tylenol nor Mor	ysician order increased the every 4 hours as needed. The stration record indicated R16 13 times in October, once in and once in March 2014. In physician's order for as ed 5/31/13 and received the ober 2013. However, neither phine had parameters as to in is to be used and which one intensity.				100 mm m
	indicated pain relative identify the use of the Tylenol or Morphine medication and for During an interview case manager-regist staff should give the then morphine, but developed paramet or Morphine for R16 3/27/14 at 9:10 a.m.	ed 2/20/14 had a plan that ed to arthritis but did not he as needed medication of e or identify when to give which what type or intensity of pain. on 3/26/14 at 9:10 a.m. the stered nurse (RN)-B stated e Tylenol first for mild pain and stated the facility had not ers for the use of the Tylenol 6. During an interview on the DON indicated the facility neters for use of the pain care plan.				
9.1% 	however, the effecti medication was not non-pharmacologic prior to the use of th Physician orders da was to receive Traz	e in Trazodone used for sleep veness of the increased determined. Nor were al interventions attempted ne sleeping medication: tted 9/25/13 indicated R16 odone 25 mg for sleep. The Trazodone be increased to 50				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E APHETRUSTI <b>2014</b>		E SURVEY IPLETED
		245482	B. WING	·	MN Dept of Health Rochester	03/	27/2014
	ROVIDER OR SUPPLIER	TER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
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F 428	The quarterly seda reviewed for 12/13/ assessments noted monitoring had been assessment stated for depression and of the residents sle sleep was found or	to 100 mg on 10/7/13.  tive/hypnotic assessment was 13 and 2/22/14. The d a sleep tracking and mood en completed. The R16 was receiving Trazodone insomnia, but no evaluations ep/awake cycle or hours of	F	428			0-76 6 (2014) 1-72 (2014) 1-72 (2015) 1-73 (2015) 1-74 (2015)
	focus/problem of hinterventions had not interfer and did not identify (non-pharmacologisleep. During an interview and RN-B indicated done prior to the pharmacking for R16 has indicated the sleep period from 6 p.m. sleep during the da 3/26/14 at 10:20 a. Sedative/Hypnotic.	istory of insomnia. The ot listed the factors that may e with normal sleep patterns specific interventions cal) to assist the resident to on 3/26/14 at 9:10 a.m., RN-Ad the sleep tracking should be hysician visit, but the sleep and not been done. RN-B tracking would cover the time to 9 a.m. and did not monitor by. During an interview on m. the DON stated the Assessment was to be y and should include					
era Avri er Nation	non-pharmacologic that sleep tracking stated R16 would gethen awake for a confidence R16 lacked monitorit is affective to treat Physician orders for	cal interventions and added was to be completed. DON go through periods of sleep and ouple days. ring of Seroquel to determine if					10 (10 (10 (10 (10 (10 (10 (10 (10 (10 (
	The quarterly RN E	Behavior Note of 11/24/13 currently taking Seroquel. The					

STATEMENT	TO FOR MEDICARE  OF DEFICIENCIES  OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
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F 428	RN quarterly Behar type or frequency of non-pharmacologic During an interview RN-A, RN-B indical long standing. RN was generally foun because the nursin nurse about the bemonitoring, RN-B is for quantitative mowas not doing it. During an interview DON stated the quitous was to include a rereview of the graduathe behaviors and The licensed social interviewed on 3/20 that in October 2010 been related to the room to a double reresident's brother hust a double resident's brother hust a double resident's brother hust a double resident's brother hust a double reresident's brother hust a double reresident's brother hust a double resident's brother hust a double resident hust a d	vior Note did not identify the of behaviors or if the use of cal interventions were effective. To no 3/26/14 at 9:10 a.m., ted R16 's behaviors were -B stated the documentation d in the nursing notes, ag assistants would tell the havior. Regarding the behavior tated had discussed the need nitoring, but that the facility on 3/26/14 at 10:20 a.m. arterly RN Behavior summary view of the medications, all dose reductions, review of interventions.  I work (LSW)-A was 7/14 at 8:45 a.m. LSW-A noted 4 R16's behaviors could have change from having a private from (companion) and also the final died in October 2013. The state of the		428			100 (100 (100 (100 (100 (100 (100 (100
The second secon	indicated she would sleep and do quanthe Seroquel. The she had sent a not referencing the new stated she would edocumented for the Morphine. The contract of the sleep state of the sleep sl	d expect the facility to monitor consultant pharmacist stated to nursing on 11/25/13 and for sleep monitoring. She expect a nurse assessment be to use of as needed Haldol or insultant pharmacist stated she acility and physician					10 SE

STATEMENT AND PLAN (	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G APR 1 8 2014	(X3) DA	TE SURVEY .
		245482	B. WING	MN Dept of Health	02	3/27/2014 : .
	PROVIDER OR SUPPLIER  MANOR CARE CENT			STREET ADDRESS, CITY, STATE, ZIP CODE  220 THIRD STREET NORTHWEST  BLOOMING PRAIRIE, MN 55917		<u>"Z112014"</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	documentation, but behavior monitoring	age 15 t was unaware that the g, sleep monitoring, and e of as needed medication was	F 428	3		
						100 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
#27 - <u>11</u> - 17 - 17 - 17 - 17 - 17 - 17 - 17 - 17						
						10 (2.4 / 1.5 /

PRINTED: 04/04/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 245482 03/27/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST PRAIRIE MANOR CARE CENTER **BLOOMING PRAIRIE, MN 55917** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) INITIAL COMMENTS K 000 K 000 POCK 4-21-14 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** APR 1 7 2014 ( K-TAGS) TO: MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE dmINISTRATOR

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.

CTING

	ROVIDER OR SUPPLIER	245482	1		1 (X3) DATE COM				
	ROVIDER OR SUPPLIER	240402	B. WING _		03/	27/2014			
	PRAIRIE MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917					
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	Continued From pa St Paul, MN 55101 By email to: Marian	T	K 00	0		7			
		RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION:				Φ <sub>10</sub>			
	A description of value to correct the deficition	what has been, or will be, done ency.							
	2. The actual, or pr	oposed, completion date.							
1		r title of the person rection and monitoring to ence of the deficiency.				į.			
	buildings. Prairie M building. The origir 1970 and was dete construction, with a	surveyed as two separate anor Care Center is a 1-story hal building was constructed in rmined to be of Type II(111) a partial basement. In 1984, ructed and was determined to onstruction.		·		2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			
	alarm system with t and spaces open to	sprinkled. The facility has a fire full corridor smoke detection the corridors that is matic fire department							
		apacity of 56 beds and had a time of the survey.							
	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	K 03	8 See ATTAChes, PLAN of Correction		4-30-14			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245482	B. WING		03/27/2014		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917	ZIP CODE EST		
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K 038 SS=D		age 2 nged so that exits are readily nes in accordance with section	K 038	3			
\$ \$	Based on observa provide means of e following requirement Section 19.2., 7.1.6	is not met as evidenced by: tion, the facility failed to egress in accordance with the ents of 2000 NFPA 101, 6.2 and 7.2.1.4.5. The deficient ct all 13 out 48 residents.				3 1 5 3 3	
	03/27/2014, observing exit discharge more than 1/2 inch panels (2 inches)	veen 9:00 AM and 12 noon on vation revealed, that the Left has a change in elevation of between concrete sidewalk paths to public way for this					
K 054 SS=F	This deficient pract facility Maintenance discovery. NFPA 101 LIFE SA All required smoke activating door hold maintained, inspect	ice was confirmed by the e Director (SB) at the time of FETY CODE STANDARD detectors, including those d-open devices, are approved, ted and tested in accordance rer's specifications. 9.6.1.3	K 054	See ATTACHES PLAN O CORRECTION	f	5-10-14	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01		TE SURVEY
		245482	B. WING	<u> </u>	03	3/27/2014
	PROVIDER OR SUPPLIER  MANOR CARE CEN	TER		STREET ADDRESS, CITY, STATE 220 THIRD STREET NORTHW BLOOMING PRAIRIE, MN	VEST	S. <sup>1</sup>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
K 054	Continued From pa	age 3	K	054		
	Based on observa facility failed mainta accordance with the 9.6.1.4 and 1999 N	s not met as evidenced by: tion and staff interview, the ain the fire alarm system in e requirement 2000 NFPA 101 IFPA 72, Sections 7-1.1.1. The ould affect all 48 residents.				
ye o	03/27/2014, observed Panel (FACP) show The trouble was a 'Maintenance Directorouble for the last 6.  This deficient pract	ice was confirmed by the				
K 144 SS=F	discovery. NFPA 101 LIFE SA Generators are insp	FETY CODE STANDARD  Dected weekly and exercised ninutes per month in FPA 99. 3.4.4.1.	K 1	See AMACHED ( CORRECTION	han of	4-30-14
	Based on documer	s not met as evidenced by: ntation review and staff y failed to test the emergency				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION D1 - MAIN BUILDING 01		E SURVEY IPLETED
		245482	B. WING			03/	27/2014
	PROVIDER OR SUPPLIER  MANOR CARE CENT	ER		22	TREET ADDRESS, CITY, STATE, ZIP CODE 20 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917		7
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 144	of 2000 NFPA 101 -	dance with the requirements - 9.1.3 and 1999 NFPA 110 6-4.2.2. The deficient practice	K	44	×		
	On facility tour betw 03/27/2014, docum emergency generat March 2014), revea been done, but indic	veen 9:00 AM and 12 noon on entation review of the monthly or testing log (April 2013 to led that the monthly test have cated that the natural gas or was not being tested under					114. 11 <u>4.</u> 11 <u>4.</u>
	load of 30 percent. documentation stati	There was no other ing that the emergency ed by one of the following					2 4 .
	Loading that main temperatures as rec manufacturer or	ntains the minimum water commended by the					
d = 1	2. under load of 30 nameplate rating of	percent or more of the generator or					
	3. 2 hour load bank	test					
э.		ce was confirmed by the Director (SB) at the time of					(*)
	*TEAM COMPOSIT Gary Schroeder, Life						

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION 11 - MAIN BUILDING 01		E SURVEY IPLETED
		245482	B. WING	·		03/	27/2014
	PROVIDER OR SUPPLIER	ER		22	REET ADDRESS, CITY, STATE, ZIP CODE  O THIRD STREET NORTHWEST  LOOMING PRAIRIE, MN 55917		ı
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
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1 021							* 10 ±
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(+-)				1			e gyte

#### 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.

F5482023

PRINTED: 04/04/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 - CHAPEL B. WING 245482 03/27/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 220 THIRD STREET NORTHWEST PRAIRIE MANOR CARE CENTER **BLOOMING PRAIRIE, MN 55917** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 POCOK YOUNY 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 APR 1 7 20**14** CORRECTION FOR THE FIRE SAFETY DEFICIENCIES ( K-TAGS) TO: MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

Facility ID: 00650

program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED		
		245482	B. WING			03	/27/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
K 000	Continued From page By email to: Marian	age 1 n.Whitney@state.mn.us	K	000			× ×	
3		PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:						
	A description of to correct the defication	what has been, or will be, done iency.		į			100	
* 127	2. The actual, or p	roposed, completion date.						
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.						
	buildings. Prairie Maddition is a 1-stor	surveyed as two separate flanor Care Center 1991 chapel y building with no basement. ddition was determined to be instruction.					31	
	fire alarm system of detection and space	y sprinkled. The facility has a with full corridor smoke ses open to the corridors that is matic fire department					80	
		apacity of 56 beds and had a time of the survey.					p*	
K 054 SS=F	NOT MET as evide	t 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD	K	)54	See ATTACHED PLAN OF CORRECTION		05-10-14	
00 <b>-</b> 1	activating door hold	detectors, including those d-open devices, are approved, ted and tested in accordance			CORRECTION			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING <b>02 - CHAPEL</b>	(X3) DATE SURVEY COMPLETED	
		245482	B. WING		0:	3/27/2014
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CC 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORE  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE A  DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 054		age 2 rer's specifications. 9.6.1.3	ΚC	54		-
	Based on observa facility failed mainta accordance with th 9.6.1.4 and 1999 N	is not met as evidenced by: tion and staff interview, the ain the fire alarm system in e requirement 2000 NFPA 101, IFPA 72, Sections 7-1.1.1. The ould affect all 48 residents.				/i /181
4	03/27/2014, observed Panel (FACP) show The trouble was a	ween 9:00 AM and 12 noon on vation of the Fire Alarm Control wed the FACP was in trouble. "Battery Charging Fault". tor indicated this has been in 6 months.				at at any
K 144 SS=F	facility Maintenance discovery. NFPA 101 LIFE SA Generators are ins	tice was confirmed by the e Director (SB) at the time of AFETY CODE STANDARD pected weekly and exercised ninutes per month in FPA 99. 3.4.4.1.	К 1	44 See ATTACHED PLAN CORRECTION	of	4-3D-14
-						ų
	This STANDARD i	is not met as evidenced by:				· in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - CHAPEL			(X3) DATE SURVEY COMPLETED		
		245482	B. WING	B. WING		03/27/2014	
	PROVIDER OR SUPPLIER  MANOR CARE CENT	ER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		n.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 144	interview, the facility generators in accord 2000 NFPA 101 - 6-4.2 (a) & (b) and could affect all 48 refindings include:  On facility tour between	ntation review and staff y failed to test the emergency dance with the requirements - 9.1.3 and 1999 NFPA 110 6-4.2.2. The deficient practice esidents.	K	144			
A <sup>1</sup>	emergency generat March 2014), revea been done, but indi- emergency generat load of 30 percent documentation stat generator was teste means:	entation review of the monthly for testing log (April 2013 to alled that the monthly test have cated that the natural gas for was not being tested under There was no other ing that the emergency and by one of the following					
27 ° *	temperatures as remanufacturer or	·					
	nameplate rating of						
	3. 2 hour load bank	test					
		ice was confirmed by the e Director (SB) at the time of					
					К.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING <b>02 - CHAPEL</b>		TE SURVEY MPLETED
		245482	B. WING		03	/27/2014
	PROVIDER OR SUPPLIER  MANOR CARE CENT	ER	STREET ADDRESS, CITY, STATE, ZIP CODE  220 THIRD STREET NORTHWEST  BLOOMING PRAIRIE, MN 55917			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 144	Continued From pa *TEAM COMPOSIT Gary Schroeder, Lif	-	K 1	44		
1,20						
					sc or	
						P.
SOURE						

#### 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.



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 <u>only a suggestion</u> 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, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring

Kumalu Fiske Downing

Minnesota Department of Health Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

PRINTED: 04/04/2014 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 00650 03/27/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST PRAIRIE MANOR CARE CENTER **BLOOMING PRAIRIE, MN 55917** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*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 Minnesota Department of Health is this Department's staff visited the above provider documenting the State Licensing and the following licensing orders were issued. Correction Orders using federal software. When corrections are completed, please sign and Tag numbers have been assigned to date on the bottom of the first page in the line Minnesota state statutes/rules for Nursing marked with "Laboratory Director's or Provider/Supplier Representative's signature."

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

allison Henricel

I ING ADMINISTRATOR

(X6) DATE

STATE FORM 6899 19VM11 If continuation sheet 1 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00650	B. WING		03/2	7/2014
	PROVIDER OR SUPPLIER  MANOR CARE CENT	ER 220 THIRE		ORTHWEST MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Make a copy of the return the original to Minnesota Departm	se orders for your records and o the address below: nent of Health e SE, Rochester, MN 55904 , Unit Supervisor	2 000	The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule out of complisted in the "Summary Statement Deficiencies" column and replaces Comply" portion of the correction of This column also includes the find which are in violation of the state after the statement, "This Rule is a sevidence by." Following the sur findings are the Suggested Metho Correction and Time period for Correction and Time period for Correction and Time period for Correction." THIS APPLIES FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT T SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." liance is of sthe "To order. ings statute not met veyors d of orrection. DING OF TO THIS ODN FOR	
2 570	Plan of Care; Revision. care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	A comprehensive plan of ved and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs,	2 570			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00650	B. WING		03/2	7/2014
	PROVIDER OR SUPPLIER	ER 220 THIRE	, ,	STATE, ZIP CODE ORTHWEST MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	by part 4658.0400,	subpart 3, item B.	2 570			
	by: Based on observati review, the facility for resident centered p in the comprhensive	ent is not met as evidenced on, interview and document ailed to ensure specific ain management was included e care plan for 1 of 3 iewed for unecessary				
	Findings include:					
	R16 lacked revision individualized interv	n of the care plan to include ventions for pain.				
	On 3/24/14 at 3:57 and not at an activit scouts. At 4:55 p.m removed from the cagain at 7:15 p.m. vR16 was observed With each observat bed, TV on, and slea.m. R16 was obse	on 3/24/14 through 3/27/14. p.m. R16 was observed in bed by program with the boy n. R16 was observed being dining room at his request and was lying in bed. On 3/25/14 from 8:54 a.m. to 1:15 p.m. tion, R16 was noted to be in seping. On 3/26/14 at 10:30 reved in bed and not at brunch. 0 p.m. to 3:30 p.m. R16 was sleeping.				
	8/29/13, 11/21/13, a no difficulty sleeping too much. The qua 2/13/14 indicated R Review the physicia received Trazodone	num Data Sets (MDS) dated and 2/13/14 indicated R16 had g, staying a sleep or sleeping arterly MDS of 11/21/13 and 16 had frequent mild pain. an orders indicated R16 e (an antidepressant used for 3 and morphine as needed for 5.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00650	B. WING		03/27/2014	
	PROVIDER OR SUPPLIER	ER 220 THIRE		STATE, ZIP CODE  ORTHWEST  MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	The care plan with indicated a focus/property arthritis. The problet administer pain mereffectiveness, encount and pain assessment assessment to manage the pain identify the use of the trylenol or morphine medication.  During an interview director of nursing include individual spincture individual spin	a review date of 2/20/14 roblem of pain related to em had interventions of dication and monitor surage verbalization of pain neverbal signs of discomfort, ent quarterly and as needed. ot identify individualized fic for R16 that would help him. The care plan did not he as needed medication of e or identify when to give which on 3/26/14 at 10:40 a.m., the indicated care plan should pecific non-pharmacological	2 570			
21330	MN Rule 4658.0725 Routine & Emerger	5 Subp. 2 A&B Providing ncy Oral Health Ser	21330			
	must be referred fo unless the resident examination within admission. B. After the ini	ental visit.  ays after admission, a resident r an initial dental examination has received a dental the six months before tial dental examination, a t ask the resident if the				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00650	B. WING		03/2	7/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE  ORTHWEST		
PRAIRIE	MANOR CARE CENT	FR	IG PRAIRIE,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21330	resident wants to so any necessary help at least an annual to annual dental check one year from the examination or with	ge 4 ee a dentist and then provide to make the appointment, on pasis. This opportunity for an kup must be provided within date of the initial dental in one year from the date of ne within the six months	21330			
	by: Based on observati review, the facility for dental services were	ent is not met as evidenced on, interview, and document ailed to ensure appropriate to provided or offered related ing teeth for 1 of 1 resident dental services.				
	have multiple upper	on 3/25/14, at 9:15 a.m. to r and lower missing teeth, and				
	R57 had her own to dental appointment prior to admission. date of 1/15/14, wa diagnosis of depres accident (CVA) with	ote dated 7/12/13, indicated eeth with some missing, last had been more than one year. The care plan with a review s reviewed and included esion, cerebrovascular a right sided hemiparesis and plan did not identify R57 had				
	7/19/13, did not ide issues or problems R57 had moderate	inimum Data Set (MDS) dated ntify R57 had any dental with teeth. The MDS indicated cognitive impairment and assistance of staff with				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00650	B. WING		03/2	7/2014
	PROVIDER OR SUPPLIER	ER 220 THIRI		STATE, ZIP CODE  ORTHWEST  MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21330	personal hygiene. F 10/23/13, identified eating a regular die weight loss. Care of were reviewed betw There was no evide or discussion with F need for dental serv On 3/26/14, at 11:5 services had not be go if offered.  On 3/26/14, at 12:2 (DON) confirmed R been assessed and missing and broken comprehensive admindicated dental serv offered during admirecord lacked docubeen offered and st offered dental servi weight loss."  A policy was reques Suggested Method nursing (DON) or di policies and proced to ensure residents dental care and ser could monitor to en are being followed.	Registered dietitian note dated R57 was independent with t, and had an unplanned onference progress notes ween 7/31/13, and 1/9/14. Ince of dental services offered R57 or family regarding the	21330			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00650	B. WING		03/2	7/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	FR	STREET N G PRAIRIE,	ORTHWEST		
040.15	CLIMMA DV CTA		-		ON	045)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 6	21530			
21530	MN Rule 4658.1310	) A.B.C Drug Regimen Review	21530			
	reviewed at least m currently licensed be This review must be Appendix N of the Surveyor Procedure Requirements in Louthe Department of Health Care Finance This standard is incompared available through the system. It is not sue B. The pharma irregularities to the cand the attending pomust be acted upor physician visit, or so pharmacist. For pure upon means the acreport and the signification of nursing services. C. If the attending the matter to the medical direct physician. If the medical direct physician does not must be referred for assessment and as by part 4658.0070. The medical direct physicial direct physicial direct physician does not must be referred for assessment and as by part 4658.0070.	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. It done in accordance with State Operations Manual, it is for Pharmaceutical Service ing-Term Care, published by Health and Human Services, ing Administration, April 1992. Corporated by reference. It is it is in Minitex interlibrary loan bject to frequent change. Coist must report any director of nursing services hysician, and these reports in by the time of the next poner, if indicated by the roses of this part, "acted acceptance or rejection of the ing or initialing by the director and the attending physician. In the pharmacist must he medical director for review for is not the attending edical director determines that coin does not have adequate or review to the attending change the order, the matter or review to the quality surance committee required. If the attending physician is or, the consulting pharmacist er directly to the quality				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00650	B. WING		03/2	7/2014
	PROVIDER OR SUPPLIER	ER 220 THIRE		STATE, ZIP CODE  ORTHWEST  MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	assessment and as  This MN Requirement by: Based on interview facility failed to ensite identified irregularitic director of nursing a residents (R16) rev medications.  Findings include: R16 was observed and not at an activity scouts. At 4:55 p.m. assisted from the dagain at 7:15 p.m. write R16 was observed With each observed With each observed with each observed with each observed bed, TV on, and slea.m. R16 was observed with each observed with each observed bed, TV on, and slea.m. R16 was observed with each observed bed, TV on, and slea.m. R16 was observed with each observed bed, TV on, and slea.m. R16 was observed with each observed bed, TV on, and slea.m. R16 was observed with each observed bed, TV on, and slea.m. R16 was observed bed, TV on, and slea.m. R16 wa	ent is not met as evidenced and document review the ure the consulting pharmacist ies and reported them to the and physician for 1 of 5 iewed for unnecessary  on 3/24/14 at 3:57 p.m. in bed by program with the boy n. R16 was observed being ining room at his request and was lying in bed. On 3/25/14 from 8:54 a.m. to 1:15 p.m. ion, R16 was noted to be in peping. On 3/26/14 at 10:30 rved in bed and not at brunch. O p.m. to 3:30 p.m. R16 was sleeping.  num Data Sets (MDS) dated and 2/13/14 indicated R16 had g, staying at sleep or sleeping urterly MDS of 11/21/13 and 16 had frequent mild pain.	21530	DEFICIENCY)		
	2/13/14 indicated R physical behaviors displayed no refusa wandering behavior 2/13/14 indicated R	of 8/29/13, 11/21/13, and 16 displayed no verbal or toward others or self, all of cares, and displayed rs. The quarterly MDS dated 16 had a brief interview of e of 8 or moderate cognitive				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00650	B. WING		03/2	7/2014
	PROVIDER OR SUPPLIER	ER 220 THIRE		STATE, ZIP CODE ORTHWEST MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	The registered nursing depression, history at risk behavior requaintain sobriety are orders signed 3/10/diagnoses of chronic disease, dementia with the resident receives times in October, 3 There was no Haldo December 2013, Jathe first two weeks physician's order diuse of the as needed the medication was non-pharmacologic used first, or if any medication should be R16's care plan had a medications as presentation of nursing (guidelines/parameters for use During an interview director of nursing (guidelines/parameters)	se (RN) Behavior Note of noses of "Alcoholism, of repeated poor choices with uiring 24-our supervision to a safety" The physician 14 also listed additional ic pain, chronic kidney with behavioral disturbances.  Seters for use of as needed ic) and as needed Morphine ysician ordered 1 mg Haldol eeded for severe agitation. In ministration record indicated at the as needed Haldol 3 times in November 2013. Sol given as needed for anuary and February 2014, or of March 2014. The donot include parameters for ed Haldol (i.e. what behaviors to be given for, what all interventions should be other assessment and one attempted.)  Setendo of 2/20/14 had a led to behaviors identified. In intervention of give scribed by physician i.e. Seroquel but did not identify of the Haldol.  On 3/26/14 at 11:00 a.m. (DON) stated lers for the use of the as not been developed for R16	21530			

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PRINTED: 04/04/2014 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00650	B. WING		03/2	27/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	FR	D STREET N IG PRAIRIE,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	On 11/25/13 the ph Morphine to 2 mg e medication adminis received morphine November 2013, ar addition R16 had a needed Tylenol date Tylenol once in Oct the Tylenol once in Oct the Tylenol nor Mor when the medicatio for what pain level/identify the use of the Tylenol or Morphine medication and for During an interview case manager-regis staff should give the then morphine, but developed paramet or Morphine for R16 3/27/14 at 9:10 a.m. had not listed paramedications on the R16 had an increas however, the effect medication was not non-pharmacologic prior to the use of the Physician orders dawas to receive Trazorders directed the mg after 1 day and The quarterly sedat reviewed for 12/13/	ysician order increased the every 4 hours as needed. The tration record indicated R16 13 times in October, once in ad once in March 2014. In physician's order for as ed 5/31/13 and received the ober 2013. However, neither phine had parameters as to in is to be used and which one intensity.  Attenuate 2/20/14 had a plan that ed to arthritis but did not he as needed medication of e or identify when to give which what type or intensity of pain. on 3/26/14 at 9:10 a.m. the stered nurse (RN)-B stated e Tylenol first for mild pain and stated the facility had not ers for the use of the Tylenol 5. During an interview on . the DON indicated the facility meters for use of the pain	21530			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A PUBLICATION OF CONSTRUCTION (X3) DATE S COMPL	
AND FEAR OF CONNECTION IDENTIFICATION NOMBERS.	
00650 B. WING 03/27	7/2014
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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530  Continued From page 10  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 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 of 11/24/13 indicated R16 was currently taking Seroquel. The RN quarterly Behavior Note of on-pharmacological interventions were effective. During an interview on 3/26/14 at 9:10 a.m., RN-A, RN-B indicated R16 to she haviors were	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00650	B. WING		03/2	27/2014
	PROVIDER OR SUPPLIER  MANOR CARE CENT	ER 220 THIR	DRESS, CITY, S D STREET NO IG PRAIRIE,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	was generally found because the nursing nurse about the bel monitoring, RN-B s for quantitative more was not doing it. During an interview DON stated the quawas to include a review of the gradu the behaviors and interviewed on 3/27 that in October 201 have been related the private room to a dealso the resident's k 2013. LSW-A indict behaviors would octobe a review of the gradu the Seroquel. The she had sent a note referencing the nees tated she would expressed and reviewed the fadocumentation, but behavior monitoring parameters for use not completed.	d in the nursing notes, g assistants would tell the navior. Regarding the behavior tated had discussed the need nitoring, but that the facility  on 3/26/14 at 10:20 a.m. arterly RN Behavior summary view of the medications, al dose reductions, review of nterventions.  work (LSW)-A was 7/14 at 8:45 a.m. LSW-A noted 4 R16's behaviors could the change from having a puble room (companion) and prother had died in October ated that she had noticed cur each time an attempt was nommate in the past.  In a strength of the companion of the change from the past of the companion of the change from the past.  In a strength of the companion of the change from the past of the companion of the c	21530			

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00650	B. WING		03/2	7/2014
	PROVIDER OR SUPPLIER	ER 220 THIRI	DRESS, CITY, S D STREET NO IG PRAIRIE,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	develop, review, an procedures to ensu identifies drug irreg indications for use of and appropriate modeffects of medication. The director of nurse educate all appropriate and irrector of nurse develop monitoring compliance.	d/or revise policies and re the consultant pharmacist ularities including appropriate of psychotropic medications initoring for efficacy and side	21530			
21540	Subp. 2. Monitoring monitor each reside unnecessary drug	g. A nursing home must ent's drug regimen for usage, based on the nursing diprocedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist not's quality of life is being the pharmacist must refer the all director for review if the not the attending physician. If or determines that the attending have adequate justification for attending physician does not not matter must be referred for y Assurance and Assessment equired by part 4658.0070. If cian is the medical director,	21540			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		00650	B. WING		03/2	7/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE	1 30/-	<u>,.,</u>
PRAIRIE	MANOR CARE CENT	FR		ORTHWEST		
0.0.15	CLIMMA DV CTA		G PRAIRIE,		ONI	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 13	21540			
	the consulting pharmacist shall refer the matter directly to the QAA.					
	by: Based on observati review, the facility for implement paramet Haldol (antipsychot (pain medication), and develop a plan manage insomnia was Trazodone (antidep failed to monitor the Seroquel to determine the seroquel the seroquel to determine the seroquel to determine the seroquel the se	on, interview and document ailed to develop and ters for use of as needed ic medications) and Morphine evaluate and assess for sleep to assist the resident to without an increase in the pressant and hypnotic) and the behaviors after the initiate of ine effectiveness of the 5 residents (R16) reviewed for eations.				
	and not at an activity scouts. At 4:55 p.m assisted from the dagain at 7:15 p.m. or R16 was observed With each observed bed, TV on, and slea.m. R16 was obse	on 3/24/14 at 3:57 p.m. in bed by program with the boy n. R16 was observed being ining room at his request and was lying in bed. On 3/25/14 from 8:54 a.m. to 1:15 p.m. ion, R16 was noted to be in seping. On 3/26/14 at 10:30 rved in bed and not at brunch. 0 p.m. to 3:30 p.m. R16 was 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					

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00650		B. WING		03/27/2014	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	FK	O STREET N IG PRAIRIE,	ORTHWEST MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	physical behaviors displayed no refusa wandering behavior 2/13/14 indicated Remental status score impairment.  The registered nursi 11/24/13 listed diag depression, history at risk behavior requaintain sobriety a orders signed 3/10/diagnoses of chrondisease, demential R16 lacked parametrial Haldol (antipsychotopain):  On 10/28/13 the phevery 8 hours as not The medication adouthe resident receive times in October, 3 There was no Haldo December 2013, Jathe first two weeks physician's order diuse of the as neede the medication was non-pharmacologic used first, or if any medication should R16's care plan had a medications as president received the medication should R16's care plan had a medications as president refusal resident received the medication should R16's care plan had a medications as president refusal resident received the medication should R16's care plan had a medications as president refusal ref	toward others or self, all of cares, and displayed rs. The quarterly MDS dated at 6 had a brief interview of e of 8 or moderate cognitive.  See (RN) Behavior Note of moses of "Alcoholism, of repeated poor choices with uiring 24-our supervision to a safety" The physician at also listed additional ic pain, chronic kidney with behavioral disturbances.  Seters for use of as needed ic) and as needed Morphine as needed for severe agitation. Set the as needed Haldol 3 times in November 2013. Sol given as needed for anuary and February 2014, or of March 2014. The donot include parameters for ed Haldol (i.e. what behaviors to be given for, what all interventions should be other assessment and	21540			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00650	B. WING		03/2	27/2014
	PRAIRIE MANOR CARE CENTER 220 THIRE			TATE, ZIP CODE  DRTHWEST  MN 55917		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETE DATE	
21540	During an interview director of nursing guidelines/paramet needed Haldol had and should have be On 11/25/13 the ph Morphine to 2 mg emedication administraceived morphine November 2013, and addition R16 had an needed Tylenol dat Tylenol once in Oct the Tylenol nor Morwhen the medication for what pain level/if R16 's care plan do indicated pain relation in the medication and for During an interview case manager-registaff should give the then morphine, but developed parameters.	con 3/26/14 at 11:00 a.m. (DON) stated ers for the use of the as not been developed for R16 een.  ysician order increased the every 4 hours as needed. The stration record indicated R16 13 times in October, once in nd once in March 2014. In physician's order for as ed 5/31/13 and received the ober 2013. However, neither phine had parameters as to on is to be used and which one intensity.  ated 2/20/14 had a plan that ed to arthritis but did not he as needed medication of e or identify when to give which what type or intensity of pain. on 3/26/14 at 9:10 a.m. the stered nurse (RN)-B stated e Tylenol first for mild pain and stated the facility had not ters for the use of the Tylenol	21540	DEL TOLENOT)		
	3/27/14 at 9:10 a.m had not listed parar medications on the R16 had an increas however, the effect medication was not non-pharmacologic prior to the use of the size of the si	6. During an interview on at the DON indicated the facility meters for use of the pain care plan.  se in Trazodone used for sleep iveness of the increased at determined. Nor were all interventions attempted the sleeping medication: atted 9/25/13 indicated R16				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00650	B. WING		03/27/2014	
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
PRAIRIE M	ANOR CARE CENT	FR	O STREET N IG PRAIRIE,	ORTHWEST MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
woom Treamation Treama	riders directed the ng after 1 day and the quarterly sedat eviewed for 12/13/25 assessments noted nonitoring had been seessment stated or depression and of the residents sleep was found or the residents sleep was found or acilitate or interferent and did not identify non-pharmacological leep. Ouring an interview and RN-B indicated the sleep during the day (26/14 at 10:20 a.m. for seedative/Hypnotic Action on the pharmacologic nat sleep tracking that all the completed quarterly on-pharmacologic nat sleep tracking that all the completed quarterly on-pharmacologic nat sleep tracking that all the completed quarterly on-pharmacologic nat sleep tracking that all the completed quarterly on-pharmacologic nat sleep tracking that all the completed quarterly on-pharmacologic nat sleep tracking that sleep t	rodone 25 mg for sleep. The Trazodone be increased to 50 to 100 mg on 10/7/13.  rive/hypnotic assessment was 13 and 2/22/14. The 1 a sleep tracking and mood in completed. The R16 was receiving Trazodone insomnia, but no evaluations rep/awake cycle or hours of documented.  Acted 2/20/14 indicated a story of insomnia. The rot listed the factors that may rewith normal sleep patterns specific interventions roal) to assist the resident to 10 on 3/26/14 at 9:10 a.m., RN-A 1 the sleep tracking should be represented by a many and did not monitor road on the DON stated the research was to be road and added was to be completed. DON or through periods of sleep and ouple days. Ting of Seroquel to determine if	21540			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMF	SURVEY PLETED	
		00650	B. WING		03/2	27/2014
_	PROVIDER OR SUPPLIER	TER 220 THIRI		STATE, ZIP CODE ORTHWEST MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21540	indicated R16 was RN quarterly Behaviors and interview DON stated the quawas to include a review of the behaviors and interviewed on 3/27 that in October 201 have been related to private room to a dalso the resident's ROTAL SUGGESTED MET The director of nurs assure that policies and that staff training and interviewed on the dalso the resident's ROTAL SUGGESTED MET The director of nurs assure that policies and that staff training assure each reside monitored and that unnecessary drugs	currently taking Seroquel. The vior Note did not identify the f behaviors or if the use of tal interventions were effective. on 3/26/14 at 9:10 a.m., ted R16's behaviors were B stated the documentation d in the nursing notes, g assistants would tell the havior. Regarding the behavior tated had discussed the need nitoring, but that the facility on 3/26/14 at 10:20 a.m. arterly RN Behavior summary view of the medications, al dose reductions, review of nterventions.  Work (LSW)-A was 7/14 at 8:45 a.m. LSW-A noted 4 R16's behaviors could to the change from having a puble room (companion) and corother had died in October tated that she had noticed four each time an attempt was roommate in the past.  THOD OF CORRECTION: sing and or designee could and procedures are updated in the gray and procedures are updated in the sidents are not taking residents are not taking	21540			

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PRINTED: 04/04/2014 FORM APPROVED Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_\_\_ B. WING \_ 00650 03/27/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST PRAIRIE MANOR CARE CENTER **BLOOMING PRAIRIE, MN 55917** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE DATE (X4) ID PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)