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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1EW8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00342

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245371**

2. STATE VENDOR OR MEDICAID NO. (L2) **681243100**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRAIRIE VIEW SENIOR LIVING**
(L4) **250 FIFTH STREET EAST**
(L5) **TRACY, MN** (L6) **56175**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/27/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 06/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 06/29/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245371

June 29, 2016

Mr. Brian Henrichs, Administrator
Prairie View Senior Living
250 Fifth Street East
Tracy, MN 56175

Dear Mr. Henrichs:

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 June 13, 2016 the above facility is certified for or recommended for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

June 29, 2016

Mr. Brian Henrichs, Administrator
Prairie View Senior Living
250 Fifth Street East
Tracy, MN 56175

RE: Project Number S5371026

Dear Mr. Henrichs:

On May 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 5, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On June 27, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 13, 2016 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 May 5, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 5, 2016, effective June 13, 2016 and therefore remedies outlined in our letter to you dated May 19, 2016, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245371 Y1	A. Building B. Wing Y2	6/27/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW SENIOR LIVING	250 FIFTH STREET EAST TRACY, MN 56175

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0280	Correction	ID Prefix F0282	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	06/06/2016	LSC	06/06/2016	LSC	06/13/2016
ID Prefix F0318	Correction	ID Prefix F0323	Correction	ID Prefix F0329	Correction
Reg. # 483.25(e)(2)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.25(l)	Completed
LSC	06/13/2016	LSC	06/06/2016	LSC	06/06/2016
ID Prefix F0332	Correction	ID Prefix F0428	Correction	ID Prefix F0441	Correction
Reg. # 483.25(m)(1)	Completed	Reg. # 483.60(c)	Completed	Reg. # 483.65	Completed
LSC	05/26/2016	LSC	06/13/2016	LSC	06/06/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/03/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	6/29/2016	03048	6/27/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/5/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245371	A. Building 01 - MAIN BUILDING 01 B. Wing	6/13/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW SENIOR LIVING	250 FIFTH STREET EAST TRACY, MN 56175

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 05/31/2016	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 06/03/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	6/29/2016	35482	6/13/2013
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/3/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1EW8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00342

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245371**

2. STATE VENDOR OR MEDICAID NO. (L2) **681243100**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRAIRIE VIEW SENIOR LIVING**
(L4) **250 FIFTH STREET EAST**
(L5) **TRACY, MN** (L6) **56175**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/05/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 05/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 06/16/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 19, 2016

Mr. Brian Henrichs, Administrator
Prairie View Senior Living
250 Fifth Street East
Tracy, MN 56175

RE: Project Number S5371026

Dear Mr. Henrichs:

On May 5, 2016, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - 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;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - 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:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

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 June 14, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 August 5, 2016 (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 November 5, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245371	A. BUILDING _____ B. WING _____	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW SENIOR LIVING	250 FIFTH STREET EAST TRACY, MN 56175

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		6/6/16

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

Electronically Signed | 05/26/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245371	A. BUILDING _____ B. WING _____	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW SENIOR LIVING	250 FIFTH STREET EAST TRACY, MN 56175

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of elevated blood pressure recordings for 1 of 6 residents (R18) reviewed for unnecessary drugs. Findings include: R18's most recent physician's progress note dated 3/24/16, identified active diagnoses including: coronary artery disease, hypertension (high blood pressure), chronic back pain, cerebral vascular disease (CVA-stroke), recurrent falls, vascular dementia and chronic kidney disease. This progress note also include an assessment and plan related to the diagnosis of essential hypertension and the physician indicated an acceptable blood pressure (BP) range for R18 as 148/88 millimeters of mercury (mm Hg), which had been documented on the monthly flow sheet. R18's most recent physician orders dated 4/14/16, identified current medications as noted: Isosorbide Mononitrate (extended release) ER tablet 24 hour 30 milligrams (mg) 1.5 tablets by mouth daily for angina attacks, Norvasc tablet 5 mg by mouth for essential hypertension and Lopressor tablet 50 mg by mouth two times a day	F 157	F 157 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. DON reviewed policies and procedures. On June 6, 2016 DON will educate staff on notifying responsible parties and physician when a change in condition (SBAR) vital sign. 2. DON or designee will monitor two resident's charts weekly for 4 weeks, then 4 residents monthly for two months. The data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding	

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F 157	Continued From page 2 for essential hypertension. R18 had a series of falls in April 2016 with multiple documented post fall BP's ranging from 155/84 mm Hg to 219/108 mm Hg. There was no evidence there had been any additional BP monitoring initiated when the BP medication dosage was increased on 1/14/16; Norvasc 5 mg was ordered. There was also no evidence the physician had been immediately notified of the 4/12/16, BP measuring 219/108 mm Hg in accordance with the Change in Condition (SBAR) procedure which directed to report a systolic BP >210 mm Hg immediately. There was no documented evidence in R18's record acknowledging a pattern of elevated blood pressures nor documented evaluation of whether the current drug regimen was effective. During a telephone interview on 5/5/16, at 9:45 a.m. the facility's medical director (MD, who was also R18's primary physician) stated, "I would not like to see a BP out of the accepted high range for this age group (which included R18). A BP of 150/90 is the goal, otherwise it will increase the risk for stroke." The MD further verified he was unaware of R18's elevated BP reading and stated he would expect to review a BP flow sheet, run some labs or change medications had he been aware. The MD further stated an elevated BP would require rechecking and stated he would expect a resident receiving an anti-hypertensive to have their BP monitored more frequently than monthly. The MD stated, "I was not aware the facility had not been monitoring R18's BPs more frequently." MD also stated it was difficult to evaluate the medication effectiveness when the BP recordings are conducted before/after the medication is administered. The MD indicated he	F 157	follow-up or changes.	

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F 157	Continued From page 3 had requested noon BP monitoring vs. early morning monitoring for those resident who were receiving anti-hypertensive medications. During an interview on 5/5/16, at 8:57 a.m. the director of nursing (DON) indicated the nursing staff were to follow the facility's protocol for Change in Condition (SBAR) to report changes in condition. The facility's procedure titled Change in Condition (SBAR) directed staff to immediately notify the nurse practitioner or MD re., blood pressure, systolic BP>210 mmHg. The procedure indicated the SBAR tool was to be used by the nurse caring for the resident with a change in condition.	F 157		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		6/6/16

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F 280	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan for 2 of 4 residents (R12, R2) reviewed for accidents and who received thickened liquids and were at risk for aspiration/choking. Findings include: R12 had diagnoses identified on the care plan dated 3/24/16, that included: Alzheimer's disease, dementia, cerebrovascular disease and hypertension. R12's care plan dated 3/24/16, identified R12 at risk for aspiration and identified a prescribed diet which included nectar consistency thickened liquids, including nectar thickened liquids at bedside. The care plan goal was for R12 to be free of aspiration over the next quarter. During observation of the evening medication pass and resident cares on 5/2/16, at 7:00 p.m. trained medication assistant (TMA)-B prepared R12's 7:00 p.m. medications. TMA-B prepared the following medications for R12: Zyprexa (anti-psychotic) 5 milligrams (mg); Tylenol 500 mg- 2 tabs; and Aricept (dementia medication) 15 mg. After placing the medications in a plastic medication cup, TMA-B crushed the medications and mixed them in applesauce. TMA-B then transported the medications into R12's room to administer them while R12 was lying in bed. TMA-B elevated the head of the bed to approximately 45 degrees. However, R12 slid	F 280	F280 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. MDS coordinator has updated resident care plans and orders were received for modified liquids including identified residents (R12, R2). 2. All other resident care plans will be reviewed and updated for accuracy. DON or designee will educate on June 6, 2016 all care plans will be updated with any change of condition. 3. All care plans of residents with modified thickened liquid diets will be monitored and audited by DON or designee weekly for 4 weeks, and then monthly for two month. The data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.	

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F 280	Continued From page 5 down in the bed with her head toward the foot of the bed. Subsequently, R12's head was not elevated to the 45 degree angle the TMA-B had attempted. After administration of these prepared medications, TMA-B administered thickened liquids while R12 remained lying on her back in bed. positioned at less than a 45 degree angle. Immediately after the noted observation, at approximately 7:15 p.m., the director of nursing (DON) was interviewed about the observation related to R12 receiving thickened liquids while lying in bed. The DON stated staff should know that the resident's head of the bed should be elevated to 90 degrees (not 45 degrees) and also ensure the resident is maintained in an upright position while administering medications and/or liquids. The DON also verified R12 was at risk for aspiration. When interviewed on 5/4/16, at 10:29 a.m. registered nurse (RN)-C stated R12 was at risk for aspiration and should be positioned sitting upright and should be alert during the administration of thickened liquids. RN-C reiterated R12 would be at risk for potential aspiration if not sitting upright. RN-C confirmed the care plan had not been revised to include staff guidance related to the appropriate position R12 should be when lying in bed during the administration of liquids and/or medications to prevent aspiration. Diagnoses listed on R2's plan of care dated 12/21/15, included: cerebrovascular accident (CA) with aphasia and hemiparesis, Alzheimer's	F 280		

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F 280	Continued From page 6 disease, failure to thrive, dysphasia and anorexia. The significant change in status Minimum Data Set (MDS) assessment dated 2/17/16, indicated R2 receives a mechanically altered diet and has severely impaired cognition. The MDS identified R2 as receiving the hospice benefit and requires total assistance with all of her activities of daily living (ADL). R2's plan of care dated/revised 12/21/15, identified: (1) Nectar thickened liquids at the bedside; and (2) Provide nectar thickened liquids of choice with meals, with meds and with snacks. The plan of care had not been updated to include the change in consistency of the thickened liquids from nectar to a honey consistency. The nursing progress notes dated 4/12/16, identified that R2 had difficulty swallowing and had been provided honey thickened liquids; documentation indicated that staff had to stop feeding R2 related to coughing. A communication sheet for the kitchen staff dated 4/12/16, indicated a (3) three day trial per hospice for R2 to use honey thickened liquid. A copy of residents who received thickened liquid was posted in the kitchen and nectar thickened liquids was crossed out and honey thickened added to R2's name. Review of the hospice note dated 4/12/16, also identified that R2's dysphagia is increasing and is now on honey thickened liquids, at times staff need to stop feeding her related to coughing. When interviewed on 5/3/16, at 12:27 p.m. the dietary manager (DM) reported that hospice changed the thickened liquid consistency from nectar to a honey consistency due to staff concerns during meal time assistance with	F 280		

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F 280	Continued From page 7 feeding.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services as directed by the written plan of care for 3 of 3 residents (R10, R13, R25) reviewed with limited functional range of motion (ROM). Findings include: R10 had diagnoses identified on the care plan dated 3/29/16, including: history of cerebral infarction, dementia, osteoporosis, polyosteoarthritis and hemiplegia. During observation on 5/2/16, at 2:22 p.m. R10 was seated in a wheelchair in his room. R10 was noted to have a contracted left hand and arm which he stated had been contracted for a long time since he'd experienced a cardiovascular accident (CVA). The care plan dated 3/29/16, identified R10 had an activities of daily living (ADL) self care performance deficit related to CVA, hemiplegia and dementia. The care plan also indicated R10 had limited mobility, with a goal the resident would maintain ability to transfer with assist of 2	F 282	F282 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. All resident care plans with limited range of motion have been reviewed to ensure they receive necessary treatment/service to prevent further limited range of motion. 2. DON or designee will monitor resident therapy documentation for completion according to resident care plans and educate appropriate staff on June 13, 2016 on the treatment and services needed for prevention of range of motion. 3. Facility will ensure staff are present	6/13/16

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F 282	Continued From page 8 staff, or 2 staff and EZ stand (mechanical lift), to maintain his current level of function. The care plan identified R10 was on a nursing rehabilitation program that included: (1) Active range of motion (ROM) utilizing the Omnicycle (Exercise bike). (2) Stretching of both Lower extremities and both hamstrings. (3) Place feet up on black stool for 5 minutes. (4) Standing in EZ stand up to 5 minutes if cooperative to work on the use of arms to pull up and use of legs for weight bearing and posture. During review of the restorative nursing logs for the month of April 2016, documentation on R10's log identified the following data: (1) active ROM utilizing the Omnicycle- 5 out of 30 opportunities for the month and (2) 5 minutes exercises with use of the EZ stand -4 out of 30 opportunities for the month. The remaining days of the month were documented that R10 had either refused and/or was unavailable. During review of R10's restorative nursing logs for the month of March 2016, documentation identified: (1) received active range of motion utilizing the Omnicycle-3 out of 31 opportunities for the month and (2) received 5 minutes exercises with use of the EZ stand-3 of 31 opportunities for the month. The remaining days were documented that R10 had either refused and/or was not available. Documentation on R10's restorative logs for the past 6 months (December 2015-May 2016) revealed R10 had not received the restorative program as directed by the care plan. When interviewed on 5/4/16, at 1:04 p.m. restorative aide (RA)-A stated R10 should use the Omnicycle 3-5 times/week and have upper extremity and lower extremity exercises while in	F 282	within facility to complete therapy programs. This will be done by training additional CNA's to complete therapy programs and when needed facility will be able to have CNA's working complete the required therapy programs. 4. DON or designee will monitor this POC to ensure implementation is being followed as well as audit four random resident therapy programs and completion of documentation for 6 weeks, then four random resident therapy programs monthly for two months. The data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.	

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F 282	Continued From page 9	F 282		

the EZ stand daily. RA-A stated the facility had pulled the restorative position from the schedule when the census was low in April and May 2016. RA-A stated there were many times when staffing was short on the floor, the restorative person would be assigned to providing personal cares versus providing restorative aide services. RA-A stated rehab services ceased for awhile when the census remained low.
R13 had diagnoses identified on the care plan dated 2/12/16, including adult failure to thrive, major depression, systemic lupus, lumbar vertebra fracture, dementia and osteoporosis.

During observation on 5/2/16, at 5:28 p.m. R13 was seated in her wheelchair at the dining room table. R13 was noted to have bilateral hand contractures. R13 was unable to open her left hand without using her right hand to pull her fingers from the palm of her hand.

During review of R13's care plan dated 2/12/16, it identified R13 had limited physical mobility related to a history of 2nd lumbar compression fracture and osteoporosis. The care plan goal identified R13 would maintain level of mobility by ambulating 25 feet through the next review date and would maintain current level of function through the review date. The care plan for R13 identified the following restorative rehabilitation interventions:
(1) Active range of motion (ROM) program identified R13 would complete any of the following: Seated bilateral lower extremity (BLE) exercises with 1 pound weight.
Maintenance/wellness/restorative therapy: nursing rehab program as patient tolerates. Follow exercise sheet. Use Omnicycle arm bike as needed for ROM of bilateral upper extremities

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F 282	Continued From page 10 (BUE). (2) PROM/splint care: Use bilateral resting hand splints in morning, afternoon and between meals. Sheep skin palm protectors on at night. Warm wash cloth or water basin before PROM of bilateral hands for 10-20 repetitions on each hand for extension. Goal: Decrease flexion contractures of BUE's. During review of R13's restorative nursing logs for the month of April 2016, documentation identified R13 received restorative services for active range of motion to BUE and BLE utilizing the Omnicycle 4 out of 30 opportunities for the month. The remaining days of the month were documented that R13 either refused and/or was unavailable. During review of R13's restorative nursing logs for month of March 2016, documentation identified she received restorative services for active range of motion to BUE and BLE utilizing the Omnicycle 0 out of 31 opportunities for the month. The remaining days of the month were documented that R13 either refused and/or was unavailable. Documentation reviewed on the restorative logs for the past 6 months (December 2015-May 2016) indicated R13 had not received a restorative program as directed by the care plan. When interviewed on 5/4/16, at 1:04 p.m. RA-A stated R13 should use the Omnicycle 3-5 times a week and should have AROM to bilateral hands 5 days/week. R25 had diagnoses identified on the care plan dated 4/8/16, including: heart failure, anxiety, depression, right femoral neck fracture with partial repair (4/2015), osteoporosis, history of humeral fracture with decreased mobility, post-herpatic neuralgia, and history of injury to the right third and fourth fingers related to fall.	F 282		

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F 282	Continued From page 11 During observation on 5/5/16, at 9:46 a.m. R25 was noted have her right hand folded in he lap with contracture while seated in the dining room. R25 was noted to wheel the wheelchair with her left hand and feet while her right hand remained resting on her lap. During review of R25's care plan dated 4/18/16, it identified that R25 had limited physical mobility. The care plan identified R25 would maintain level of mobility through the next review date with the following interventions in the nursing rehabilitation program: (1) Active ROM Program with pink therapy-putty exercises (with pegs removed). Right hand pushing/pulling x 10 each way. Digi-flexors right hand x 5 minutes. The goal was identified as maintenance of to apply hand splint on the right hand. (2) Active ROM Program with use of Omnicycle 10-15 minutes for legs. May vary according to any pain complaints. The goal identified for the program was to maintain strength for transfers with one assist limited physical mobility related to a history of 2nd lumbar compression fracture and osteoporosis. During review of R25's restorative nursing logs for the month of April 2016, documentation identified she received restorative services for active range of motion utilizing the Omnicycle 2 out of 30 opportunities for the month and received ROM exercises to her hands 0 of 30 opportunities for the month. The remaining days of the month were documented that R10 either refused or was unavailable and/or was left undocumented. During review of R25's restorative nursing logs for the month of March 2016, documentation identified she received restorative services for active ROM utilizing the Omnicycle 4 out of 30	F 282		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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opportunities for the month and received ROM exercises to her hands 0 of 30 opportunities for the month. The remaining days of the month were documented that R10 either refused or was unavailable, or was left undocumented. Documentation reviewed on the restorative logs for the past 6 months (December 2015-May 2016) indicated R25 had not received a restorative program as directed by the care plan. When nursing assistants (NA)- B, NA-C and NA-F were interviewed on 5/4/16, at 2:00 p.m. they stated they did not have the time to implement the restorative nursing duties when the restorative aide was removed from those duties to assist them with resident cares. They all verified the NA's did not complete the restorative programs during the time when the resident census was low.

When interviewed on 5/5/16, at 8:12 a.m. the director of nursing (DON) verified the RA had been removed from the restorative program from the time period 3/29/16 through 4/21/16, related to staffing changes affected by low resident census. The DON further verified sometimes the RA was pulled from rehab to cover for call-ins to perform NA cares. The DNS verified the census was low the past month and the RA was utilized on the floor instead of the RA position. The DNS further stated the NA's caring for the residents should conduct the restorative exercises during cares but verified the logs indicated the rehabilitation program was not documented to support completion of the services.

During a follow-up interview with the RA-A on 5/5/16, at 9:18 a.m. she indicated she was asked to provide personal cares for resident's today instead of providing restorative care due to a

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F 282	Continued From page 13 different staff calling in ill. The RA-A stated she is unsure if she would be able to do restorative program. When interviewed on 5/5/16, at 9:38 a.m. the DON verified the restorative aide was re-assigned to work on the floor (to provide personal cares) due to a NA who failed to show up for work today.	F 282		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the assessed treatment and services for 3 of 3 residents (R10, R13, R25) reviewed who had limited range of motion (ROM). Findings include: R10 had diagnoses identified on the care plan dated 3/29/16, including: history of cerebral infarction, dementia, osteoporosis, polyosteoarthritis and hemiplegia. During observation on 5/2/16, at 2:22 p.m. R10 was seated in a wheelchair in his room. R10 was noted to have a contracted left hand and arm	F 318	F318 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. MDS coordinator, DON, Therapy manager, and restorative assistant have met to review and revise all residents on	6/13/16

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F 318	Continued From page 14 which he stated had been contracted for a long time since he'd experienced a cardiovascular accident (CVA). The care plan dated 3/29/16, identified R10 had an activities of daily living (ADL) self care performance deficit related to CVA, hemiplegia and dementia. The care plan also indicated R10 had limited mobility, with a goal the resident would maintain ability to transfer with assist of 2 staff, or 2 staff and EZ stand (mechanical lift), to maintain his current level of function. The care plan identified R10 was on a nursing rehabilitation program that included: (1) Active range of motion (ROM) utilizing the Omnicycle (Exercise bike). (2) Stretching of both Lower extremities and both hamstrings. (3) Place feet up on black stool for 5 minutes. (4) Standing in EZ stand up to 5 minutes if cooperative to work on the use of arms to pull up and use of legs for weight bearing and posture. During review of the restorative nursing logs for the month of April 2016, documentation on R10's log identified the following data: (1) active ROM utilizing the Omnicycle- 5 out of 30 opportunities for the month and (2) 5 minutes exercises with use of the EZ stand -4 out of 30 opportunities for the month. The remaining days of the month were documented that R10 had either refused and/or was unavailable. During review of R10's restorative nursing logs for the month of March 2016, documentation identified: (1) received active range of motion utilizing the Omnicycle-3 out of 31 opportunities for the month and (2) received 5 minutes exercises with use of the EZ stand-3 of 31 opportunities for the month. The remaining days	F 318	therapy programs including R10, R13, and R25. All programs were review and revised as indicated and staff that provides therapy services will be educated on June 13, 2016 to the therapy programs care planned. 2. DON or designee will monitor four random resident therapy programs and completion of documentation for 6 weeks, then four random resident therapy programs monthly. 3. Facility will ensure staff are present within facility to complete therapy programs. This will be done by training additional CNA's to complete therapy programs and when needed facility will be able to have CNA's working complete the required therapy programs. 4.DON will monitor this POC to ensure implantation is being followed as well as audit 4 random resident therapy programs and completion of documentation for 6 weeks, then four random resident therapy programs monthly for two months. The data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.	

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were documented that R10 had either refused and/or was not available.
Documentation on R10's restorative logs for the past 6 months (December 2015-May 2016) revealed R10 had not received the restorative program as directed by the care plan.
When interviewed on 5/4/16, at 1:04 p.m. restorative aide (RA)-A stated R10 should use the Omnicycle 3-5 times/week and have upper extremity and lower extremity exercises while in the EZ stand daily. RA-A stated the facility had pulled the restorative position from the schedule when the census was low in April and May 2016. RA-A stated there were many times when staffing was short on the floor, the restorative person would be assigned to providing personal cares versus providing restorative aide services. RA-A stated rehab services had ceased for awhile when the census remained low.
R13 had diagnoses identified on the care plan dated 2/12/16, including adult failure to thrive, major depression, systemic lupus, lumbar vertebral fracture, dementia and osteoporosis.

During observation on 5/2/16, at 5:28 p.m. R13 was seated in her wheelchair at the dining room table. R13 was noted to have bilateral hand contractures. R13 was unable to open her left hand without using her right hand to pull her fingers from the palm of her hand.

During review of R13's care plan dated 2/12/16, it identified R13 had limited physical mobility related to a history of 2nd lumbar compression fracture and osteoporosis. The care plan goal identified R13 would maintain level of mobility by ambulating 25 feet through the next review date and would maintain current level of function through the review date. The care plan for R13

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identified the following restorative rehabilitation interventions:
(1) Active range of motion (ROM) program identified R13 would complete any of the following: Seated bilateral lower extremity (BLE) exercises with 1 pound weight. Maintenance/wellness/restorative therapy: nursing rehab program as patient tolerates. Follow exercise sheet. Use Omnicycle arm bike as needed for ROM of bilateral upper extremities (BUE). (2) PROM/splint care: Use bilateral resting hand splints in morning, afternoon and between meals. Sheep skin palm protectors on at night. Warm wash cloth or water basin before PROM of bilateral hands for 10-20 repetitions on each hand for extension. Goal: Decrease flexion contractures of BUE's.
During review of R13's restorative nursing logs for the month of April 2016, documentation identified R13 received restorative services for active range of motion to BUE and BLE utilizing the Omnicycle 4 out of 30 opportunities for the month. The remaining days of the month were documented that R13 either refused and/or was unavailable.
During review of R13's restorative nursing logs for month of March 2016, documentation identified she received restorative services for active range of motion to BUE and BLE utilizing the Omnicycle 0 out of 31 opportunities for the month. The remaining days of the month were documented that R13 either refused and/or was unavailable.
Documentation reviewed on the restorative logs for the past 6 months (December 2015-May 2016) indicated R13 had not received a restorative program as directed by the care plan.
When interviewed on 5/4/16, at 1:04 p.m. RA-A stated R13 should use the Omnicycle 3-5 times a

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F 318	Continued From page 17 week and should have AROM to bilateral hands 5 days/week. R25 had diagnoses identified on the care plan dated 4/8/16, including: heart failure, anxiety, depression, right femoral neck fracture with partial repair (4/2015), osteoporosis, history of humeral fracture with decreased mobility, post-herpatic neuralgia, and history of injury to the right third and fourth fingers related to fall. During observation on 5/5/16, at 9:46 a.m. R25 was noted have her right hand folded in he lap with contracture while seated in the dining room. R25 was noted to wheel the wheelchair with her left hand and feet while her right hand remained resting on her lap. During review of R25's care plan dated 4/18/16, it identified that R25 had limited physical mobility. The care plan identified R25 would maintain level of mobility through the next review date with the following interventions in the nursing rehabilitation program: (1) Active ROM Program with pink therapy-putty exercises (with pegs removed). Right hand pushing/pulling x 10 each way. Digi-flexors right hand x 5 minutes. The goal was identified as maintenance of to apply hand splint on the right hand. (2) Active ROM Program with use of Omnicycle 10-15 minutes for legs. May vary according to any pain complaints. The goal identified for the program was to maintain strength for transfers with one assist limited physical mobility related to a history of 2nd lumbar compression fracture and osteoporosis. During review of R25's restorative nursing logs for the month of April 2016, documentation identified she received restorative services for active range of motion utilizing the Omnicycle 2 out of 30 opportunities for the month and received	F 318		

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ROM exercises to her hands 0 of 30 opportunities for the month. The remaining days of the month were documented that R10 either refused or was unavailable and/or was left undocumented.

During review of R25's restorative nursing logs for the month of March 2016, documentation identified she received restorative services for active ROM utilizing the Omnicycle 4 out of 30 opportunities for the month and received ROM exercises to her hands 0 of 30 opportunities for the month. The remaining days of the month were documented that R10 either refused or was unavailable, or was left undocumented. Documentation reviewed on the restorative logs for the past 6 months (December 2015-May 2016) indicated R25 had not received a restorative program as directed by the care plan. When nursing assistants (NA)- B, NA-C and NA-F were interviewed on 5/4/16, at 2:00 p.m. they stated they did not have the time to implement the restorative nursing duties when the restorative aide was removed from those duties to assist them with resident cares. They all verified the NA's did not complete the restorative programs during the time when the resident census was low.

When interviewed on 5/5/16, at 8:12 a.m. the director of nursing (DON) verified the RA had been removed from the restorative program from the time period 3/29/16 through 4/21/16, related to staffing changes affected by low resident census. The DON further verified sometimes the RA was pulled from rehab to cover for call-ins to perform NA cares. The DNS verified the census was low the past month and the RA was utilized on the floor instead of the RA position. The DNS further stated the NA's caring for the residents

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F 318	Continued From page 19 should conduct the restorative exercises during cares but verified the logs indicated the rehabilitation program was not documented to support completion of the services. During a follow-up interview with the RA-A on 5/5/16, at 9:18 a.m. she indicated she was asked to provide personal cares for resident's today instead of providing restorative care due to a different staff calling in ill. The RA-A stated she is unsure if she would be able to do restorative program. When interviewed on 5/5/16, at 9:38 a.m. the DON verified the restorative aide was re-assigned to work on the floor (to provide personal cares) due to a NA who failed to show up for work today.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure thickened liquids and medications were administered in a safe manner to prevent aspiration for 1 of 3 residents (R12) reviewed who were at risk for choking.	F 323	F323 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of	6/6/16

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F 323	Continued From page 20 Findings include: R12's care plan dated 3/24/16, identified diagnoses including: Alzheimer's disease, dementia, cerebrovascular disease and hypertension. R12's care plan dated 3/24/16, identified R12 as at risk for aspiration and identified a prescribed diet to include nectar consistency thickened liquids, including liquids at the bedside. The care plan goal was for R12 to be free of aspiration over the next quarter. During observation of the evening medication pass and resident cares on 5/2/16, at 7:00 p.m. trained medication assistant (TMA)-B prepared R12's 7:00 p.m. medications. TMA-B prepared the following medications for R12: Zyprexa (antipsychotic) 5 milligrams (mg); Tylenol 500 mg- 2 tabs; and Aricept (dementia medication) 15 mg. After placing the medications in a plastic medication cup, TMA-B crushed the medications and mixed them in applesauce. TMA-B then transported the medications into R12's room to administer them while R12 was lying in bed. TMA-B elevated the head of the bed to approximately 45 degrees. However, R12 slid down in the bed with her head toward the foot of the bed. Subsequently, R12's head was not elevated to the 45 degree angle the TMA-B had attempted. After administration of these prepared medications, TMA-B administered thickened liquids while R12 remained lying on her back in bed. positioned at less than a 45 degree angle. Immediately after the noted observation, at approximately 7:15 p.m., the director of nursing (DON) was interviewed about the observation	F 323	deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. On 5/2/2016 DON provided education to all nursing staff this was provided in regards to giving fluid and nutrition while in bed. 2. On June 6, 2016 Speech Therapy and dietary manager will provide further education for dysphasia diets and prevention of aspiration. 3. DON or designee will audit and observe staff giving residents with altered consistence liquids for safe standard of practice and monitor 4 episodes weekly for four weeks, then 2 episodes monthly for two months. The data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.	

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related to R12 receiving thickened liquids while lying in bed. The DON stated staff should know that the resident's head of the bed should be elevated to 90 degrees (not 45 degrees) and also ensure the resident is maintained in an upright position while administering medications and/or liquids. The DON also verified R12 was at risk for aspiration.

During interview with registered nurse (RN)-D on 5/3/16, at 3:00 p.m. RN-D stated R12 had thickened liquids at her bedside and staff should provide the liquids to R12 while she is in a seated position.

When interviewed on 5/4/16, at 10:29 a.m. registered nurse (RN)-C stated R12 was at risk for aspiration and should be placed in a position sitting upright and be alert during the administration of thickened liquids. RN-C reiterated R12 would be at risk for potential aspiration if not sitting upright. RN-C stated the care plan lacked guidance to direct staff as to which position R12 should be in when laying in bed during administration of liquids or medications.

During interview with the DON on 5/4/16, at 10:40 a.m. the surveyor requested the facility policy related to the administration of thickened liquids. The DON submitted the nursing assistant training curriculum (Hartman's Nursing Assistant Care, 1994), which identified how nursing assistants should feed residents. The curriculum identified the following:
8. Properly positioning residents for eating.
a. Usually the proper positioning is upright, at a 90 degree angle. This helps prevent swallowing problems. Residents who use geri-chairs

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F 323	Continued From page 22 (reclining chairs on wheels) should be upright, no reclined, while eating. The curriculum did not identify how to administer foods or liquids for a resident in bed but identified how to provide food and liquids to a resident in a lying position in a geri-chair. The curriculum addressed the different consistencies of thickened liquids (nectar, honey) but failed to provide instruction related to the administration of thickened liquids. The DON stated the standard identified in the training guide would be the expectation for all staff to follow when feeding and/or giving liquids to residents. During interview with the speech therapist (ST) on 5/4/16 at 11:00 a.m. the ST stated it would be best practice to administer liquids and foods to any resident with a risk for aspiration in an upright position. The ST further stated she would not advise anyone to have liquids or foods while in a lying position whether they were at aspiration risk or not. The ST stated, " That would not be a safe practice " . The facility failed to provide evidence of how staff were trained when administering thickened liquids to residents at risk for aspiration and failed to have the the process identified on the care plan. The facility further placed R12 at risk for aspiration related to the lack of following standards of practice for administering medications and thickened liquids to a resident while positioned in lying position in bed.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		6/6/16

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F 329	Continued From page 23 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to monitor the effectiveness of anti-hypertensive medications for 1 of 1 resident (R18) who received multiple anti-hypertensive medications and did not have ongoing blood pressure (BP) recordings. Findings include: R18's most recent physician's progress note dated 3/24/16, identified active diagnoses including: coronary artery disease, hypertension (high blood pressure), chronic back pain, cerebral	F 329	F329 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states	

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F 329	Continued From page 24 vascular disease (CVA-stroke), recurrent falls, vascular dementia and chronic kidney disease. This progress note also include an assessment and plan related to the diagnosis of essential hypertension and the physician indicated an acceptable blood pressure (BP) range for R18 as 148/88 millimeters of mercury (mm Hg), which had been documented on the monthly flow sheet. R18's most recent physician orders dated 4/14/16, identified current medications as noted: Isosorbide Mononitrate (extended release) ER tablet 24 hour 30 milligrams (mg) 1.5 tablets by mouth daily for angina attacks, Norvasc tablet 5 mg by mouth for essential hypertension and Lopressor tablet 50 mg by mouth two times a day for essential hypertension. The pharmacy consultant note dated 1/13/16, indicated the following: [R18] has been experiencing elevated blood pressures lately, although there are also some very low results also; has been falling out of bed and BP checks following these incidents have been elevated; most recent BP's are: 110/58 (1/13), 187/102 and 166/89 on 1/12/16. R18's Norvasc medication was increased on 1/14/16, from 2.5 mg to 5 mg daily due to elevated BP's. Upon review of the BP flowsheet and progress notes it was noted that R2's BP was not followed-up until 1/29/16, (2 week after a medication increase). The next BP reading documented was 3/24/16, at 3:16 a.m. and measured 148/88 mm Hg. There were no documented BP readings from 1/29/16 thru 3/24/16. There was no evidence documented in the record indicating that ongoing BP readings had been evaluated to determine the	F 329	that with respect to: 1. Regarding R18 monitored blood pressures three times per day, once on each shift and were reported to physician for review. 2. Reviewed vital sign guidelines and reviewed change of condition charting and SBAR policy along with condition charging guidelines. DON will provide education to nursing staff on the above areas June 6, 2016. 3. DON or designee will monitor PCC for documentation and compliance with weekly blood pressures and monitor 20% of residents weekly for four weeks, then 10% of residents weekly for four weeks. The data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245371	A. BUILDING _____ B. WING _____	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW SENIOR LIVING	250 FIFTH STREET EAST TRACY, MN 56175

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 25	F 329		

effectiveness of the dosage increase and ascertain R18's response to treatment.

During an interview on 5/5/16, at 8:57 a.m. the director of nursing (DON) indicated the facility practice was to obtain monthly routine vital signs unless a physician orders indicated otherwise. The nursing assistants record the BP readings monthly on the resident's scheduled bath day.

During a telephone interview on 5/5/16, at 9:45 a.m. the facility's medical director (MD, who was also R18's primary physician) stated, "I would not like to see a BP out of the accepted high range for this age group (included R18). A BP of 150/90 is the goal, otherwise it will increase the risk for stroke." The MD further stated an elevated BP would require rechecking and stated he would expect a resident receiving an anti-hypertensive to have their BP monitored more frequently than monthly. He verified that monthly BP measurements were not frequent enough to be a useful tool to evaluate the effectiveness of the anti-hypertensive medication, indicating daily or every other day BP may be appropriate. The MD stated, "I was not aware the facility had not been monitoring R18's BPs more frequently." MD also stated it was difficult to evaluate the medication effectiveness when the BP recordings are conducted before/after the medication is administered. The MD indicated he had requested noon BP monitoring vs. early morning monitoring for those residents who were receiving anti-hypertensive medications.

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	245371	A. BUILDING _____ B. WING _____	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW SENIOR LIVING	250 FIFTH STREET EAST TRACY, MN 56175

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 26	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure all medications were administered for 1 of 9 residents (R12) observed during medication administration. This resulted in a medication error rate of 12%. Findings include. During observation of the evening medication pass on 5/2/16, at 7:00 p.m. trained medication assistant (TMA)-B prepared R12's bedtime medications. The following medications were set up by TMA-B: Zyprexa (antipsychotic) 5 milligrams (mg); Tylenol 500 mg, 2 tabs; and Aricept (dementia medication) 15 mg. After placing the medications into a plastic medication cup, TMA-B crushed the medications and placed them in applesauce. TMA-B transported the medications into R12's room and administered them with a spoon to R12. R12 remained lying in bed. TMA-B elevated the head of the bed to approximately 45 degrees but R12 slid down toward the foot of the bed and thus her head was not raised to the 45 degree level. After	F 332	F332 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Upon notification of medication error on 5/2/2016 by surveyor for R12, TMA-B was reassigned off medication pass until coaching and education was completed by DON on medication errors. 2. On June 6, 2016 Speech Therapy and dietary manager will provide further education for dysphasia diets and prevention of aspiration. 3. On May 26, 2016 and annually all TMA's and licensed nursing staff will	5/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245371	A. BUILDING _____ B. WING _____	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW SENIOR LIVING	250 FIFTH STREET EAST TRACY, MN 56175

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 27 administering the medications to R12, it was noted that TMA-B set the medication cup (medications/applesauce) on top of the medication administration cart. The cart was located in the hallway outside of R12's room. TMA-B documented in the medication administration record (MAR) that she had administered the medications. However, it was noted there was additional medication mixed with the applesauce remaining in the cup. The spoon used to administer the medication and applesauce mixture contained chunks of the mixture as did the bottom of the medication cup, which contained additional residue. During interview with TMA-B on 5/2/16, at 7:10 p.m. it was verified that not all of the medications were administered and consequently could not verify R12 had received the full dose of the prescribed medications. TMA-B indicated she did not realize she left so much medication in the cup. When interviewed on 5/2/16, at 7:30 p.m. the director of nursing services (DON) was made aware of the observation and stated staff were properly trained to administer medications and should ensure residents receive the full dosing as prescribed. During review of the facility policy for, General Dose Preparation and Medication Administration, Omnicare 2013, the following guidance was identified: 3. Dose Preparation: Facility should take all measures required by facility policy including, but not limited to the following: 3.8 Facility staff should crush oral medications only in accordance with pharmacy guidelines as set forth Appendix 16. Appendix 16 identified which med's	F 332	complete a medication administration refresher course and need to successfully pass a competency test. 4. Two TMA's will be randomly audited by DON or designee on one medication pass each week for 8 weeks, then two medication passes each month for two months. The data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.	

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PRAIRIE VIEW SENIOR LIVING	250 FIFTH STREET EAST TRACY, MN 56175

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F 332	Continued From page 28 could or could not be crushed but did not identify any information related to the administration of crushed medications in applesauce. The facility was unable to produce any policy related to the administration of medications in applesauce.	F 332		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the pharmacy consultant failed to report the lack of blood pressure monitoring to assess effectiveness for 1 of 1 resident (R18) reviewed who received multiple anti-hypertensive medications. Findings include: R18's most recent physician's progress note dated 3/24/16, identified active diagnoses including: coronary artery disease, hypertension (high blood pressure), chronic back pain, cerebral vascular disease (CVA-stroke), recurrent falls, vascular dementia and chronic kidney disease.	F 428	F428 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. By June 13, 2016 the administrator,	6/13/16

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F 428	Continued From page 29 This progress note also include an assessment and plan related to the diagnosis of essential hypertension and the physician indicated an acceptable blood pressure (BP) range for R18 as 148/88 millimeters of mercury (mm Hg), which had been documented on the monthly flow sheet. R18's most recent physician orders dated 4/14/16, identified current medications as noted: Isosorbide Mononitrate (extended release) ER tablet 24 hour 30 milligrams (mg) 1.5 tablets by mouth daily for angina attacks, Norvasc tablet 5 mg by mouth for essential hypertension and Lopressor tablet 50 mg by mouth two times a day for essential hypertension. The pharmacy consultant note dated 1/13/16, indicated the following: [R18] has been experiencing elevated blood pressures lately, although there are also some very low results also; has been falling out of bed and BP checks following these incidents have been elevated; most recent BP's are: 110/58 (1/13), 187/102 and 166/89 on 1/12/16; [R18] receiving Isosorbide Mononitrate ER- "this is an extended release medication and should not be crushed or chewed". R18's Norvasc medication was increased on 1/14/16, due to elevated BP's as documented by staff. Review of the medical record since the Norvasc had been increased revealed R18's BP had been recorded only 1 time in the following 2 months; from 1/29/16 to 3/24/16 there were no BP readings documented. . There was no other evidence documented in the record indicating that ongoing BP readings had been evaluated to determine the effectiveness of the dosage increase and ascertain R18's response to	F 428	director or nursing, and consulting pharmacist will review and revise policies and procedures for proper monitoring of medication usage, especially medications prescribed for hypertension control. Nursing staff will be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist will audit medication reviews on a monthly basis to ensure compliance. The data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.	

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F 428	Continued From page 30 treatment. Review of subsequent monthly pharmacy consultant notes dated 2/20/16, 3/20/16 and 4/20/16 lacked any further recommendations related to staff monitoring the effectiveness (BP readings) of the Norvasc medication since the dose had been increased. During an interview on 5/5/16, at 8:57 a.m. the director of nursing (DON) indicated the facility practice was to obtain monthly routine vital signs unless a physician orders indicated otherwise. The DON verified the pharmacy consultant had not identified nor recommended any increase BP monitoring after the Norvasc had been increased. During a telephone interview on 5/5/16, at 10:15 a.m. the pharmacy consultant indicated he had discussed with the DON and recommended weekly BP's would be sufficient monitoring for residents prescribed anti-hypertensive medications.	F 428		
F 441 SS=D	. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		6/6/16

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PRAIRIE VIEW SENIOR LIVING	250 FIFTH STREET EAST TRACY, MN 56175

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F 441	Continued From page 31 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the multi-use blood glucose meter was properly sanitized between use for 2 of 2 residents (R12, R23) who required blood sugar level monitoring and resided on the North and Central wings. Findings include: During observation on 5/2/16, at 7:00 p.m. trained	F 441	F441 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions	

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PRAIRIE VIEW SENIOR LIVING	250 FIFTH STREET EAST TRACY, MN 56175

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F 441	Continued From page 32 medication assistant (TMA)-B retrieved a blood glucose meter (glucometer), test strips and a lancet (pricking needle used to obtain blood) from the medication cart. TMA-B entered R12's room, donned gloves, conducted the blood sugar (BS) check and verbalized the results of the blood sugar (BS) to R12. After checking R12's blood sugar, TMA-B exited the room, walked to the medication cart, removed her soiled gloves and placed the glucometer in a plastic basket located on top of the cart. TMA-B then retrieved a 70% isopropyl alcohol wipe from the basket where the glucometer was stored and proceeded to cleanse the glucometer with the alcohol wipe. After she finished cleansing the glucometer, TMA-B returned the glucometer back into the plastic basket located on top of the medication administration cart which also stored the test strips, alcohol wipes and lancets. When interviewed on 5/2/16, at 7:15 p.m. TMA-B stated she always uses the alcohol wipes to cleanse the glucometer. TMA-B stated she is scheduled to work several days/week in the role of a TMA and frequently administers medications, which also includes conducting blood glucose testing. TMA-B stated she had checked R23's BS prior to conducting R12's blood sugar and had implemented the same procedure. She had cleansed the glucometer with the alcohol wipe after performing the blood glucose check for R23. TMA-B stated she had not been instructed to use anything different other than the alcohol wipes which were the only item available on the medication cart to cleanse the glucometer after use. TMA-B was assigned to the North and Central wings for the evening, which included checking the blood sugar levels for 2 residents, R12 and R23.	F 441	of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. On 5/2/2016 education to TMA-B was completed for disinfection procedures on glucometer use to follow manufacturer cleaning and disinfecting guidelines. On 5/3/2016 educations to remaining licensed nursing staff and TMA□s was completed for disinfection procedures on glucometer use to follow manufacturer cleaning and disinfecting guidelines. 2. On 5/3/2016 glucometers were ordered for all residents who use glucometers to prevent any sharing of glucometers in the future. 3. On June 6, 2016 DON or designee will educate all licensed nursed and TMA's to the manufacturers recommendations on cleaning of glucometers. 4. DON or designee will monitor proper cleaning techniques for glucometers by auditing 3 licensed staff or TMA's weekly for 6 weeks, then 4 licensed staff or TMA's monthly for two months. The data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245371	A. BUILDING _____ B. WING _____	05/05/2016

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PRAIRIE VIEW SENIOR LIVING	250 FIFTH STREET EAST TRACY, MN 56175

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F 441	Continued From page 33 When interviewed on 5/2/16, at 7:30 p.m. the director of nursing (DON) stated staff should be utilizing the Super Sani-Cloth before and after use when utilizing the glucometer equipment to monitor blood glucose levels. The facility policy for disinfecting the Arkray blood glucometer was identified by the DON as the manufacturer's cleaning and disinfecting guidelines. The instructions for cleaning and disinfecting were identified in the device handbook as follows: Cleaning guidelines: To clean the outside of the blood glucose meter, use a lint-free cloth dampened with soapy water or isopropyl alcohol (70%-80%). Disinfecting guidelines: To disinfect the meter, dilute 1 milliliter (ml) household bleach (5%-6% sodium Hypochlorite solution) in 9 ml of water to achieve a 1:10 dilution (finale concentration of 0.5%-0.6% sodium Hypochlorite). The solution can be used to dampen a paper towel (do not saturate towel). Then use the dampened towel to thoroughly wipe down the meter.	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain the condition of the ceiling tiles	F 465	F465 The preparation of the following plan of	6/3/16

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F 465	Continued From page 34 for 15 of 17 resident bathrooms located on all 3 wings of the facility. (100 wing room #: 102/104, 101/103, 105/107, 109/111; 200 wing room #: 202/204, 206/208, 207, 210/212, 211/213, 214/216; 300 wings room #: 301, 302/304, 303/305, 306/308, 307/309). Findings include: During observations on 5/2/16, at 2:20 p.m. through 5/5/16, at 2:00 p.m. the following resident bathrooms had ceiling tiles which were stained and/or discolored: 100 wing rooms: 102/104, 101/103, 105/107, 109/111; 200 wing rooms: 202/204, 206/208, 207, 210/212, 211/213, 214/216; and 300 wing rooms: 301, 302/304, 303/305, 306/308, 307/309. A tour was conducted with the maintenance director and the regional director on 5/5/16, at 11:39 a.m. It was confirmed the stains on the ceiling tiles in resident bathrooms were a result of water damage related to snow getting into the vents and melting. The maintenance director stated on 5/5/16, at 11:45 a.m. the ventilation system located on the roof of the building had not been inspected since 2014 by the ventilation company.	F 465	correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. All ceiling tiles found to be stained and/or discolored will be replaced with new tiles by June 3, 2016, by Maintenance Supervisor 2. Each quarter an inspection of ceiling tiles will be conducted to identify tiles that may need to be replaced by Maintenance Supervisor. An inspection work order will be placed on the Direct Supply TELS maintenance program for each quarter and monitored each quarter for two quarters by ED. The data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245371	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW SENIOR LIVING	**250 FIFTH STREET EAST** **TRACY, MN 56175**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on May 03, 2016. At the time of this survey, Prairie View Healthcare Center was found not to be 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/26/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245371	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VIEW SENIOR LIVING	**250 FIFTH STREET EAST** **TRACY, MN 56175**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Prairie View Healthcare Center was constructed in 1965, is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. Additionally, all resident rooms are equipped with battery-operated smoke alarms. The facility has a capacity of 55 beds and had a census of 43 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an	K 025		5/31/16

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	245371	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/03/2016**

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K 025	Continued From page 2 atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 FINDINGS INCLUDE: During Facility Inspection on May 03, 2016, between the hours of 09:00 AM and 12:30 PM, open penetrations around cables were observed above the lay-in ceiling on the North Wing Smoke Barrier. This was also observed by the Director of Environmental Services.	K 025	K025 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. On May 31, 2016 the open penetration around cables which were observed above the lay-in ceiling on the North Wing Smoke Barrier was filled with fire protection sealant that is rated for at least one half hour fire resistance. The data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent	K 050		6/3/16

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K 050	Continued From page 3 persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 FINDINGS INCLUDE: During Facility Documentation Review on May 03, 2016,between the hours of 09:00 AM and 12:30 PM, documentation review revealed that the night shift (10pm-6am) fire drill was not conducted during the 3rd quarter (Jul-Sep) and the 4th quarter (Oct-Dec) of 2015. This was also observed by the Director of Environmental Services.	K 050	K050 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. By June 3, 2016 all fire drills and required shifts will be verified and placed on the Direct Supply TELS monthly maintenance program. 2. ED will monitor monthly for 6 months to ensure correct shift or fire drill has been complete. The data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.	

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
May 19, 2016

Mr. Brian Henrichs, Administrator
Prairie View Senior Living
250 Fifth Street East
Tracy, MN 56175

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5371026

Dear Mr. Henrichs:

The above facility was surveyed on May 2, 2016 through May 5, 2016 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, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 contact Kathryn Serie, Unit Supervisor at (507) 476-4233.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00342	A. BUILDING: _____ B. WING _____	05/05/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 5/2/16 through 5/5/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for	2 265		6/6/16

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2 265	Continued From page 2 example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of elevated blood pressure recordings for 1 of 6 residents (R18) reviewed for unnecessary drugs. Findings include: R18's most recent physician's progress note dated 3/24/16, identified active diagnoses including: coronary artery disease, hypertension (high blood pressure), chronic back pain, cerebral vascular disease (CVA-stroke), recurrent falls, vascular dementia and chronic kidney disease. This progress note also include an assessment and plan related to the diagnosis of essential hypertension and the physician indicated an acceptable blood pressure (BP) range for R18 as 148/88 millimeters of mercury (mm Hg), which had been documented on the monthly flow sheet. R18's most recent physician orders dated 4/14/16, identified current medications as noted: Isosorbide Mononitrate (extended release) ER tablet 24 hour 30 milligrams (mg) 1.5 tablets by	2 265	Completed	

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2 265	Continued From page 3	2 265		

mouth daily for angina attacks, Norvasc tablet 5 mg by mouth for essential hypertension and Lopressor tablet 50 mg by mouth two times a day for essential hypertension.

R18 had a series of falls in April 2016 with multiple documented post fall BP's ranging from 155/84 mm Hg to 219/108 mm Hg. There was no evidence there had been any additional BP monitoring initiated when the BP medication dosage was increased on 1/14/16; Norvasc 5 mg was ordered. There was also no evidence the physician had been immediately notified of the 4/12/16, BP measuring 219/108 mm Hg in accordance with the Change in Condition (SBAR) procedure which directed to report a systolic BP >210 mm Hg immediately. There was no documented evidence in R18's record acknowledging a pattern of elevated blood pressures nor documented evaluation of whether the current drug regimen was effective.

During a telephone interview on 5/5/16, at 9:45 a.m. the facility's medical director (MD, who was also R18's primary physician) stated, "I would not like to see a BP out of the accepted high range for this age group (which included R18). A BP of 150/90 is the goal, otherwise it will increase the risk for stroke." The MD further verified he was unaware of R18's elevated BP reading and stated he would expect to review a BP flow sheet, run some labs or change medications had he been aware. The MD further stated an elevated BP would require rechecking and stated he would expect a resident receiving an anti-hypertensive to have their BP monitored more frequently than monthly. The MD stated, "I was not aware the facility had not been monitoring R18's BPs more frequently." MD also stated the time of day the measurement of the BP recording for R18 could

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2 265	Continued From page 4 determine when the anti-hypertensive medication is administered. During an interview on 5/5/16, at 8:57 a.m. the director of nursing (DON) indicated the nursing staff were to follow the facility's protocol for Change in Condition (SBAR) to report changes in condition. The facility's procedure titled Change in Condition (SBAR) directed staff to immediately notify the nurse practitioner or MD re., blood pressure, systolic BP>210 mmHg. The procedure indicated the SBAR tool was to be used by the nurse caring for the resident with a change in condition. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure responsible parties and the physician are notified of changes.The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 265		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		6/6/16

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2 565	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services as directed by the written plan of care for 3 of 3 residents (R10, R13, R25) reviewed for rehabilitation and restorative needs, and who had limitations to functional range of motion (ROM). Findings include: R10 had diagnoses identified on the care plan dated 3/29/16, including: history of cerebral infarction, dementia, osteoporosis, polyosteoarthritis and hemiplegia. During observation on 5/2/16, at 2:22 p.m. R10 was seated in a wheelchair in his room. R10 was noted to have a contracted left hand and arm which he stated had been contracted for a long time since he'd experienced a cardiovascular accident (CVA). The care plan dated 3/29/16, identified R10 had an activities of daily living (ADL) self care performance deficit related to CVA, hemiplegia and dementia. The care plan also indicated R10 had limited mobility, with a goal the resident would maintain ability to transfer with assist of 2 staff, or 2 staff and EZ stand (mechanical lift), to maintain his current level of function. The care plan identified R10 was on a nursing rehabilitation program that included: (1) Active range of motion (ROM) utilizing the Omnicycle (Exercise bike). (2) Stretching of both Lower extremities and both hamstrings. (3) Place feet up on black stool for 5 minutes. (4) Standing in EZ stand up to 5 minutes if	2 565	Completed	

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2 565	Continued From page 6	2 565		

cooperative to work on the use of arms to pull up and use of legs for weight bearing and posture.
During review of the restorative nursing logs for the month of April 2016, documentation on R10's log identified the following data: (1) active ROM utilizing the Omnicycle- 5 out of 30 opportunities for the month and (2) 5 minutes exercises with use of the EZ stand -4 out of 30 opportunities for the month. The remaining days of the month were documented that R10 had either refused and/or was unavailable.
During review of R10's restorative nursing logs for the month of March 2016, documentation identified: (1) received active range of motion utilizing the Omnicycle-3 out of 31 opportunities for the month and (2) received 5 minutes exercises with use of the EZ stand-3 of 31 opportunities for the month. The remaining days were documented that R10 had either refused and/or was not available.
Documentation on R10's restorative logs for the past 6 months (December 2015-May 2016) revealed R10 had not received the restorative program as directed by the care plan.
When interviewed on 5/4/16, at 1:04 p.m. restorative aide (RA)-A stated R10 should use the Omnicycle 3-5 times/week and have upper extremity and lower extremity exercises while in the EZ stand daily. RA-A stated the facility had pulled the restorative position from the schedule when the census was low in April and May 2016. RA-A stated there were many times when staffing was short on the floor, the restorative person would be assigned to providing personal cares versus providing restorative aide services. RA-A stated rehab services ceased for awhile when the census remained low.
R13 had diagnoses identified on the care plan dated 2/12/16, including adult failure to thrive,

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2 565	Continued From page 7 major depression, systemic lupus, lumbar vertebra fracture, dementia and osteoporosis. During observation on 5/2/16, at 5:28 p.m. R13 was seated in her wheelchair at the dining room table. R13 was noted to have bilateral hand contractures. R13 was unable to open her left hand without using her right hand to pull her fingers from the palm of her hand. During review of R13's care plan dated 2/12/16, it identified R13 had limited physical mobility related to a history of 2nd lumbar compression fracture and osteoporosis. The care plan goal identified R13 would maintain level of mobility by ambulating 25 feet through the next review date and would maintain current level of function through the review date. The care plan for R13 identified the following restorative rehabilitation interventions: (1) Active range of motion (ROM) program identified R13 would complete any of the following: Seated bilateral lower extremity (BLE) exercises with 1 pound weight. Maintenance/wellness/restorative therapy: nursing rehab program as patient tolerates. Follow exercise sheet. Use Omnicycle arm bike as needed for ROM of bilateral upper extremities (BUE). (2) PROM/splint care: Use bilateral resting hand splints in morning, afternoon and between meals. Sheep skin palm protectors on at night. Warm wash cloth or water basin before PROM of bilateral hands for 10-20 repetitions on each hand for extension. Goal: Decrease flexion contractures of BUE's. During review of R13's restorative nursing logs for the month of April 2016, documentation identified R13 received restorative services for active range of motion to BUE and BLE utilizing	2 565		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 8 the Omnicycle 4 out of 30 opportunities for the month. The remaining days of the month were documented that R13 either refused and/or was unavailable. During review of R13's restorative nursing logs for month of March 2016, documentation identified she received restorative services for active range of motion to BUE and BLE utilizing the Omnicycle 0 out of 31 opportunities for the month. The remaining days of the month were documented that R13 either refused and/or was unavailable. Documentation reviewed on the restorative logs for the past 6 months (December 2015-May 2016) indicated R13 had not received a restorative program as directed by the care plan. When interviewed on 5/4/16, at 1:04 p.m. RA-A stated R13 should use the Omnicycle 3-5 times a week and should have AROM to bilateral hands 5 days/week. R25 had diagnoses identified on the care plan dated 4/8/16, including: heart failure, anxiety, depression, right femoral neck fracture with partial repair (4/2015), osteoporosis, history of humeral fracture with decreased mobility, post-herpatic neuralgia, and history of injury to the right third and fourth fingers related to fall. During observation on 5/5/16, at 9:46 a.m. R25 was noted have her right hand folded in he lap with contracture while seated in the dining room. R25 was noted to wheel the wheelchair with her left hand and feet while her right hand remained resting on her lap. During review of R25's care plan dated 4/18/16, it identified that R25 had limited physical mobility. The care plan identified R25 would maintain level of mobility through the next review date with the following interventions in the nursing rehabilitation program: (1) Active ROM Program with pink therapy-putty	2 565		

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2 565	Continued From page 9 exercises (with pegs removed). Right hand pushing/pulling x 10 each way. Digi-flexors right hand x 5 minutes. The goal was identified as maintenance of to apply hand splint on the right hand. (2) Active ROM Program with use of Omnicycle 10-15 minutes for legs. May vary according to any pain complaints. The goal identified for the program was to maintain strength for transfers with one assist limited physical mobility related to a history of 2nd lumbar compression fracture and osteoporosis. During review of R25's restorative nursing logs for the month of April 2016, documentation identified she received restorative services for active range of motion utilizing the Omnicycle 2 out of 30 opportunities for the month and received ROM exercises to her hands 0 of 30 opportunities for the month. The remaining days of the month were documented that R10 either refused or was unavailable and/or was left undocumented. During review of R25's restorative nursing logs for the month of March 2016, documentation identified she received restorative services for active ROM utilizing the Omnicycle 4 out of 30 opportunities for the month and received ROM exercises to her hands 0 of 30 opportunities for the month. The remaining days of the month were documented that R10 either refused or was unavailable, or was left undocumented. Documentation reviewed on the restorative logs for the past 6 months (December 2015-May 2016) indicated R25 had not received a restorative program as directed by the care plan. When nursing assistants (NA)- B, NA-C and NA-F were interviewed on 5/4/16, at 2:00 p.m. they stated they did not have the time to implement the restorative nursing duties when the restorative aide was removed from those duties	2 565		

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2 565	Continued From page 10 to assist them with resident cares. They all verified the NA's did not complete the restorative programs during the time when the resident census was low. When interviewed on 5/5/16, at 8:12 a.m. the director of nursing (DON) verified the RA had been removed from the restorative program from the time period 3/29/16 through 4/21/16, related to staffing changes affected by low resident census. The DON further verified sometimes the RA was pulled from rehab to cover for call-ins to perform NA cares. The DNS verified the census was low the past month and the RA was utilized on the floor instead of the RA position. The DNS further stated the NA's caring for the residents should conduct the restorative exercises during cares but verified the logs indicated the rehabilitation program was not documented to support completion of the services. During a follow-up interview with the RA-A on 5/5/16, at 9:18 a.m. she indicated she was asked to provide personal cares for resident's today instead of providing restorative care due to a different staff calling in ill. The RA-A stated she is unsure if she would be able to do restorative program. When interviewed on 5/5/16, at 9:38 a.m. the DON verified the restorative aide was re-assigned to work on the floor (to provide personal cares) due to a NA who failed to show up for work today. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff	2 565		

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2 565	Continued From page 11 and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. SUGGESTED METHOD OF CORRECTION: TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the care plan for 2 of 4 residents (R12, R2) reviewed for accidents	2 570	Completed	6/6/16

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2 570	Continued From page 12 and who received thickened liquids and were at risk for aspiration/choking. Findings include: R12 had diagnoses identified on the care plan dated 3/24/16, that included: Alzheimer's disease, dementia, cerebrovascular disease and hypertension. R12's care plan dated 3/24/16, identified R12 at risk for aspiration and identified a prescribed diet which included nectar consistency thickened liquids, including nectar thickened liquids at bedside. The care plan goal was for R12 to be free of aspiration over the next quarter. During observation of the evening medication pass and resident cares on 5/2/16, at 7:00 p.m. trained medication assistant (TMA)-B prepared R12's 7:00 p.m. medications. TMA-B prepared the following medications for R12: Zyprexa (anti-psychotic) 5 milligrams (mg); Tylenol 500 mg- 2 tabs; and Aricept (dementia medication) 15 mg. After placing the medications in a plastic medication cup, TMA-B crushed the medications and mixed them in applesauce. TMA-B then transported the medications into R12's room to administer them while R12 was lying in bed. TMA-B elevated the head of the bed to approximately 45 degrees. However, R12 slid down in the bed with her head toward the foot of the bed. Subsequently, R12's head was not elevated to the 45 degree angle the TMA-B had attempted. After administration of these prepared medications, TMA-B administered thickened liquids while R12 remained lying on her back in bed. positioned at less than a 45 degree angle. Immediately after the noted observation, at	2 570		

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2 570	Continued From page 13	2 570		

approximately 7:15 p.m., the director of nursing (DON) was interviewed about the observation related to R12 receiving thickened liquids while lying in bed. The DON stated staff should know that the resident's head of the bed should be elevated to 90 degrees (not 45 degrees) and also ensure the resident is maintained in an upright position while administering medications and/or liquids. The DON also verified R12 was at risk for aspiration.

When interviewed on 5/4/16, at 10:29 a.m. registered nurse (RN)-C stated R12 was at risk for aspiration and should be positioned sitting upright and should be alert during the administration of thickened liquids. RN-C reiterated R12 would be at risk for potential aspiration if not sitting upright. RN-C confirmed the care plan had not been revised to include staff guidance related to the appropriate position R12 should be when lying in bed during the administration of liquids and/or medications to prevent aspiration.

Diagnoses listed on R2's plan of care dated 12/21/15, included: cerebrovascular accident (CA) with aphasia and hemiparesis, Alzheimer's disease, failure to thrive, dysphasia and anorexia.

The significant change in status Minimum Data Set (MDS) assessment dated 2/17/16, indicated R2 receives a mechanically altered diet and has severely impaired cognition. The MDS identified R2 as receiving the hospice benefit and requires total assistance with all of her activities of daily living (ADL).

R2's plan of care dated/revised 12/21/15, identified: (1) Nectar thickened liquids at the bedside; and (2) Provide nectar thickened liquids

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2 570	Continued From page 14 of choice with meals, with meds and with snacks. The plan of care had not been updated to include the change in consistency of the thickened liquids from nectar to a honey consistency. The nursing progress notes dated 4/12/16, identified that R2 had difficulty swallowing and had been provided honey thickened liquids; documentation indicated that staff had to stop feeding R2 related to coughing. A communication sheet for the kitchen staff dated 4/12/16, indicated a (3) three day trial per hospice for R2 to use honey thickened liquid. A copy of residents who received thickened liquid was posted in the kitchen and nectar thickened liquids was crossed out and honey thickened added to R2's name. Review of the hospice note dated 4/12/16, also identified that R2's dysphagia is increasing and is now on honey thickened liquids, at times staff need to stop feeding her related to coughing. When interviewed on 5/3/16, at 12:27 p.m. the dietary manager (DM) reported that hospice changed the thickened liquid consistency from nectar to a honey consistency due to staff concerns during meal time assistance with feeding. SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for resident care plan development for the utilization of thickened liquids. Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor the care plan to ensure revisions are completed timely. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 570		

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2 830	Continued From page 15	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure thickened liquids and medications were administered in a safe manner to prevent aspiration for 1 of 3 residents (R12) reviewed who were at risk for choking. Findings include: R12's care plan dated 3/24/16, identified diagnoses including: Alzheimer's disease, dementia, cerebrovascular disease and hypertension. R12's care plan dated 3/24/16, identified R12 as at risk for aspiration and identified a prescribed diet to include nectar consistency thickened liquids, including liquids at the bedside. The care plan goal was for R12 to be free of aspiration	2 830	Completed	6/6/16

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2 830	Continued From page 16 over the next quarter. During observation of the evening medication pass and resident cares on 5/2/16, at 7:00 p.m. trained medication assistant (TMA)-B prepared R12's 7:00 p.m. medications. TMA-B prepared the following medications for R12: Zyprexa (antipsychotic) 5 milligrams (mg); Tylenol 500 mg- 2 tabs; and Aricept (dementia medication) 15 mg. After placing the medications in a plastic medication cup, TMA-B crushed the medications and mixed them in applesauce. TMA-B then transported the medications into R12's room to administer them while R12 was lying in bed. TMA-B elevated the head of the bed to approximately 45 degrees. However, R12 slid down in the bed with her head toward the foot of the bed. Subsequently, R12's head was not elevated to the 45 degree angle the TMA-B had attempted. After administration of these prepared medications, TMA-B administered thickened liquids while R12 remained lying on her back in bed. positioned at less than a 45 degree angle. Immediately after the noted observation, at approximately 7:15 p.m., the director of nursing (DON) was interviewed about the observation related to R12 receiving thickened liquids while lying in bed. The DON stated staff should know that the resident's head of the bed should be elevated to 90 degrees (not 45 degrees) and also ensure the resident is maintained in an upright position while administering medications and/or liquids. The DON also verified R12 was at risk for aspiration. During interview with registered nurse (RN)-D on 5/3/16, at 3:00 p.m. RN-D stated R12 had thickened liquids at her bedside and staff should provide the liquids to R12 while she is in a seated	2 830		

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2 830	Continued From page 17 position. When interviewed on 5/4/16, at 10:29 a.m. registered nurse (RN)-C stated R12 was at risk for aspiration and should be placed in a position sitting upright and be alert during the administration of thickened liquids. RN-C reiterated R12 would be at risk for potential aspiration if not sitting upright. RN-C stated the care plan lacked guidance to direct staff as to which position R12 should be in when laying in bed during administration of liquids or medications. During interview with the DON on 5/4/16, at 10:40 a.m. the surveyor requested the facility policy related to the administration of thickened liquids. The DON submitted the nursing assistant training curriculum (Hartman's Nursing Assistant Care, 1994), which identified how nursing assistants should feed residents. The curriculum identified the following: 8. Properly positioning residents for eating. a. Usually the proper positioning is upright, at a 90 degree angle. This helps prevent swallowing problems. Residents who use geri-chairs (reclining chairs on wheels) should be upright, no reclined, while eating. The curriculum did not identify how to administer foods or liquids for a resident in bed but identified how to provide food and liquids to a resident in a lying position in a geri-chair. The curriculum addressed the different consistencies of thickened liquids (nectar, honey) but failed to provide instruction related to the administration of thickened liquids. The DON stated the standard identified in the training guide would be the expectation for all staff to follow when feeding and/or giving liquids to residents.	2 830		

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2 830	Continued From page 18 During interview with the speech therapist (ST) on 5/4/16 at 11:00 a.m. the ST stated it would be best practice to administer liquids and foods to any resident with a risk for aspiration in an upright position. The ST further stated she would not advise anyone to have liquids or foods while in a lying position whether they were at aspiration risk or not. The ST stated, " That would not be a safe practice " . The facility failed to provide evidence of how staff were trained when administering thickened liquids to residents at risk for aspiration and failed to have the the process identified on the care plan. The facility further placed R12 at risk for aspiration related to the lack of following standards of practice for administering medications and thickened liquids to a resident while positioned in lying position in bed. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and re-educate all staff on the policies and procedures to ensure that all resident's health issues; including thickened liquids offered are properly monitored. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be	2 895		6/6/16

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2 895	Continued From page 19 implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the assessed treatment and services for 3 of 3 residents (R10, R13, R25) reviewed who had limited range of motion (ROM). Findings include: R10 had diagnoses identified on the care plan dated 3/29/16, including: history of cerebral infarction, dementia, osteoporosis, polyosteoarthritis and hemiplegia. During observation on 5/2/16, at 2:22 p.m. R10 was seated in a wheelchair in his room. R10 was noted to have a contracted left hand and arm which he stated had been contracted for a long time since he'd experienced a cardiovascular accident (CVA). The care plan dated 3/29/16, identified R10 had an activities of daily living (ADL) self care performance deficit related to CVA, hemiplegia and dementia. The care plan also indicated R10 had limited mobility, with a goal the resident would maintain ability to transfer with assist of 2	2 895	Completed	

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2 895	Continued From page 20	2 895		

staff, or 2 staff and EZ stand (mechanical lift), to maintain his current level of function. The care plan identified R10 was on a nursing rehabilitation program that included:
(1) Active range of motion (ROM) utilizing the Omnicycle (Exercise bike).
(2) Stretching of both Lower extremities and both hamstrings.
(3) Place feet up on black stool for 5 minutes.
(4) Standing in EZ stand up to 5 minutes if cooperative to work on the use of arms to pull up and use of legs for weight bearing and posture.
During review of the restorative nursing logs for the month of April 2016, documentation on R10's log identified the following data: (1) active ROM utilizing the Omnicycle- 5 out of 30 opportunities for the month and (2) 5 minutes exercises with use of the EZ stand -4 out of 30 opportunities for the month. The remaining days of the month were documented that R10 had either refused and/or was unavailable.
During review of R10's restorative nursing logs for the month of March 2016, documentation identified: (1) received active range of motion utilizing the Omnicycle-3 out of 31 opportunities for the month and (2) received 5 minutes exercises with use of the EZ stand-3 of 31 opportunities for the month. The remaining days were documented that R10 had either refused and/or was not available.
Documentation on R10's restorative logs for the past 6 months (December 2015-May 2016) revealed R10 had not received the restorative program as directed by the care plan.
When interviewed on 5/4/16, at 1:04 p.m. restorative aide (RA)-A stated R10 should use the Omnicycle 3-5 times/week and have upper extremity and lower extremity exercises while in the EZ stand daily. RA-A stated the facility had

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2 895	Continued From page 21 pulled the restorative position from the schedule when the census was low in April and May 2016. RA-A stated there were many times when staffing was short on the floor, the restorative person would be assigned to providing personal cares versus providing restorative aide services. RA-A stated rehab services had ceased for awhile when the census remained low. R13 had diagnoses identified on the care plan dated 2/12/16, including adult failure to thrive, major depression, systemic lupus, lumbar vertebral fracture, dementia and osteoporosis. During observation on 5/2/16, at 5:28 p.m. R13 was seated in her wheelchair at the dining room table. R13 was noted to have bilateral hand contractures. R13 was unable to open her left hand without using her right hand to pull her fingers from the palm of her hand. During review of R13's care plan dated 2/12/16, it identified R13 had limited physical mobility related to a history of 2nd lumbar compression fracture and osteoporosis. The care plan goal identified R13 would maintain level of mobility by ambulating 25 feet through the next review date and would maintain current level of function through the review date. The care plan for R13 identified the following restorative rehabilitation interventions: (1) Active range of motion (ROM) program identified R13 would complete any of the following: Seated bilateral lower extremity (BLE) exercises with 1 pound weight. Maintenance/wellness/restorative therapy: nursing rehab program as patient tolerates. Follow exercise sheet. Use Omnicycle arm bike as needed for ROM of bilateral upper extremities (BUE). (2) PROM/splint care: Use bilateral resting hand	2 895		

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2 895	Continued From page 22 splints in morning, afternoon and between meals. Sheep skin palm protectors on at night. Warm wash cloth or water basin before PROM of bilateral hands for 10-20 repetitions on each hand for extension. Goal: Decrease flexion contractures of BUE's. During review of R13's restorative nursing logs for the month of April 2016, documentation identified R13 received restorative services for active range of motion to BUE and BLE utilizing the Omnicycle 4 out of 30 opportunities for the month. The remaining days of the month were documented that R13 either refused and/or was unavailable. During review of R13's restorative nursing logs for month of March 2016, documentation identified she received restorative services for active range of motion to BUE and BLE utilizing the Omnicycle 0 out of 31 opportunities for the month. The remaining days of the month were documented that R13 either refused and/or was unavailable. Documentation reviewed on the restorative logs for the past 6 months (December 2015-May 2016) indicated R13 had not received a restorative program as directed by the care plan. When interviewed on 5/4/16, at 1:04 p.m. RA-A stated R13 should use the Omnicycle 3-5 times a week and should have AROM to bilateral hands 5 days/week. R25 had diagnoses identified on the care plan dated 4/8/16, including: heart failure, anxiety, depression, right femoral neck fracture with partial repair (4/2015), osteoporosis, history of humeral fracture with decreased mobility, post-herpatic neuralgia, and history of injury to the right third and fourth fingers related to fall. During observation on 5/5/16, at 9:46 a.m. R25 was noted have her right hand folded in he lap with contracture while seated in the dining room.	2 895		

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2 895	Continued From page 23 R25 was noted to wheel the wheelchair with her left hand and feet while her right hand remained resting on her lap. During review of R25's care plan dated 4/18/16, it identified that R25 had limited physical mobility. The care plan identified R25 would maintain level of mobility through the next review date with the following interventions in the nursing rehabilitation program: (1) Active ROM Program with pink therapy-putty exercises (with pegs removed). Right hand pushing/pulling x 10 each way. Digi-flexors right hand x 5 minutes. The goal was identified as maintenance of to apply hand splint on the right hand. (2) Active ROM Program with use of Omnicycle 10-15 minutes for legs. May vary according to any pain complaints. The goal identified for the program was to maintain strength for transfers with one assist limited physical mobility related to a history of 2nd lumbar compression fracture and osteoporosis. During review of R25's restorative nursing logs for the month of April 2016, documentation identified she received restorative services for active range of motion utilizing the Omnicycle 2 out of 30 opportunities for the month and received ROM exercises to her hands 0 of 30 opportunities for the month. The remaining days of the month were documented that R10 either refused or was unavailable and/or was left undocumented. During review of R25's restorative nursing logs for the month of March 2016, documentation identified she received restorative services for active ROM utilizing the Omnicycle 4 out of 30 opportunities for the month and received ROM exercises to her hands 0 of 30 opportunities for the month. The remaining days of the month were documented that R10 either refused or was	2 895		

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2 895	Continued From page 24 unavailable, or was left undocumented. Documentation reviewed on the restorative logs for the past 6 months (December 2015-May 2016) indicated R25 had not received a restorative program as directed by the care plan. When nursing assistants (NA)- B, NA-C and NA-F were interviewed on 5/4/16, at 2:00 p.m. they stated they did not have the time to implement the restorative nursing duties when the restorative aide was removed from those duties to assist them with resident cares. They all verified the NA's did not complete the restorative programs during the time when the resident census was low. When interviewed on 5/5/16, at 8:12 a.m. the director of nursing (DON) verified the RA had been removed from the restorative program from the time period 3/29/16 through 4/21/16, related to staffing changes affected by low resident census. The DON further verified sometimes the RA was pulled from rehab to cover for call-ins to perform NA cares. The DNS verified the census was low the past month and the RA was utilized on the floor instead of the RA position. The DNS further stated the NA's caring for the residents should conduct the restorative exercises during cares but verified the logs indicated the rehabilitation program was not documented to support completion of the services. During a follow-up interview with the RA-A on 5/5/16, at 9:18 a.m. she indicated she was asked to provide personal cares for resident's today instead of providing restorative care due to a different staff calling in ill. The RA-A stated she is unsure if she would be able to do restorative program. When interviewed on 5/5/16, at 9:38 a.m. the	2 895		

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2 895	Continued From page 25 DON verified the restorative aide was re-assigned to work on the floor (to provide personal cares) due to a NA who failed to show up for work today. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk of a decline in range of motion. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control	21390		5/5/16

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21390	Continued From page 26 practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the multi-use blood glucose meter was properly sanitized between use for 2 of 2 residents (R12, R23) who required blood sugar level monitoring and resided on the North and Central wings. Findings include: During observation on 5/2/16, at 7:00 p.m. trained medication assistant (TMA)-B retrieved a blood glucose meter (glucometer), test strips and a lancet (pricking needle used to obtain blood) from the medication cart. TMA-B entered R12's room, donned gloves, conducted the blood sugar (BS) check and verbalized the results of the blood sugar (BS) to R12. After checking R12's blood sugar, TMA-B exited the room, walked to the medication cart, removed her soiled gloves and placed the glucometer in a plastic basket located on top of the cart. TMA-B then retrieved a 70% isopropyl alcohol wipe from the basket where the glucometer was stored and proceeded to cleanse the glucometer with the alcohol wipe. After she finished cleansing the glucometer, TMA-B returned the glucometer back into the plastic basket located on top of the medication	21390	Completed	

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21390	Continued From page 27 administration cart which also stored the test strips, alcohol wipes and lancets. When interviewed on 5/2/16, at 7:15 p.m. TMA-B stated she always uses the alcohol wipes to cleanse the glucometer. TMA-B stated she is scheduled to work several days/week in the role of a TMA and frequently administers medications, which also includes conducting blood glucose testing. TMA-B stated she had checked R23's BS prior to conducting R12's blood sugar and had implemented the same procedure. She had cleansed the glucometer with the alcohol wipe after performing the blood glucose check for R23. TMA-B stated she had not been instructed to use anything different other than the alcohol wipes which were the only item available on the medication cart to cleanse the glucometer after use. TMA-B was assigned to the North and Central wings for the evening, which included checking the blood sugar levels for 2 residents, R12 and R23. When interviewed on 5/2/16, at 7:30 p.m. the director of nursing (DON) stated staff should be utilizing the Super Sani-Cloth before and after use when utilizing the glucometer equipment to monitor blood glucose levels. The facility policy for disinfecting the Arkray blood glucometer was identified by the DON as the manufacturer's cleaning and disinfecting guidelines. The instructions for cleaning and disinfecting were identified in the device handbook as follows: Cleaning guidelines: To clean the outside of the blood glucose meter, use a lint-free cloth dampened with soapy water or isopropyl alcohol (70%-80%). Disinfecting guidelines: To disinfect the meter,	21390		

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21390	Continued From page 28 dilute 1 milliliter (ml) household bleach (5%-6% sodium Hypochlorite solution) in 9 ml of water to achieve a 1:10 dilution (finale concentration of 0.5%-0.6% sodium Hypochlorite). The solution can be used to dampen a paper towel (do not saturate towel). Then use the dampened towel to thoroughly wipe down the meter. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice staff related to the standard of practice when cleaning the glucometer between resident use and then conduct periodic audits to ensure facility policy is implemented consistently. The results of the audit could be reported to quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the	21530		6/13/16

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21530	Continued From page 29 pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the pharmacy consultant failed to report the lack of blood pressure monitoring to assess effectiveness for 1 of 1 resident (R18) reviewed who received multiple anti-hypertensive medications. Findings include: R18's most recent physician's progress note dated 3/24/16, identified active diagnoses including: coronary artery disease, hypertension (high blood pressure), chronic back pain, cerebral vascular disease (CVA-stroke), recurrent falls, vascular dementia and chronic kidney disease. This progress note also include an assessment	21530	Completed	

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21530	Continued From page 30 and plan related to the diagnosis of essential hypertension and the physician indicated an acceptable blood pressure (BP) range for R18 as 148/88 millimeters of mercury (mm Hg), which had been documented on the monthly flow sheet. R18's most recent physician orders dated 4/14/16, identified current medications as noted: Isosorbide Mononitrate (extended release) ER tablet 24 hour 30 milligrams (mg) 1.5 tablets by mouth daily for angina attacks, Norvasc tablet 5 mg by mouth for essential hypertension and Lopressor tablet 50 mg by mouth two times a day for essential hypertension. The pharmacy consultant note dated 1/13/16, indicated the following: [R18] has been experiencing elevated blood pressures lately, although there are also some very low results also; has been falling out of bed and BP checks following these incidents have been elevated; most recent BP's are: 110/58 (1/13), 187/102 and 166/89 on 1/12/16; [R18] receiving Isosorbide Mononitrate ER- "this is an extended release medication and should not be crushed or chewed". R18's Norvasc medication was increased on 1/14/16, due to elevated BP's as documented by staff. Review of the medical record since the Norvasc had been increased revealed R18's BP had been recorded only 1 time in the following 2 months; from 1/29/16 to 3/24/16 there were no BP readings documented. . There was no other evidence documented in the record indicating that ongoing BP readings had been evaluated to determine the effectiveness of the dosage increase and ascertain R18's response to treatment.	21530		

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21530	Continued From page 31 Review of subsequent monthly pharmacy consultant notes dated 2/20/16, 3/20/16 and 4/20/16 lacked any further recommendations related to staff monitoring the effectiveness (BP readings) of the Norvasc medication since the dose had been increased. During an interview on 5/5/16, at 8:57 a.m. the director of nursing (DON) indicated the facility practice was to obtain monthly routine vital signs unless a physician orders indicated otherwise. The DON verified the pharmacy consultant had not identified nor recommended any increase BP monitoring after the Norvasc had been increased. During a telephone interview on 5/5/16, at 10:15 a.m. the pharmacy consultant indicated he had discussed with the DON and recommended weekly BP's would be sufficient monitoring for residents prescribed anti-hypertensive medications. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage, especially medications prescribed for hypertension control. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General	21535		6/6/16

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21535	Continued From page 32 Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to monitor the effectiveness of anti-hypertensive medications for 1 of 1 resident (R18) who received multiple anti-hypertensive medications and did not have ongoing blood pressure (BP) recordings. Findings include: R18's most recent physician's progress note dated 3/24/16, identified active diagnoses including: coronary artery disease, hypertension (high blood pressure), chronic back pain, cerebral	21535	Completed	

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21535	Continued From page 33	21535		

vascular disease (CVA-stroke), recurrent falls, vascular dementia and chronic kidney disease. This progress note also include an assessment and plan related to the diagnosis of essential hypertension and the physician indicated an acceptable blood pressure (BP) range for R18 as 148/88 millimeters of mercury (mm Hg), which had been documented on the monthly flow sheet.

R18's most recent physician orders dated 4/14/16, identified current medications as noted: Isosorbide Mononitrate (extended release) ER tablet 24 hour 30 milligrams (mg) 1.5 tablets by mouth daily for angina attacks, Norvasc tablet 5 mg by mouth for essential hypertension and Lopressor tablet 50 mg by mouth two times a day for essential hypertension.

The pharmacy consultant note dated 1/13/16, indicated the following: [R18] has been experiencing elevated blood pressures lately, although there are also some very low results also; has been falling out of bed and BP checks following these incidents have been elevated; most recent BP's are: 110/58 (1/13), 187/102 and 166/89 on 1/12/16.

R18's Norvasc medication was increased on 1/14/16, from 2.5 mg to 5 mg daily due to elevated BP's. Upon review of the BP flowsheet and progress notes it was noted that R2's BP was not followed-up until 1/29/16, (2 week after a medication increase). The next BP reading documented was 3/24/16, at 3:16 a.m. and measured 148/88 mm Hg. There were no documented BP readings from 1/29/16 thru 3/24/16. There was no evidence documented in the record indicating that ongoing BP readings had been evaluated to determine the effectiveness of the dosage increase and

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21535	Continued From page 34 ascertain R18's response to treatment. During an interview on 5/5/16, at 8:57 a.m. the director of nursing (DON) indicated the facility practice was to obtain monthly routine vital signs unless a physician orders indicated otherwise. The nursing assistants record the BP readings monthly on the resident's scheduled bath day. During a telephone interview on 5/5/16, at 9:45 a.m. the facility's medical director (MD, who was also R18's primary physician) stated, "I would not like to see a BP out of the accepted high range for this age group (included R18). A BP of 150/90 is the goal, otherwise it will increase the risk for stroke." The MD further stated an elevated BP would require rechecking and stated he would expect a resident receiving an anti-hypertensive to have their BP monitored more frequently than monthly. He verified that monthly BP measurements were not frequent enough to be a useful tool to evaluate the effectiveness of the anti-hypertensive medication, indicating daily or every other day BP may be appropriate. The MD stated, "I was not aware the facility had not been monitoring R18's BPs more frequently." MD also stated it was difficult to evaluate the medication effectiveness when the BP recordings are conducted before/after the medication is administered. The MD indicated he had requested noon BP monitoring vs. early morning monitoring for those residents who were receiving anti-hypertensive medications. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage, especially medications prescribed for hypertension control. Nursing staff	21535		

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	00342	A. BUILDING: _____ B. WING _____	05/05/2016

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21535	Continued From page 35 could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21535		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or	21545		5/26/16

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21545	Continued From page 36 resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure all medications were administered without error for 1 of 9 residents (R12) observed during medication administration. Findings include. During observation of the evening medication pass on 5/2/16, at 7:00 p.m. trained medication assistant (TMA)-B prepared R12's bedtime medications. The following medications were set up by TMA-B: Zyprexa (antipsychotic) 5 milligrams (mg); Tylenol 500 mg, 2 tabs; and Aricept (dementia medication) 15 mg. After placing the medications into a plastic medication cup, TMA-B crushed the medications and placed them in applesauce. TMA-B transported the medications into R12's room and administered them with a spoon to R12. R12 remained lying in bed. TMA-B elevated the head of the bed to	21545	Completed	

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21545	Continued From page 37	21545		

approximately 45 degrees but R12 slid down toward the foot of the bed and thus her head was not raised to the 45 degree level. After administering the medications to R12, it was noted that TMA-B set the medication cup (medications/applesauce) on top of the medication administration cart. The cart was located in the hallway outside of R12's room. TMA-B documented in the medication administration record (MAR) that she had administered the medications. However, it was noted there was additional medication mixed with the applesauce remaining in the cup. The spoon used to administer the medication and applesauce mixture contained chunks of the mixture as did the bottom of the medication cup, which contained additional residue.

During interview with TMA-B on 5/2/16, at 7:10 p.m. it was verified that not all of the medications were administered and consequently could not verify R12 had received the full dose of the prescribed medications. TMA-B indicated she did not realize she left so much medication in the cup.

When interviewed on 5/2/16, at 7:30 p.m. the director of nursing services (DON) was made aware of the observation and stated staff were properly trained to administer medications and should ensure residents receive the full dosing as prescribed.

During review of the facility policy for, General Dose Preparation and Medication Administration, Omnicare 2013, the following guidance was identified: 3. Dose Preparation: Facility should take all measures required by facility policy and applicable law, including, but not limited to the following: 3.8 Facility staff should crush oral

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21545	Continued From page 38 medications only in accordance with pharmacy guidelines as set forth Appendix 16. Appendix 16 identified which med's could or could not be crushed but did not identify any information related to the administration of crushed medications in applesauce. The facility was unable to produce a policy related to the administration of medications in applesauce. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could re-educate the involved staff as to proper procedure for following medication administration. She could also conduct periodic audits to ensure staff compliance administer all medications during the medication pass. TIME PERIOD FOR CORRECTION: Seven (7) days.	21545		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to maintain the condition of the ceiling tiles	21685	Completed	6/3/16

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21685	Continued From page 39 for 15 of 17 resident bathrooms located on all 3 wings of the facility. (100 wing room #: 102/104, 101/103, 105/107, 109/111; 200 wing room #: 202/204, 206/208, 207, 210/212, 211/213, 214/216; 300 wing room #: 301, 302/304, 303/305, 306/308, 307/309). Findings include: During observations on 5/2/16, at 2:20 p.m. through 5/5/16, at 2:00 p.m. the following resident bathrooms had ceiling tiles which were stained and/or discolored: 100 wing rooms: 102/104, 101/103, 105/107, 109/111; 200 wing rooms: 202/204, 206/208, 207, 210/212, 211/213, 214/216; and 300 wing rooms: 301, 302/304, 303/305, 306/308, 307/309. A tour was conducted with the maintenance director and the regional director on 5/5/16, at 11:39 a.m. It was confirmed the stains on the ceiling tiles in resident bathrooms were a result of water damage related to snow getting into the vents and melting. The maintenance director stated on 5/5/16, at 11:45 a.m. the ventilation system located on the roof of the building had not been inspected since 2014 by the ventilation company. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike	21685		

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21685	Continued From page 40 environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		