| DEPARTMENT OF HEALTH   | AND HUMA        | N SERVICES                               |                    |                  | CENTERS FOR MED  | ICARE & MEDICAID SERVIC   | ES |  |
|--|-----------------|--|--------------------|------------------|--|---|----|--|
|  |                 |  |                    |                  | AND TRANSMITTAL  | ID: 1EW8  |    |  |
|  | PART I -        | TO BE COMPL                              | LETED BY T         | THE STAT         | TE SURVEY AGENCY   | Facility ID: 00342  |    |  |
| 1. MEDICARE/MEDICAID PROVIDE                                   | R               | 3. NAME AND AD<br>(L3) <b>PRAIRIE VI</b> |                    |                  |  | 4. TYPE OF ACTION: $\underline{7}$ (L8)   |    |  |
| NO.(L1) 245371   |                 | (L4) 250 FIFTH S                         |                    |                  |  | 1. Initial 2. Recertificati   | on |  |
| 2. STATE VENDOR OR MEDICAID N<br>(L2) 681243100                | <b>Ю</b> .      | (L5) <b>TRACY</b> , MN                   |                    | 1                | (L6) <b>56175</b>  | 3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other |    |  |
| 5. EFFECTIVE DATE CHANGE OF OV<br>(L9)                         | WNERSHIP        | 7. PROVIDER/SU<br>01 Hospital            | PPLIER CATEC       | GORY<br>09 ESRD  | <u>02</u> (L7)<br>13 PTIP 22 CLIA                                    | <ol> <li>8. Full Survey After Complaint</li> </ol>  |    |  |
|  | /2016 (L34)     | 02 SNF/NF/Dual                           | 05 IIIA<br>06 PRTF | 09 ESRD<br>10 NF | 14 CORF  |   |    |  |
| 8. ACCREDITATION STATUS:                                       | (L10)           | 03 SNF/NF/Distinct                       | 07 X-Ray           | 11 ICF/IID       |  | FISCAL YEAR ENDING DATE: (L3  | 5) |  |
| 0 Unaccredited 1 TJC<br>2 AOA 3 Other                          |                 | 04 SNF                                   | 08 OPT/SP          | 12 RHC           | 16 HOSPICE   | 09/30   |    |  |
| 11LTC PERIOD OF CERTIFICATION                                  |                 | 10.THE FACILITY                          | IS CERTIFIED       | AS:              |  |   |    |  |
| From (a):  |                 | X A. In Complia                          | nce With           |                  | And/Or Approved Waivers Of 7   | The Following Requirements:   |    |  |
| To (b):  |                 | Program Re                               | •                  |                  | 2. Technical Personnel   | 6. Scope of Services Limit  |    |  |
|  |                 | Compliance                               |                    |                  | 3. 24 Hour RN  | 7. Medical Director   |    |  |
| 12.Total Facility Beds   | 55 (L18)        | 1. Ad                                    | cceptable POC      |                  | 4. 7-Day RN (Rural SN  | · _   |    |  |
| 13.Total Certified Beds  | 55 (L17)        | B. Not in Compl                          | liance with Progr  | am               | 5. Life Safety Code  | 9. Beds/Room  |    |  |
|  |                 | Requirements                             | and/or Applied     | Waivers:         | * Code: A*   | (L12)   |    |  |
| 14. LTC CERTIFIED BED BREAKDOW                                 | 'N              |  |                    |                  | 15. FACILITY MEETS   |   |    |  |
| 18 SNF 18/19 SNF   | 19 SNF          | ICF                                      | IID                |                  | 1861 (e) (1) or 1861 (j) (1):  | (L15)   |    |  |
| 55   |                 |  |                    |                  |  |   |    |  |
| (L37) (L38)  | (L39)           | (L42)                                    | (L43)              |                  |  |   |    |  |
| 16. STATE SURVEY AGENCY REMAI                                  | RKS (IF APPLICA | ABLE SHOW LTC CA                         | NCELLATION         | DATE):           |  |   |    |  |
|  |                 |  |                    |                  |  |   |    |  |
| 17. SURVEYOR SIGNATURE   |                 | Date :                                   |                    |                  | 18. STATE SURVEY AGENCY  | APPROVAL Date:  |    |  |
| Kathryn Serie, Unit Sur  | pervisor        | 0  | 6/29/2016          | (L19)            | Kamala Fiske-Downing, Health Program Representative 06/29/2016 (L20) |   |    |  |
| PAR  | Г II - ТО BE    | COMPLETED E                              | BY HCFA RI         | EGIONAI          | <b>COFFICE OR SINGLE S</b>   | FATE AGENCY   |    |  |
| 19. DETERMINATION OF ELIGIBILIT                                | ſΥ              | 20. COM                                  | PLIANCE WIT        | HCIVIL           | 21. 1. Statement of Finan  | cial Solvency (HCFA-2572)   |    |  |
| 1 Englisty is Eligible to Dep                                  | tiginata        |  | ITS ACT:           |                  | 2. Ownership/Control   | I Interest Disclosure Stmt (HCFA-1513)  |    |  |
| 1. Facility is Eligible to Par     2. Facility is not Eligible | ucipate         |  |                    |                  | 3. Both of the Above   | :<br>   |    |  |
| 2. Facility is not Englote                                     | (L21)           |  |                    |                  |  |   |    |  |
| 22. ORIGINAL DATE  | 23. LTC AGREE   | MENT 24                                  | 4. LTC AGREEN      | MENT             | 26. TERMINATION ACTION:  | (L30)   |    |  |
| OF PARTICIPATION   | BEGINNINC       | DATE                                     | ENDING DA          | TE               | VOLUNTARY 00   | INVOLUNTARY   |    |  |
| 12/01/1986   |                 |  |                    |                  | 01-Merger, Closure   | 05-Fail to Meet Health/Safety   |    |  |
| (L24)  | (L41)           |  | (L25)              |                  | 02-Dissatisfaction W/ Reimburse                                      | ment 06-Fail to Meet Agreement  |    |  |
| 25. LTC EXTENSION DATE:  | 27. ALTERNATI   | VE SANCTIONS                             |                    |                  | 03-Risk of Involuntary Termination                                   | 1 <u>OTHER</u>  |    |  |
|  | A. Suspension   | n of Admissions:                         |                    |                  | 04-Other Reason for Withdrawal                                       | 07-Provider Status Change   |    |  |
| (L27)  |                 |  | (L44)              |                  |  | 00-Active   |    |  |
| (L27)  | B. Rescind St   | spension Date:                           |                    |                  |  |   |    |  |
|  |                 |  | (L45)              |                  |  |   |    |  |
| 28. TERMINATION DATE:  | 29              | 0. INTERMEDIARY/                         | CARRIER NO.        |                  | 30. REMARKS  |   |    |  |
|  |                 | 03001                                    |                    |                  |  |   |    |  |
|  | (L28)           |  |                    | (L31)            |  |   |    |  |
| 31. RO RECEIPT OF CMS-1539                                     | 21              | . DETERMINATION                          |                    | DATE             |  |   |    |  |
| 51. KO KECEIF I OF CMI3-1339                                   | 32              | , DETERMINATION                          | JIATIKUVAL         | DALE             |  |   |    |  |
|  | (L32)           |  |                    | (L33)            | DETERMINATION APPR   | ROVAL   |    |  |



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,

Kumala Fiske Downing

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



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,

Kumala Fiske Downing

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

### **POST-CERTIFICATION REVISIT REPORT**

| PROVIDER / SUPPLIER / CLIA / | MULTIPLE CONSTRUCTION |                                       | D               | DATE OF REVIS | IT |
|------------------------------|-----------------------|---------------------------------------|-----------------|---------------|----|
| IDENTIFICATION NUMBER        | A. Building           |                                       |                 |               |    |
| 245371 <sub>Y1</sub>         | B. Wing               | Y2                                    | <sub>2</sub> 6/ | 6/27/2016     | Y3 |
| NAME OF FACILITY             |                       | STREET ADDRESS, CITY, STATE, ZIP CODE |                 |               |    |
| PRAIRIE VIEW SENIOR LIVIN    | G                     | 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).

| ITE   |               | DATE                      | ITEM         |   | DATE           | ITEM      |                  |        | DATE       |
|---|---------------|---------------------------|--------------|---|----------------|-----------|------------------|--------|------------|
| Y4  |               | Y5                        | Y4           |   | Y5             | Y4        |                  |        | Y5         |
| ID Prefix                                   | F0157         | Correction                | ID Prefix F  | 0280                                    | Correction     | ID Prefix | F0282            |        | Correction |
| Reg. #                                      | 483.10(b)(11) | Completed                 | Reg. # 48    | 33.20(d)(3), 483.1                      | 0(k) Completed | Reg. #    | 483.20(k)(3)(ii) |        | Completed  |
| LSC   |               | 06/06/2016                |              |   | 06/06/2016     | LSC       |                  |        | 06/13/2016 |
| ID Prefix                                   | F0318         | Correction                | ID Prefix F  | 0323                                    | Correction     | ID Prefix | F0329            |        | Correction |
| Reg. #                                      | 483.25(e)(2)  | Completed                 | 48<br>Reg. # | 33.25(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 F  | 0428                                    | Correction     | ID Prefix | F0441            |        | Correction |
| Reg. #                                      | 483.25(m)(1)  | Completed                 | 48 Reg. #    | 33.60(c)                                | Completed      | Reg. #    | 483.65           |        | Completed  |
| LSC   |               | 05/26/2016                |              |   | 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       |                  |        |            |
| REVIEW                                      |               | REVIEWED BY<br>(INITIALS) | DATE         |   | E OF SURVEYOR  |           |                  | DATE   |            |
|   |               | KS/kfd                    | 6/29/201     | -                                       | 03048          |           |                  | -      | /2016      |
| CMS RO                                      |               | REVIEWED BY<br>(INITIALS) | DATE         | TITLE                                   |                |           |                  | DATE   |            |
| FOLLOWUP TO SURVEY COMPLETED ON<br>5/5/2016 |               |                           |              | DRRECTED DEFICIEN<br>IENCIES (CMS-2567) |                |           | T YE             | s 🗌 no |            |

## **POST-CERTIFICATION REVISIT REPORT**

|                           | MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 |                                       | DATE OF I | REVISIT         |
|---------------------------|---|---------------------------------------|-----------|-----------------|
|                           | B. Wing   | Y2                                    | 6/13/2016 | 6 <sub>Y3</sub> |
| NAME OF FACILITY          |   | STREET ADDRESS, CITY, STATE, ZIP CODE |           |                 |
| PRAIRIE VIEW SENIOR LIVIN | G   | 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  | DATE                      | ITEM   | DATE                  | ITEM      | DATE       |  |  |
|---|---------------------------|--|-----------------------|-----------|------------|--|--|
| Y4  | Y5                        | Y4   | Y5                    | Y4        | Y5         |  |  |
| ID Prefix                                   | Correction                | ID Prefix  | Correction            | ID Prefix | Correction |  |  |
| NFPA 101                                    | Completed                 | Reg. #   | 101 Completed         | Reg. #    | Completed  |  |  |
| LSC K0025                                   | 05/31/2016                | LSC <u>K0050</u>   | 06/03/2016            | LSC       |            |  |  |
| ID Prefix                                   | Correction                | ID Prefix  | Correction            | ID Prefix | Correction |  |  |
| Reg. #                                      | Completed                 | Reg. #   | Completed             | Reg. #    | Completed  |  |  |
| LSC   |                           | LSC  |                       | LSC       |            |  |  |
| ID Prefix                                   | Correction                | ID Prefix  | Correction            | ID Prefix | Correction |  |  |
| Reg. #                                      | Completed                 | Reg. #   | Completed             | Reg. #    | Completed  |  |  |
| LSC   |                           | LSC  |                       | LSC       |            |  |  |
| ID Prefix                                   | Correction                | ID Prefix  | Correction            | ID Prefix | Correction |  |  |
| Reg. #                                      | Completed                 | Reg. #   | Completed             | Reg. #    | Completed  |  |  |
| LSC   |                           | LSC  |                       |           |            |  |  |
| ID Prefix                                   | Correction                | ID Prefix  | Correction            | ID Prefix | Correction |  |  |
| Reg. #                                      | Completed                 | Reg. #   | Completed             | Reg. #    | Completed  |  |  |
| LSC   |                           | LSC  |                       | LSC       |            |  |  |
| REVIEWED BY<br>STATE AGENCY                 | REVIEWED BY<br>(INITIALS) | DATE   | SIGNATURE OF SURVEYOR |           | DATE       |  |  |
|   | TĽ/kfd                    | 6/29/2016  |                       | 5482      | 6/13/2013  |  |  |
| REVIEWED BY<br>CMS RO                       | REVIEWED BY<br>(INITIALS) | DATE   | TITLE                 |           | DATE       |  |  |
| FOLLOWUP TO SURVEY COMPLETED ON<br>5/3/2016 |                           | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? |                       |           |            |  |  |

| DEPARTMENT OF HEALTH AN   | ND HUMA                       | N SERVICES  |   | CENTERS FOR MED   | ICARE & MEDICAID SERVICES   |  |  |
|---|-------------------------------|---|---|---|---|--|--|
|   |                               | <b>ARE/MEDICAID CERTIFIC</b>  |   |   | ID: 1EW8  |  |  |
|   | PART I -                      | TO BE COMPLETED BY TH   | HE STAT                                 | TE SURVEY AGENCY  | Facility ID: 00342  |  |  |
| 1. MEDICARE/MEDICAID PROVIDER<br>NO.(L1) <b>245371</b>  |                               | 3. NAME AND ADDRESS OF FACI<br>(L3) <b>PRAIRIE VIEW SENIOR I</b>  | LIVING                                  |   | <ol> <li>TYPE OF ACTION: <u>2</u>(L8)</li> <li>Initial 2. Recertification</li> </ol>  |  |  |
| 2. STATE VENDOR OR MEDICAID NO.<br>(L2) 681243100   |                               | (L4) <b>250 FIFTH STREET EAST</b><br>(L5) <b>TRACY, MN</b>  |   | (L6) <b>56175</b>   | 3. Termination     4. CHOW       5. Validation     6. Complaint       7. Or Site Visite     0. Other                            |  |  |
| 5. EFFECTIVE DATE CHANGE OF OWN<br>(L9)   | ERSHIP                        | 7. PROVIDER/SUPPLIER CATEGO<br>01 Hospital 05 HHA   | )RY<br><b>09 ESRD</b>                   | <u>02</u> (L7)<br>13 PTIP 22 CLIA   | <ol> <li>7. On-Site Visit</li> <li>9. Other</li> <li>8. Full Survey After Complaint</li> </ol>                                  |  |  |
| 6. DATE OF SURVEY 05/05/20<br>8. ACCREDITATION STATUS:<br>0 Unaccredited 1 TJC<br>2 AOA 3 Other | <b>)16</b> (L34)<br>(L10)     | 02 SNF/NF/Dual06 PRTF03 SNF/NF/Distinct07 X-Ray04 SNF08 OPT/SP  | 10 NF<br>11 ICF/IID<br>12 RHC           | 14 CORF<br>15 ASC<br>16 HOSPICE   | FISCAL YEAR ENDING DATE: (L35)<br>09/30   |  |  |
| •   | 55 (L18)<br>55 (L17)          | 10.THE FACILITY IS CERTIFIED A         A. In Compliance With         Program Requirements         Compliance Based On:        1. Acceptable POC         X B. Not in Compliance with Program | am                                      | And/Or Approved Waivers Of T<br>2. Technical Personnel<br>3. 24 Hour RN<br>4. 7-Day RN (Rural SNF<br>5. Life Safety Code  | <ul> <li>6. Scope of Services Limit</li> <li>7. Medical Director</li> <li>8. Patient Room Size</li> <li>9. Beds/Room</li> </ul> |  |  |
| 14. LTC CERTIFIED BED BREAKDOWN<br>18 SNF 18/19 SNF   | 19 SNF                        | Requirements and/or Applied W   | aivers:                                 | * Code: <b>B</b> *<br>15. FACILITY MEETS<br>1861 (e) (1) or 1861 (j) (1):   | (L12)<br>(L15)  |  |  |
| 55<br>(L37) (L38)   | (L39)                         | (L42) (L43)   |   |   |   |  |  |
| 16. STATE SURVEY AGENCY REMARKS   | S (IF APPLICA                 | BLE SHOW LTC CANCELLATION D   | ATE).                                   |   |   |  |  |
|   |                               |   | · • • • • • • • • • • • • • • • • • • • |   |   |  |  |
| 17. SURVEYOR SIGNATURE  | 17. SURVEYOR SIGNATURE Date : |   |   |   | APPROVAL Date:  |  |  |
| Lois Boerboom, HFE NE   | II                            | 05/27/2016  | (L19)                                   | Kamala Fiske-Downing, Health Program Representative 06/16/2016 (L20)  |   |  |  |
| PART I  | I - TO BE                     | COMPLETED BY HCFA REG   | GIONAL                                  | OFFICE OR SINGLE ST   | TATE AGENCY   |  |  |
| <ol> <li>DETERMINATION OF ELIGIBILITY</li> <li>1. Facility is Eligible to Particip</li> </ol>   | pate                          | 20. COMPLIANCE WITH<br>RIGHTS ACT:  | CIVIL                                   | <ol> <li>I. Statement of Financial Solvency (HCFA-2572)</li> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol> |   |  |  |
| 2. Facility is not Eligible   | (L21)                         |   |   |   |   |  |  |
| 22. ORIGINAL DATE 23.   | LTC AGREEN                    | MENT 24. LTC AGREEM   | ENT                                     | 26. TERMINATION ACTION:   | (L30)   |  |  |
| OF PARTICIPATION 12/01/1986   | BEGINNING                     | DATE ENDING DATE  | Е                                       | VOLUNTARY     00       01-Merger, Closure   | INVOLUNTARY<br>05-Fail to Meet Health/Safety  |  |  |
| (L24)   | (L41)                         | (L25)   |   | 02-Dissatisfaction W/ Reimburser  | · · · · · · · · · · · · · · · · · · ·   |  |  |
|   |                               | VE SANCTIONS<br>a of Admissions:  |   | 03-Risk of Involuntary Termination<br>04-Other Reason for Withdrawal  | OTHER<br>07-Provider Status Change<br>00-Active   |  |  |
| (L27)   | B. Rescind Su                 | (L44)<br>Ispension Date:  |   |   | 00 10010  |  |  |
|   |                               | (L45)   |   |   |   |  |  |
| 28. TERMINATION DATE:   | 29                            | . INTERMEDIARY/CARRIER NO.  |   | 30. REMARKS   |   |  |  |
|   |                               | 03001   |   |   |   |  |  |
| (1  | L28)                          |   | (L31)                                   |   |   |  |  |
| 31. RO RECEIPT OF CMS-1539  | 32                            | . DETERMINATION OF APPROVAL I   | DATE                                    |   |   |  |  |
| (]  | L32)                          |   | (L33)                                   | DETERMINATION APPR  | OVAL  |  |  |



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:

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Health Regulation Division Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 Email: <u>Kathryn.serie@state.mn.us</u> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumalu Piske Downing

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

| DEPART                   | MENT OF HEALTH   | AND HUMAN SERVICES  |                     |    |   |        | APPROVED                   |
|--------------------------|--|---|---------------------|----|---|--------|----------------------------|
| CENTER                   | RS FOR MEDICARE  | & MEDICAID SERVICES   |                     |    | 0   | MB NO. | 0938-0391                  |
|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |    |   |        | E SURVEY<br>IPLETED        |
|                          |  | 245371  | B. WING _           |    |   | 05/    | 05/2016                    |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                     |    | REET ADDRESS, CITY, STATE, ZIP CODE   |        |                            |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G   |                     |    | 50 FIFTH STREET EAST<br>RACY, MN 56175  |        |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | K  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE     | (X5)<br>COMPLETION<br>DATE |
| F 000                    | INITIAL COMMENT  | ſS  | F 0(                | 00 |   |        |                            |
| F 157<br>SS=D            | as your allegation of<br>Department's accept<br>enrolled in ePOC, y<br>at the bottom of the<br>form. Your electronic<br>be used as verification<br>Upon receipt of an<br>on-site revisit of your<br>validate that substare<br>regulations has beet<br>your verification.<br>483.10(b)(11) NOT<br>(INJURY/DECLINE<br>A facility must immediate<br>consult with the resist<br>known, notify the resist<br>or an interested fan<br>accident involving the<br>intervention; a significantly (i.e., a<br>existing form of treat<br>consequences, or to<br>treatment); or a dece<br>the resident from the<br>§483.12(a).<br>The facility must als<br>and, if known, the resist | acceptable electronic POC, an<br>ur facility may be conducted to<br>initial compliance with the<br>en attained in accordance with<br>IFY OF CHANGES | F 1                 | 57 |   |        | 6/6/16                     |
|                          |  | DER/SUPPLIER REPRESENTATIVE'S SIGN  | NATURE              |    | TITLE   |        | (X6) DATE                  |
| Electron                 | ically 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.

PRINTED: 05/27/2016

| 021112                   | NO FUN IVIEDIUANE  | & MEDICAID SERVICES  | 1                   |   |   | 0938-039                  |
|--------------------------|--|--|---------------------|---|---|---------------------------|
|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | TIPLE CONSTRUCTION  |   | E SURVEY<br>PLETED        |
|                          |  | 245371   | B. WING             |   | 05/   | 05/2016                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | •  |                     | STREET ADDRESS, CITY, STATE, ZIP  | CODE  |                           |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G  |                     | 250 FIFTH STREET EAST<br>TRACY, MN 56175  |   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTIO)<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | N SHOULD BE   | (X5)<br>COMPLETIO<br>DATE |
| F 157                    | change in room or<br>specified in §483.1<br>resident rights under<br>regulations as speci-<br>this section.<br>The facility must re-<br>the address and ph-<br>legal representative<br>This REQUIREMEI<br>by:<br>Based on interview<br>facility failed to noti-<br>blood pressure rect<br>(R18) reviewed for<br>Findings include:<br>R18's most recent<br>dated 3/24/16, iden-<br>including: coronary<br>(high blood pressur-<br>vascular disease (C<br>vascular dementia<br>This progress note<br>and plan related to<br>hypertension and th<br>acceptable blood p<br>148/88 millimeters<br>had been documer<br>R18's most recent<br>4/14/16, identified c<br>Isosorbide Mononit<br>tablet 24 hour 30 m | age 1<br>roommate assignment as<br>15(e)(2); or a change in<br>er Federal or State law or<br>cified in paragraph (b)(1) of<br>cord and periodically update<br>none number of the resident's<br>e or interested family member.<br>NT is not met as evidenced<br>v and document review the<br>fy the physician of elevated<br>ordings for 1 of 6 residents<br>runnecessary drugs.<br>physician's progress note<br>tified active diagnoses<br>artery disease, hypertension<br>re), chronic back pain, cerebral<br>CVA-stroke), recurrent falls,<br>and chronic kidney disease.<br>also include an assessment<br>the diagnosis of essential<br>ne physician indicated an<br>ressure (BP) range for R18 as<br>of mercury (mm Hg), which<br>need on the monthly flow sheet.<br>physician orders dated<br>current medications as noted:<br>rrate (extended release) ER<br>nilligrams (mg) 1.5 tablets by<br>ina attacks, Norvasc tablet 5 | F 1                 | <ul> <li>F 157</li> <li>The preparation of the folloc correction for this deficience constitute and should not be as an admission nor an ag facility of the truth of the fac conclusions set forth in the deficiencies. The plan of correpared for this deficiency solely because it is require of State and Federal law. If the foregoing statement, the that with respect to: <ol> <li>DON reviewed policie procedures. On June 6, 20 educate staff on notifying reparties and physician where condition (SBAR) vital sign</li> <li>DON or designee will resident's charts weekly for 4 residents monthly for two The data collected will be p Quarterly Quality Assurance the ED. It will be reviewed</li> </ol> </li> </ul> | y does not<br>be interpreted<br>reement by the<br>cts alleged on<br>statement of<br>orrection<br>was executed<br>d by provisions<br>Without waiving<br>e facility states<br>s and<br>16 DON will<br>esponsible<br>a change in<br>monitor two<br>r 4 weeks, then<br>oresented to the<br>e committee by |                           |

Facility ID: 00342

If continuation sheet Page 2 of 35

|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |   | FORM      | 05/27/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|--------------------|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    | E CONSTRUCTION  | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245371   | B. WING            | <br>  | 05/       | 05/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                    | TREET ADDRESS, CITY, STATE, ZIP CODE  |           |                                     |
| PRAIRIE                  | VIEW SENIOR LIVING  | G  |                    | 50 FIFTH STREET EAST<br>RACY, MN 56175  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
|                          | REGULATORY OR La<br>Continued From pa<br>for essential hyperte<br>R18 had a series of<br>multiple documente<br>155/84 mm Hg to 2<br>evidence there had<br>monitoring initiated<br>dosage was increas<br>was ordered. There<br>physician had been<br>4/12/16, BP measu<br>accordance with the<br>procedure which din<br>>210 mm Hg imme<br>documented evider<br>acknowledging a pa<br>pressures nor docu<br>the current drug reg<br>During a telephone<br>a.m. the facility's m<br>also R18's primary<br>like to see a BP out<br>for this age group (<br>150/90 is the goal, or<br>risk for stroke." The<br>unaware of R18's e<br>he would expect to<br>some labs or chang<br>aware. The MD furt<br>would require reche<br>expect a resident re<br>to have their BP mo | ge 2<br>ension.<br>If falls in April 2016 with<br>ed post fall BP's ranging from<br>19/108 mm Hg. There was no<br>been any additional BP<br>when the BP medication<br>sed on 1/14/16; Norvasc 5 mg<br>was also no evidence the<br>immediately notified of the<br>ring 219/108 mm Hg in<br>e Change in Condition (SBAR)<br>rected to report a systolic BP<br>diately. There was no<br>nee in R18's record<br>attern of elevated blood<br>mented evaluation of whether<br>gimen was effective.<br>interview on 5/5/16, at 9:45<br>edical director (MD, who was<br>physician) stated, "I would not<br>of the accepted high range<br>which included R18). A BP of<br>otherwise it will increase the<br>e MD further verified he was<br>levated BP reading and stated<br>review a BP flow sheet, run<br>ge medications had he been<br>her stated an elevated BP<br>ecking and stated he would<br>eceiving an anti-hypertensive<br>onitored more frequently than |                    | CROSS-REFERENCED TO THE APPROPF   |           | DATE                                |
|                          | facility had not beer<br>frequently." MD als<br>evaluate the medica<br>BP recordings are of   | tated, "I was not aware the<br>n monitoring R18's BPs more<br>to stated it was difficult to<br>ation effectiveness when the<br>conducted before/after the<br>histered. The MD indicated he   |                    |   |           |                                     |

Facility ID: 00342

If continuation sheet Page 3 of 35

|                          |   | AND HUMAN SERVICES  |                     |   | FORM     | : 05/27/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|---|---|---------------------|---|----------|---|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 | LE CONSTRUCTION   | (X3) DAT | E SURVEY<br>IPLETED                     |
|                          |   | 245371  | B. WING             |   | 05/      | /05/2016                                |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |          |   |
| PRAIRIE                  | VIEW SENIOR LIVING  | 3   |                     | 250 FIFTH STREET EAST<br>FRACY, MN 56175  |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE   | (X5)<br>COMPLETION<br>DATE              |
| F 157<br>F 280<br>SS=D   | had requested noor<br>morning monitoring<br>receiving anti-hyper<br>During an interview<br>director of nursing (<br>staff were to follow<br>Change in Condition<br>Change in Condition<br>Condition.<br>The facility's proced<br>(SBAR) directed sta<br>nurse practitioner o<br>systolic BP>210 mm<br>the SBAR tool was<br>for the resident with<br>483.20(d)(3), 483.1<br>PARTICIPATE PLA<br>The resident has the<br>incompetent or othe<br>incapacitated under<br>participate in planni<br>changes in care and<br>A comprehensive car<br>within 7 days after t<br>comprehensive ass<br>interdisciplinary teal<br>physician, a registe<br>for the resident, and<br>disciplines as detern<br>and, to the extent p<br>the resident, the resi<br>legal representative | n BP monitoring vs. early<br>for those resident who were<br>rtensive medications.<br>r on 5/5/16, at 8:57 a.m. the<br>(DON) indicated the nursing<br>the facility's protocol for<br>n (SBAR) to report changes in<br>dure titled Change in Condition<br>aff to immediately notify the<br>or MD re., blood pressure,<br>mHg. The procedure indicated<br>to be used by the nurse caring<br>n a change in condition.<br>0(k)(2) RIGHT TO<br>NNING CARE-REVISE CP<br>the right, unless adjudged<br>erwise found to be<br>r the laws of the State, to<br>ing care and treatment or | F 157               |   |          | 6/6/16                                  |

Facility ID: 00342

If continuation sheet Page 4 of 35

|                          |  | AND HUMAN SERVICES  |                     |   | FORM   | 05/27/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|---------------------|---|--|-------------------------------------|
|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | TIPLE CONSTRUCTION  |  | E SURVEY<br>PLETED                  |
|                          |  | 245371  | B. WING             |   | 05/  | 05/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   | ·   |                     | STREET ADDRESS, CITY, STATE, ZIF  | CODE   |                                     |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G   |                     | 250 FIFTH STREET EAST<br>TRACY, MN 56175  |  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>X (EACH CORRECTIVE ACTIX<br>CROSS-REFERENCED TO TH<br>DEFICIENCY  | ON SHOULD BE<br>HE APPROPRIATE   | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | Continued From pa  | ge 4  | F 2                 | 80  |  |                                     |
|                          | by:<br>Based on observat<br>review the facility fa<br>2 of 4 residents (R1<br>and who received the<br>risk for aspiration/c<br>Findings include:<br>R12 had diagnoses<br>dated 3/24/16, that<br>dementia, cerebrow<br>hypertension.<br>R12's care plan data<br>risk for aspiration a<br>which included nec-<br>liquids, including net<br>bedside. The care p<br>free of aspiration of<br>During observation<br>pass and resident of<br>trained medication<br>R12's 7:00 p.m. met<br>the following medic<br>(anti-psychotic) 5 m<br>mg- 2 tabs; and Ari-<br>mg. After placing the<br>medication cup, TM<br>and mixed them in<br>transported the met<br>administer them wh<br>TMA-B elevated the | NT is not met as evidenced<br>tion, interview and document<br>ailed to revise the care plan for<br>12, R2) reviewed for accidents<br>hickened liquids and were at<br>hoking.<br>a identified on the care plan<br>included: Alzheimer's disease,<br>vascular disease and<br>ted 3/24/16, identified R12 at<br>nd identified a prescribed diet<br>tar consistency thickened<br>ectar thickened liquids at<br>olan goal was for R12 to be<br>ver the next quarter.<br>of the evening medication<br>cares on 5/2/16, at 7:00 p.m.<br>assistant (TMA)-B prepared<br>edications. TMA-B prepared<br>ations for R12: Zyprexa<br>nilligrams (mg); Tylenol 500<br>cept (dementia medication) 15<br>ne medications in a plastic<br>IA-B crushed the medications<br>applesauce. TMA-B then<br>dications into R12's room to<br>nile R12 was lying in bed.<br>e head of the bed to<br>egrees. However, R12 slid |                     | F280<br>The preparation of the foll<br>correction for this deficien<br>constitute and should not<br>as an admission nor an ag<br>facility of the truth of the fac<br>conclusions set forth in the<br>deficiencies. The plan of<br>prepared for this deficience<br>solely because it is require<br>of State and Federal law.<br>the foregoing statement, t<br>that with respect to:<br>1. MDS coordinator has<br>resident care plans and of<br>received for modified liqui<br>identified residents (R12,<br>2. All other resident car<br>reviewed and updated for<br>or designee will educate of<br>all care plans will be updat<br>change of condition.<br>3. All care plans of reside<br>modified thickened liquid<br>monitored and audited by<br>designee weekly for 4 weat<br>monthly for two month. The<br>will be presented to the Q<br>Assurance committee by<br>reviewed/discussed and at<br>QA committee will make at<br>decision/recommendation<br>follow-up or changes. | cy does not<br>be interpreted<br>greement by the<br>acts alleged on<br>e statement of<br>correction<br>cy was executed<br>ed by provisions<br>Without waiving<br>he facility states<br>s updated<br>rders were<br>ds including<br>R2).<br>e plans will be<br>accuracy. DON<br>on June 6, 2016<br>ted with any<br>dents with<br>diets will be<br>DON or<br>eks, and then<br>he data collected<br>uarterly Quality<br>the ED. It will be<br>at that time the |                                     |

Facility ID: 00342

If continuation sheet Page 5 of 35

|                          |  | AND HUMAN SERVICES  |                   |     |  | FORM      | APPROVED<br>0938-0391      |
|--------------------------|--|---|-------------------|-----|--|-----------|----------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ` '               |     | PLE CONSTRUCTION   | (X3) DATE | E SURVEY<br>PLETED         |
|                          |  | 245371  | B. WING           | ì   |  | 05/       | 05/2016                    |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                   |     | STREET ADDRESS, CITY, STATE, ZIP CODE  |           |                            |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G   |                   |     | 250 FIFTH STREET EAST<br>TRACY, MN 56175   |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE |
| F 280                    | the bed. Subseque<br>elevated to the 45 of<br>attempted. After ac<br>medications, TMA-I<br>liquids while R12 re<br>bed. positioned at le<br>Immediately after th<br>approximately 7:15<br>(DON) was intervier<br>related to R12 rece<br>lying in bed. The DO<br>that the resident's h<br>elevated to 90 degr<br>ensure the resident<br>position while admin<br>liquids. The DON a<br>aspiration.<br>When interviewed of<br>registered nurse (R<br>for aspiration and s<br>upright and should<br>administration of th<br>reiterated R12 would<br>aspiration if not sitti<br>the care plan had n<br>staff guidance relatt<br>R12 should be whe<br>administration of liq<br>prevent aspiration. | h her head toward the foot of<br>ently, R12's head was not<br>degree angle the TMA-B had<br>dministration of these prepared<br>B administered thickened<br>emained lying on her back in<br>ess than a 45 degree angle.<br>The noted observation, at<br>p.m., the director of nursing<br>wed about the observation<br>iving thickened liquids while<br>ON stated staff should know<br>head of the bed should be<br>ees (not 45 degrees) and also<br>is maintained in an upright<br>nistering medications and/or<br>lso verified R12 was at risk for<br>on 5/4/16, at 10:29 a.m.<br>N)-C stated R12 was at risk<br>hould be positioned sitting<br>be alert during the<br>ickened liquids. RN-C<br>ld be at risk for potential<br>ng upright. RN-C confirmed<br>ot been revised to include<br>ed to the appropriate position<br>n lying in bed during the<br>juids and/or medications to | F                 | 280 |  |           |                            |
|                          | 12/21/15, included:  | cerebrovascular accident<br>and hemiparesis, Alzheimer's  |                   |     |  |           |                            |

If continuation sheet Page 6 of 35

PRINTED: 05/27/2016

|                          | -  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |     |  |       | FORM      | 05/27/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|--------------------|-----|--|-------|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | E CONSTRUCTION   |       | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |  | 245371   | B. WING            |     |  |       | 05/0      | 05/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                    |     | TREET ADDRESS, CITY, STATE, ZIP COD  | E     |           |                                     |
| PRAIRIE                  | VIEW SENIOR LIVING   | G  |                    |     | 50 FIFTH STREET EAST<br>RACY, MN 56175   |       |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | IOULD | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | Continued From par<br>disease, failure to the<br>The significant char<br>Set (MDS) assessing<br>R2 receives a mec<br>severely impaired of<br>R2 as receiving the<br>total assistance with<br>living (ADL).<br>R2's plan of care dat<br>identified: (1) Nectable<br>bedside; and (2) Pro-<br>of choice with meal<br>The plan of care hat<br>the change in consist<br>from nectar to a hold<br>The nursing progression<br>from nectar to a hold<br>The nursing progression<br>identified that R2 hat<br>had been provided<br>documentation indic<br>feeding R2 related to<br>sheet for the kitche<br>indicated a (3) thread<br>to use honey thicked<br>who received thicked<br>kitchen and nectar<br>out and honey thicked<br>now on honey thicked<br>now on honey thicked<br>now on honey thicked<br>when interviewed of<br>dietary manager (D<br>changed the thicked | ge 6<br>hrive, dysphasia and anorexia.<br>Inge in status Minimum Data<br>hent dated 2/17/16, indicated<br>hanically altered diet and has<br>ognition. The MDS identified<br>hospice benefit and requires<br>in all of her activities of daily<br>ated/revised 12/21/15,<br>ar thickened liquids at the<br>ovide nectar thickened liquids<br>s, with meds and with snacks.<br>d not been updated to include<br>stency of the thickened liquids<br>ney consistency.<br>ss notes dated 4/12/16,<br>ad difficulty swallowing and<br>honey thickened liquids;<br>cated that staff had to stop<br>to coughing. A communication<br>in staff dated 4/12/16,<br>e day trial per hospice for R2<br>ned liquid. A copy of residents<br>ened liquid was posted in the<br>thickened liquids was crossed<br>ened added to R2's name.<br>ice note dated 4/12/16, also<br>dysphagia is increasing and is<br>ened liquids, at times staff<br>g her related to coughing. | F 2                | 280 |  |       |           |                                     |
|                          | need to stop feedin<br>When interviewed of<br>dietary manager (D<br>changed the thicken<br>nectar to a honey of  | g her related to coughing.<br>on 5/3/16, at 12:27 p.m. the<br>M) reported that hospice   |                    |     |  |       |           |                                     |

If continuation sheet Page 7 of 35

|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                     |  | FORM   | 05/27/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|---------------------|--|--|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                      |                     |  |  | E SURVEY<br>PLETED                  |
|                          |   | 245371   | B. WING             |  | 05/0   | 05/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |  |                                     |
| PRAIRIE                  | VIEW SENIOR LIVING  | G  |                     | 250 FIFTH STREET EAST<br>TRACY, MN 56175   |  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)  | BE   | (X5)<br>COMPLETION<br>DATE          |
| F 280                    | Continued From pa feeding.  | ge 7   | F 280               |  |  |                                     |
| F 282<br>SS=D            | 483.20(k)(3)(ii) SEF<br>PERSONS/PER CA  | RVICES BY QUALIFIED<br>ARE PLAN  | F 282               | 2  |  | 6/13/16                             |
|                          | must be provided by   | led or arranged by the facility<br>y qualified persons in<br>ch resident's written plan of |                     |  |  |                                     |
|                          | by:<br>Based on observat<br>review the facility fa<br>directed by the writt<br>residents (R10, R13<br>functional range of the<br>Findings include:<br>R10 had diagnoses<br>dated 3/29/16, inclu-<br>infarction, dementia<br>polyosteoarthritis ar<br>During observation<br>was seated in a why<br>noted to have a cor-<br>which he stated had<br>time since he'd exp<br>accident (CVA).<br>The care plan dated<br>an activities of daily<br>performance deficit<br>and dementia. The<br>had limited mobility. | identified on the care plan<br>Iding: history of cerebral<br>a, osteoporosis,              |                     | <ul> <li>F282</li> <li>The preparation of the following placorrection for this deficiency does no constitute and should not be interprised and admission nor an agreement facility of the truth of the facts allege conclusions set forth in the statement deficiencies. The plan of corrections prepared for this deficiency was exercised by because it is required by provided of State and Federal law. Without with the foregoing statement, the facility that with respect to: <ol> <li>All resident care plans with liming range of motion have been reviewed ensure they receive necessary treatment/service to prevent further range of motion.</li> <li>DON or designee will monitor resident therapy documentation for completion according to resident care plans and educate appropriate staff June 13, 2016 on the treatment and services needed for prevention of ramotion.</li> <li>Facility will ensure staff are prevented of the staff and the staff are prevented of the staff are</li></ol></li></ul> | ot<br>eted<br>by the<br>ed on<br>ent of<br>ecuted<br>visions<br>waiving<br>states<br>ited<br>d to<br>limited |                                     |

Facility ID: 00342

PRINTED: 05/27/2016

| STATEMENT                | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIF         | PLE CONSTRUCTION   | (X3) DATE   | 0938-039                  |
|--------------------------|---|--|---------------------|--|---|---------------------------|
| ND PLAN C                | OF CORRECTION   | IDENTIFICATION NUMBER:   | A. BUILDING         | B  | COMI  | PLETED                    |
|                          |   | 245371   | B. WING             |  | 05/0  | 05/2016                   |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 250 FIFTH STREET EAST  |   |                           |
| PRAIRIE                  | VIEW SENIOR LIVIN   | G  |                     |  |   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)  | D BE  | (X5)<br>COMPLETIC<br>DATE |
| F 282                    |   | -  | F 282               |  |   |                           |
|                          | maintain his curren<br>plan identified R10<br>program that includ<br>(1) Active range of<br>Omnicycle (Exercis<br>(2) Stretching of bo<br>hamstrings.<br>(3) Place feet up o<br>(4) Standing in EZ<br>cooperative to work<br>pull up and use of le<br>posture.<br>During review of the<br>the month of April 2<br>log identified the fol<br>utilizing the Omnicy<br>for the month and (<br>use of the EZ stand<br>the month. The rem<br>were documented t<br>and/or was unavaila<br>During review of R1<br>for the month of Ma<br>identified: (1) receiv<br>utilizing the Omnicy<br>for the month and (<br>exercises with use<br>opportunities for the<br>were documented t<br>and/or was not ava<br>Documentation on<br>past 6 months (Dec<br>revealed R10 had r<br>program as directed<br>When interviewed of<br>restorative aide (R4<br>Omnicycle 3-5 time | motion (ROM) utilizing the<br>le bike).<br>oth Lower extremities and both<br>in black stool for 5 minutes.<br>stand up to 5 minutes if<br>a on the use of arms to<br>legs for weight bearing and<br>e restorative nursing logs for<br>2016, documentation on R10's<br>lowing data: (1) active ROM<br>rcle- 5 out of 30 opportunities<br>2) 5 minutes exercises with<br>1-4 out of 30 opportunities for<br>naining days of the month<br>hat R10 had either refused<br>able.<br>10's restorative nursing logs<br>arch 2016, documentation<br>rcle-3 out of 31 opportunities<br>2) received 5 minutes<br>of the EZ stand-3 of 31<br>e month. The remaining days<br>hat R10 had either refused<br>ilable.<br>R10's restorative logs for the<br>cember 2015-May 2016)<br>not received the restorative |                     | within facility to complete therapy<br>programs. This will be done by tra<br>additional CNA's to complete thera<br>programs and when needed facilit<br>able to have CNA's working comp<br>required therapy programs.<br>4. DON or designee will monitor<br>POC to ensure implementation is<br>followed as well as audit four rand<br>resident therapy programs and co<br>of documentation for 6 weeks, the<br>random resident therapy programs<br>monthly for two months.<br>The data collected will be presente<br>Quarterly Quality Assurance comm<br>the ED. It will be reviewed/discuss<br>at that time the QA committee will<br>decision/recommendation regardin<br>follow-up or changes. | apy<br>y will be<br>lete the<br>r this<br>being<br>om<br>mpletion<br>n four<br>s<br>ed to the<br>nittee by<br>sed and<br>make a |                           |

|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                   |     |  | FORM                          | 05/27/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|-------------------|-----|--|-------------------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,               |     | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245371   | B. WING           | i   |  | 05/                           | 05/2016                             |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                   | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                                     |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G  |                   |     | 250 FIFTH STREET EAST<br>TRACY, MN 56175   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 282                    | the EZ stand daily.<br>pulled the restorative<br>when the census we<br>RA-A stated there we<br>was short on the flow<br>would be assigned<br>versus providing re-<br>stated rehab service<br>census remained for<br>R13 had diagnoses<br>dated 2/12/16, inclu-<br>major depression, se<br>vertebra fracture, d<br>During observation<br>was seated in her we<br>table. R13 was note<br>contractures. R13<br>hand without using<br>fingers from the part<br>dentified R13 had I<br>to a history of 2nd II<br>and osteoporosis. T<br>R13 would maintain<br>ambulating 25 feet<br>and would maintain<br>through the review<br>identified R13 would<br>following: Seated be<br>exercises with 1 po<br>Maintenance/welling<br>Follow exercise she | RA-A stated the facility had<br>ve position from the schedule<br>as low in April and May 2016.<br>vere many times when staffing<br>por, the restorative person<br>to providing personal cares<br>storative aide services. RA-A<br>es ceased for awhile when the<br>ow.<br>identified on the care plan<br>iding adult failure to thrive,<br>systemic lupus, lumbar<br>ementia and osteoporosis.<br>on 5/2/16, at 5:28 p.m. R13<br>wheelchair at the dining room<br>ed to have bilateral hand<br>was unable to open her left<br>her right hand to pull her<br>m of her hand.<br>I's care plan dated 2/12/16, it<br>imited physical mobility related<br>umbar compression fracture<br>The care plan goal identified<br>n level of mobility by<br>through the next review date<br>current level of function<br>date. The care plan for R13<br>ing restorative rehabilitation<br>motion (ROM) program<br>d complete any of the<br>bilateral lower extremity (BLE) | F                 | 282 |  |                               |                                     |

Facility ID: 00342

If continuation sheet Page 10 of 35

|                          |   | AND HUMAN SERVICES  |                   |     |  | FORM                          | : 05/27/2016<br>APPROVED<br>: 0938-0391 |
|--------------------------|---|---|-------------------|-----|--|-------------------------------|---|
| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |   |
|                          |   | 245371  | B. WING           | i   |  | 05/                           | 05/2016                                 |
| NAME OF                  | PROVIDER OR SUPPLIER  | -   |                   | 5   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |   |
| PRAIRIE                  | VIEW SENIOR LIVIN   | G   |                   |     | 250 FIFTH STREET EAST<br>TRACY, MN 56175   |                               |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETION<br>DATE              |
| F 282                    | splints in morning, a<br>Sheep skin palm pr<br>wash cloth or water<br>bilateral hands for<br>for extension. Goal<br>contractures of BUI<br>During review of R <sup>-</sup><br>for the month of Ap<br>identified R13 recei<br>active range of mot<br>the Omnicycle 4 ou<br>month. The remain<br>documented that R<br>unavailable.<br>During review of R <sup>-</sup><br>for month of March<br>identified she rece<br>active range of mot<br>the Omnicycle 0 ou<br>month. The remain<br>documented that R<br>unavailable.<br>Documentation rev<br>for the past 6 mont<br>2016) indicated R1<br>restorative program<br>When interviewed of<br>stated R13 should he<br>days/week.<br>R25 had diagnoses<br>dated 4/8/16, inclue<br>depression, right fe<br>partial repair (4/201<br>humeral fracture wi<br>post-herpatic neura | re: Use bilateral resting hand<br>afternoon and between meals.<br>rotectors on at night. Warm<br>basin before PROM of<br>10-20 repetitions on each hand<br>: Decrease flexion | F                 | 282 |  |                               |   |

If continuation sheet Page 11 of 35

| STATE BURNOR OF CORRECTION       (X) PROVIDERSUPPLIER       (X) DATE SUPPLIER         DAME OF PROVIDER OR SUPPLIER       245371       B. WING       000052016         MALE OF PROVIDER OR SUPPLIER       STREET ADDRESS, GITY, STATE, ZIP CODE       230 FFTH STREET E AST       7500 FFTH STREET CORRECTION         MALE OF PROVIDER OR SUPPLIER       STREET ADDRESS, GITY, STATE, ZIP CODE       200 FFTH STREET E AST       7500 FFTH STREET CORRECTION         MALE OF PROVIDER OR SUPPLIER       STREET ADDRESS, GITY, STATE, ZIP CODE       200 FFTH STREET E AST       7500 FFTH STREET CORRECTION         MALE OF PROVIDER STATEMENT OF DEFICIENTIES       FTACY, MN 56175       PROVIDERS PLANA OF CORRECTION       0000 FFT         MALE OF PROVIDER OF USE OF THE OF DEFICIENTIES       FTACY, MN 56175       OFTO STATEMENT OF DEFICIENTIES       PROVIDERS PLANA OF CORRECTION         MALE OF PROVIDER OF USE OF THE OF DEFICIENTIES       FTACY, MN 56175       OFTO STATE OF THE OFTO STATEMENT OF DEFICIENTIES       PROVIDERS PLANA OF CORRECTION         MALE OF PROVIDER OF USE OF THE OFTO STATEMENT OF DEFICIENTIES       FTACY, MN 56175       OFTO STATEMENT OF DEFICIENTIES       PROVIDERS PLANA OF CORRECTION         MALE OF PROVIDER OF USE OFTO STATEMENT OF DEFICIENTIES       FTACY, MN 56175       OFTO STATEMENT OF DEFICIENTIES       OFTO STATEMENT OF DEFICIENTIES         F 282       Continued From page 11       DURING OFTO STATEMENT OF DEFICIENTIES       FTACY   |           |  | AND HUMAN SERVICES  |         |     |  | FORM | 05/27/2016<br>APPROVED<br>0938-0391 |
|---|-----------|--|---|---------|-----|--|------|-------------------------------------|
| NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CTY, STATE, ZIP CODE       PRAIRIE VIEW SENIOR LIVING     STREET ADDRESS, CTY, STATE, ZIP CODE       200 FFTH STREET EAST<br>TRACY, MN 56175     200 FFTH STREET EAST<br>TRACY, MN 56175       PRILIX, RESULATORY OR LSC IDENTFYING INFORMATION,<br>RESULATORY OR LSC IDENTIFYING INFORMATION,<br>RESULATORY OR LSC IDENTIFYING INFORMATION,<br>RESULATORY OR LSC IDENTIFYING INFORMATION,<br>RESULATORY | STATEMENT | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA   | . ,     |     | E CONSTRUCTION   |      |                                     |
| PRAIRIE VIEW SENIOR LIVING     280 FIFH STREET EAST<br>TRX/ MN 56175       (X4) ID<br>FREETX<br>TAG     SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MIST BE PRECEDED BY FULL<br>(EACH CORRECTIVE ACTION HOULD BE<br>REGULTIONY OR LSC DENTIFYING INFORMATION)     PREFX<br>TAG     PRODUCT STANDARD CORRECTION<br>(EACH CORRECTIVE ACTION HOULD BE<br>DEFICIENCY)     000000000000000000000000000000000000  |           |  | 245371  | B. WING | i   | ·····  | 05/  | 05/2016                             |
| PPARIE VIEW SENOR LIVING         TRACY, MN 56175           (X4) ID<br>PHEFX<br>TAG         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY WILST ERECEDED BY FULL<br>RECULATIONY OR LSC IDENTIFYING INFORMATION)         ID<br>PROVIDERS/ENANCE CORRECTION<br>(CACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCE) TO THE APPROPRIATE<br>DURING observation on 5/5/16, at 9:46 a.m. R25<br>was noted have her right hand folded in he lap<br>with contracture while seated in the ding room.<br>R25 was noted to wheel the wheelchair with her<br>left hand and feet while her right hand remained<br>resting on her lap.<br>During review of R25's care plan dated 4/18/16, it<br>identified that R25 had limited physical mobility.<br>The care plan identified R25 would maintain level<br>of mobility through the next review date with the<br>following interventions in the nursing rehabilitation<br>program.<br>(1) Active ROM Program with pink therapy-putty<br>exercises (with page removed). Right hand<br>pushing/pulling x 10 each way. Digi-flexors right<br>hand x 5 minutes. The goal was identified as<br>maintenance of to apply hand splint on the right<br>hand.<br>(2) Active ROM Program with use of Omnicycle<br>10-15 minutes for legs. May vary according to any<br>pain complaints. The goal identified to<br>a history of 2nd lumbar compression fracture and<br>osteoprosis.<br>During review of R25's restorative nursing logs<br>for the month of April 2016, documentation<br>lidentified shar 2016, documentation<br>for the month of April 2016, documentation<br>lidentified shar R25's restorative nursing logs<br>for the month of March 2016, documentation  | NAME OF F | ROVIDER OR SUPPLIER  |   |         | S   | TREET ADDRESS, CITY, STATE, ZIP CODE                             |      |                                     |
| Priečy<br>TAG       (EACH ODERCISNY MUST BE PRECEDED BY FULL<br>REGULTIONY OR LSC IDENTIFYING INFORMATION)       PREEX<br>TAG       (EACH CORRECTVE ACTION SHOLD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)         F 282       Continued From page 11       F 282         During observation on 5/5/16, at 9:46 a.m. R25<br>was noted have her right hand folded in he lap<br>with contracture while seated in the dining room.<br>R25 was noted to wheel the wheelchair with her<br>left hand and feet while her right hand remained<br>resting on her lap.       F 282         During review of R25's care plan dated 4/18/16, it<br>identified that R25 had limited physical mobility.<br>The care plan identified R25 would maintain level<br>of mobility through the next review date with the<br>following interventions in the nursing rehabilitation<br>program:<br>(1) Active ROM Program with pink therapy-puty<br>exercises (with pegs removed). Right hand<br>pushing/pulling x 10 each way. Dig-flexors right<br>hand.       (2) Active ROM Program with use of Omnicycle<br>10-15 minutes for legs. May vary according to any<br>pain complaints. The goal lexified of the<br>program was to maintain strength for transfers<br>with not assist inmited physical mobility related to<br>a history of 2nd lumbar compression fracture and<br>osteoporosis.<br>During review of R25's restorative nursing logs<br>for the month of April 2016, documentation<br>lidentified sher received restorative services for<br>active range of motion utilizing the Omnicycle 2<br>out of 30 opportunities for the month and received<br>ROM exercises to her hands 0 of 30 opportunities<br>for the month of April 2016, documentation         During review of R25's restorative nursing logs<br>for the month of March 2016, documentation   | PRAIRIE   | VIEW SENIOR LIVING   | G   |         |     |  |      |                                     |
| During observation on 5/5/16, at 9:46 a.m. R25<br>was noted have her right hand folded in he lap<br>with contracture while seated in the dining room.<br>R25 was noted to wheel the wheelchair with her<br>left hand and feet while her right hand remained<br>resting on her lap.<br>During review of R25's care plan dated 4/18/16, it<br>identified that R25 had limited physical mobility.<br>The care plan identified R25 would maintain level<br>of mobility through the next review date with the<br>following interventions in the nursing rehabilitation<br>program:<br>(1) Active ROM Program with pink therapy-putty<br>exercises (with pegs removed). Right hand<br>pushing/pulling x 10 each way. Digi-flexors right<br>hand.<br>(2) Active ROM Program with use of Omnicycle<br>10-15 minutes. The goal identified for the<br>program was to maintain strength for transfers<br>with one assist limited physical mobility related to<br>a history of ZA0 lumbar compression fracture and<br>osteoporosis.<br>During review of R25's restorative exvices for<br>active range of motion utilizing the Omnicycle 2<br>out of 30 opportunities for the month and received<br>ROM exercises to her hands 0 of 30 opportunities<br>for the month. The remaining days of the month<br>were documented that R10 either refused or was<br>unavailable and/or was left undocumentation<br>if of the month. The remaining days of the month<br>were documented that R10 either refused or was<br>unavailable and/or was left undocumentation   | PRÉFIX    | (EACH DEFICIENCY   | Y MUST BE PRECEDED BY FULL  | PREF    |     | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP | BE   | COMPLETION                          |
| identified she received restorative services for<br>active ROM utilizing the Omnicycle 4 out of 30  | F 282     | During observation<br>was noted have here<br>with contracture wh<br>R25 was noted to w<br>left hand and feet w<br>resting on her lap.<br>During review of R2<br>identified that R25 H<br>The care plan ident<br>of mobility through f<br>following intervention<br>program:<br>(1) Active ROM Pro-<br>exercises (with peg<br>pushing/pulling x 10<br>hand x 5 minutes. The<br>program was to re-<br>maintenance of to a<br>hand.<br>(2) Active ROM Pro-<br>10-15 minutes for le<br>pain complaints. The<br>program was to ma<br>with one assist limit<br>a history of 2nd lum<br>osteoporosis.<br>During review of R2<br>for the month of Ap-<br>identified she recei-<br>active range of mot<br>out of 30 opportunit<br>ROM exercises to h<br>for the month. The<br>were documented t<br>unavailable and/or w | on 5/5/16, at 9:46 a.m. R25<br>r right hand folded in he lap<br>hile seated in the dining room.<br>wheel the wheelchair with her<br>while her right hand remained<br>25's care plan dated 4/18/16, it<br>had limited physical mobility.<br>tified R25 would maintain level<br>the next review date with the<br>ons in the nursing rehabilitation<br>ogram with pink therapy-putty<br>is removed). Right hand<br>0 each way. Digi-flexors right<br>The goal was identified as<br>apply hand splint on the right<br>ogram with use of Omnicycle<br>egs. May vary according to any<br>he goal identified for the<br>aintain strength for transfers<br>ted physical mobility related to<br>obar compression fracture and<br>25's restorative nursing logs<br>ril 2016, documentation<br>ived restorative services for<br>tion utilizing the Omnicycle 2<br>ties for the month and received<br>her hands 0 of 30 opportunities<br>remaining days of the month<br>that R10 either refused or was<br>was left undocumented.<br>25's restorative nursing logs<br>arch 2016, documentation<br>ived restorative services for<br>tion utilizing the Omnicycle 2<br>ties for the month and received<br>her hands 0 of 30 opportunities<br>remaining days of the month<br>that R10 either refused or was<br>was left undocumented. |         | 282 |  |      |                                     |

If continuation sheet Page 12 of 35

| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)  | CENTEF<br>STATEMENT<br>AND PLAN O<br>NAME OF F |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br>245371  | A. BUILDING<br>B. WING | LE CONSTRUCTION  | FORM<br>OMB NO<br>(X3) DAT<br>COM | : 05/27/2016<br>APPROVED<br>. 0938-0391<br>E SURVEY<br>MPLETED |
|--|--|---|---|------------------------|--|-----------------------------------|--|
| F 282     Continued From page 12<br>opportunities for the month and received ROM<br>exercises to her hands 0 of 30 opportunities for<br>the month. The remaining days of the month<br>were documented that R10 either refused or was<br>unavailable, or was left undocumented.<br>Documentation reviewed on the restorative logs<br>for the past 6 months (December 2015-May<br>2016) indicated R25 had not received a<br>restorative program as directed by the care plan.<br>When nursing assistants (NA)- B, NA-C and<br>NA-F were interviewed on 5/4/16, at 2:00 p.m.<br>they stated they did not have the time to<br>implement the restorative nursing duties when the<br>restorative aide was removed from those duties<br>to assist them with resident cares. They all<br>verified the NA's did not complete the restorative<br>programs during the time when the resident<br>census was low.     When interviewed on 5/5/16, at 8:12 a.m. the<br>director of nursing (DON) verified the RA had<br>been removed from the restorative program from<br>the time period 3/29/16 through 4/21/16, related<br>to staffing changes affected by low resident<br>census. The DON further verified sometimes the<br>RA was pulled from rehab to cover for call-ins to<br>perform NA cares. The DNS verified the census     DEFICIENCY) | (X4) ID<br>PREFIX                              | SUMMARY STA<br>(EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL  | ID<br>PREFIX           | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO | ULD BE                            | COMPLETION   |
| on the floor instead of the RA position. The DNS<br>further stated the NA's caring for the residents<br>should conduct the restorative exercises during<br>cares but verified the logs indicated the<br>rehabilitation program was not documented to<br>support completion of the services.<br>During a follow-up interview with the RA-A on<br>5/5/16, at 9:18 a.m. she indicated she was asked<br>to provide personal cares for resident's today<br>instead of providing restorative care due to a   |  | Continued From pa<br>opportunities for the<br>exercises to her ha<br>the month. The rem<br>were documented t<br>unavailable, or was<br>Documentation revi<br>for the past 6 month<br>2016) indicated R22<br>restorative program<br>When nursing assis<br>NA-F were interview<br>they stated they did<br>implement the restor<br>restorative aide was<br>to assist them with<br>verified the NA's did<br>programs during the<br>census was low.<br>When interviewed of<br>director of nursing (<br>been removed from<br>the time period 3/25<br>to staffing changes<br>census. The DON<br>RA was pulled from<br>perform NA cares.<br>was low the past m<br>on the floor instead<br>further stated the N<br>should conduct the<br>cares but verified th<br>rehabilitation progra<br>support completion<br>During a follow-up i<br>5/5/16, at 9:18 a.m.<br>to provide personal | age 12<br>e month and received ROM<br>nds 0 of 30 opportunities for<br>naining days of the month<br>that R10 either refused or was<br>left undocumented.<br>iewed on the restorative logs<br>hs (December 2015-May<br>5 had not received a<br>n as directed by the care plan.<br>stants (NA)- B, NA-C and<br>wed on 5/4/16, at 2:00 p.m.<br>I not have the time to<br>prative nursing duties when the<br>s removed from those duties<br>resident cares. They all<br>d not complete the restorative<br>e time when the resident<br>on 5/5/16, at 8:12 a.m. the<br>(DON) verified the RA had<br>n the restorative program from<br>9/16 through 4/21/16, related<br>affected by low resident<br>further verified sometimes the<br>n rehab to cover for call-ins to<br>The DNS verified the census<br>onth and the RA was utilized<br>of the RA position. The DNS<br>IA's caring for the residents<br>restorative exercises during<br>he logs indicated the<br>am was not documented to<br>of the services. | 1                      | DEFICIENCY)  |                                   |  |

If continuation sheet Page 13 of 35

|                          | OF DEFICIENCIES  | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA   | (X2) MIII TIDI      |  | NO. 0938-039<br>3) DATE SURVEY |
|--------------------------|--|--|---------------------|--|--------------------------------|
|                          | OF CORRECTION  | IDENTIFICATION NUMBER:   |                     |  | COMPLETED                      |
|                          |  | 245371   | B. WING             |  | 05/05/2016                     |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                     | TREET ADDRESS, CITY, STATE, ZIP CODE   |                                |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G  |                     | 50 FIFTH STREET EAST<br>RACY, MN 56175   |                                |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |                                |
| F 282                    | different staff calling  | ge 13<br>g in ill. The RA-A stated she is<br>I be able to do restorative   | F 282               |  |                                |
| F 318<br>SS=D            | DON verified the re<br>to work on the floor<br>due to a NA who fa<br>483.25(e)(2) INCR   | on 5/5/16, at 9:38 a.m. the<br>storative aide was re-assigned<br>(to provide personal cares)<br>iled to show up for work today.<br>EASE/PREVENT DECREASE<br>TION | F 318               |  | 6/13/16                        |
|                          | resident, the facility<br>with a limited range<br>appropriate treatme  | ent and services to increase<br>d/or to prevent further  |                     |  |                                |
|                          | by:<br>Based on observative<br>review the facility factoriate the facility factoriate facility factoriate | NT is not met as evidenced<br>tion, interview and document<br>ailed to provide the assessed<br>ices for 3 of 3 residents (R10,<br>d who had limited range of     |                     | F318<br>The preparation of the following plan<br>correction for this deficiency does not<br>constitute and should not be interprete<br>as an admission nor an agreement by<br>facility of the truth of the facts alleged   | ed<br>v the<br>on              |
|                          | dated 3/29/16, incluinfarction, dementia polyosteoarthritis a  |  |                     | <ul> <li>conclusions set forth in the statement deficiencies. The plan of correction prepared for this deficiency was exect solely because it is required by provis of State and Federal law. Without wa the foregoing statement, the facility st that with respect to:</li> <li>1. MDS coordinator, DON, Therapy</li> </ul> | uted<br>ions<br>iving<br>ates  |

Facility ID: 00342

If continuation sheet Page 14 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245371 **B** WING 05/05/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 FIFTH STREET EAST PRAIRIE VIEW SENIOR LIVING **TRACY, MN 56175** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 318 Continued From page 14 F 318 which he stated had been contracted for a long therapy programs including R10, R13, and R25. All programs were review and time since he'd experienced a cardiovascular revised as indicated and staff that accident (CVA). provides therapy services will be educated The care plan dated 3/29/16, identified R10 had on June 13, 2016 to the therapy programs an activities of daily living (ADL) self care care planned. performance deficit related to CVA, hemiplegia DON or designee will monitor four 2. and dementia. The care plan also indicated R10 random resident therapy programs and had limited mobility, with a goal the resident completion of documentation for 6 weeks, would maintain ability to transfer with assist of 2 then four random resident therapy staff, or 2 staff and EZ stand (mechanical lift), to programs monthly. maintain his current level of function. The care Facility will ensure staff are present 3. plan identified R10 was on a nursing rehabilitation within facility to complete therapy program that included: programs. This will be done by training (1) Active range of motion (ROM) utilizing the additional CNA's to complete therapy Omnicycle (Exercise bike). programs and when needed facility will be (2) Stretching of both Lower extremities and both able to have CNA's working complete the hamstrings. required therapy programs. (3) Place feet up on black stool for 5 minutes. 4.DON will monitor this POC to ensure (4) Standing in EZ stand up to 5 minutes if implantation is being followed as well as cooperative to work on the use of arms to audit 4 random resident therapy programs pull up and use of legs for weight bearing and and completion of documentation for 6 posture. weeks, then four random resident therapy During review of the restorative nursing logs for programs monthly for two months. the month of April 2016, documentation on R10's The data collected will be presented to the log identified the following data: (1) active ROM Quarterly Quality Assurance committee by utilizing the Omnicycle- 5 out of 30 opportunities the ED. It will be reviewed/discussed and for the month and (2) 5 minutes exercises with at that time the QA committee will make a use of the EZ stand -4 out of 30 opportunities for decision/recommendation regarding the month. The remaining days of the month follow-up or changes. 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

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 15 of 35

PRINTED: 05/27/2016

|                          |  | I AND HUMAN SERVICES<br>E & MEDICAID SERVICES  |                     |    |  | FORM                          | 05/27/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|---------------------|----|--|-------------------------------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |    | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |  | 245371   | B. WING             |    |  | 05/0                          | 05/2016                             |
| NAME OF !                | PROVIDER OR SUPPLIER   |  |                     |    | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                                     |
| PRAIRIE                  | VIEW SENIOR LIVING   | G  |                     | -  | 50 FIFTH STREET EAST<br>RACY, MN 56175   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | ×  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 318                    | were documented t<br>and/or was not avail<br>Documentation on I<br>past 6 months (Dec<br>revealed R10 had m<br>program as directed<br>When interviewed of<br>restorative aide (RA<br>Omnicycle 3-5 time<br>extremity and lower<br>the EZ stand daily,<br>pulled the restorative<br>when the census w<br>RA-A stated there w<br>was short on the flow<br>would be assigned<br>versus providing resistated rehab service<br>when the census resistated rehab service<br>and would maintain<br>ambulating 25 feet<br>and would maintain | that R10 had either refused<br>ilable.<br>R10's restorative logs for the<br>cember 2015-May 2016)<br>not received the restorative<br>d by the care plan.<br>on 5/4/16, at 1:04 p.m.<br>A)-A stated R10 should use the<br>es/week and have upper<br>r extremity exercises while in<br>RA-A stated the facility had<br>ve position from the schedule<br>vas low in April and May 2016.<br>were many times when staffing<br>por, the restorative person<br>to providing personal cares<br>estorative aide services. RA-A<br>as had ceased for awhile<br>emained low.<br>s identified on the care plan<br>uding adult failure to thrive,<br>systemic lupus, lumbar<br>dementia and osteoporosis.<br>on 5/2/16, at 5:28 p.m. R13<br>wheelchair at the dining room<br>ed to have bilateral hand<br>was unable to open her left<br>her right hand to pull her | F 3                 | 18 |  |                               |                                     |

If continuation sheet Page 16 of 35

|  |   | AND HUMAN SERVICES  |                    |     |  | FORM     | 05/27/2016<br>APPROVED<br>0938-0391 |
|--|---|---|--------------------|-----|--|----------|-------------------------------------|
| STATEMENT OF DE<br>AND PLAN OF COR   | FICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | PLE CONSTRUCTION   | (X3) DAT | E SURVEY<br>PLETED                  |
|  |   | 245371  | B. WING            |     |  | 05/      | 05/2016                             |
| NAME OF PROVID   | DER OR SUPPLIER   |   |                    | ę   | STREET ADDRESS, CITY, STATE, ZIP CODE  |          |                                     |
| PRAIRIE VIEW   | SENIOR LIVIN  | G   |                    |     | 250 FIFTH STREET EAST  |          |                                     |
|  |   |   |                    |     | TRACY, MN 56175  |          | 1                                   |
|  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE       | (X5)<br>COMPLETION<br>DATE          |
| iden<br>inter<br>(1) <i>A</i><br>iden<br>follo<br>exer<br>Mair<br>nurs<br>Folk<br>as n<br>(BU)<br>resti<br>betw<br>nigh<br>PRC<br>each<br>cont<br>Duri<br>for t<br>iden<br>activ<br>the 0<br>mon<br>docu<br>unav<br>Duri<br>for n<br>iden<br>activ<br>the 0<br>mon<br>docu<br>unav<br>Doc<br>for t<br>2016 | ventions:<br>Active range of Active range of Acti | ing restorative rehabilitation<br>motion (ROM) program<br>d complete any of the<br>bilateral lower extremity (BLE)<br>und weight.<br>ess/restorative therapy:<br>ram as patient tolerates.<br>eet. Use Omnicycle arm bike<br>of bilateral upper extremities<br>splint care: Use bilateral<br>is in morning, afternoon and<br>eep skin palm protectors on at<br>cloth or water basin before<br>hands for 10-20 repetitions on<br>nsion. Goal: Decrease flexion | F                  | 318 | 3  |          |                                     |

If continuation sheet Page 17 of 35

| CENTER                   | RS FOR MEDICARE  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                    |     | (  | FORM<br><u>OMB NO.</u> | : 05/27/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|--|---|--------------------|-----|--|------------------------|---|
|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                |     | E CONSTRUCTION   |                        | E SURVEY<br>IPLETED                     |
|                          |  | 245371  | B. WING            |     |  | 05/                    | 05/2016                                 |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                        |   |
| PRAIRIE                  | VIEW SENIOR LIVING   | 3   |                    |     | 50 FIFTH STREET EAST<br>RACY, MN 56175   |                        |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                   | (X5)<br>COMPLETION<br>DATE              |
| F 318                    | week and should had ays/week.<br>R25 had diagnoses dated 4/8/16, include depression, right fe partial repair (4/201 humeral fracture wi post-herpatic neura the right third and fe During observation was noted have here with contracture wh R25 was noted to we left hand and feet we resting on her lap.<br>During review of R2 identified that R25 H The care plan ident of mobility through following intervention program:<br>(1) Active ROM Protexers (with peg pushing/pulling x 10 hand.<br>(2) Active ROM Protexers for left pain complaints. The program was to ma with one assist limit a history of 2nd lum osteoporosis.<br>During review of R2 for the month of Apidentified she receit active range of mot | ge 17<br>ave AROM to bilateral hands 5<br>didentified on the care plan<br>ling: heart failure, anxiety,<br>moral neck fracture with<br>5), osteoporosis, history of<br>th decreased mobility,<br>llgia, and history of injury to<br>burth fingers related to fall.<br>on 5/5/16, at 9:46 a.m. R25<br>r right hand folded in he lap<br>ile seated in the dining room.<br>wheel the wheelchair with her<br>while her right hand remained<br>25's care plan dated 4/18/16, it<br>had limited physical mobility.<br>ified R25 would maintain level<br>the next review date with the<br>ons in the nursing rehabilitation<br>ogram with pink therapy-putty<br>s removed). Right hand<br>0 each way. Digi-flexors right<br>The goal was identified as<br>apply hand splint on the right<br>ogram with use of Omnicycle<br>egs. May vary according to any<br>he goal identified for the<br>intain strength for transfers<br>ted physical mobility related to<br>abar compression fracture and<br>25's restorative nursing logs<br>ril 2016, documentation<br>wed restorative services for<br>ion utilizing the Omnicycle 2<br>ies for the month and received | F3                 | 318 |  |                        |   |

|                          |   | AND HUMAN SERVICES   |                     |  | FORM                          | 05/27/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|---------------------|--|-------------------------------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | PLE CONSTRUCTION<br>G  | (X3) DATE SURVEY<br>COMPLETED |                                     |
|                          |   | 245371   | B. WING             |  | 05/0                          | 05/2016                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |                               |                                     |
| PRAIRIE                  | VIEW SENIOR LIVIN   | G  |                     | 250 FIFTH STREET EAST<br>TRACY, MN 56175   |                               |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE          |
| F 318                    | ROM exercises to h<br>for the month. The<br>were documented t<br>unavailable and/or<br>During review of R2<br>for the month of Ma<br>identified she receive<br>active ROM utilizing<br>opportunities for the<br>exercises to her ha<br>the month. The rem<br>were documented t<br>unavailable, or was<br>Documentation rev<br>for the past 6 month<br>2016) indicated R2<br>restorative program<br>When nursing assis<br>NA-F were interview<br>they stated they did<br>implement the restor<br>restorative aide was<br>to assist them with<br>verified the NA's did<br>programs during th<br>census was low.<br>When interviewed of<br>director of nursing (<br>been removed from<br>the time period 3/25<br>to staffing changes<br>census. The DON<br>RA was pulled from<br>perform NA cares.<br>was low the past m<br>on the floor instead | age 18<br>her hands 0 of 30 opportunities<br>remaining days of the month<br>that R10 either refused or was<br>was left undocumented.<br>25's restorative nursing logs<br>arch 2016, documentation<br>ved restorative services for<br>g the Omnicycle 4 out of 30<br>e month and received ROM<br>nds 0 of 30 opportunities for<br>naining days of the month<br>that R10 either refused or was<br>a left undocumented.<br>iewed on the restorative logs<br>hs (December 2015-May<br>5 had not received a<br>n as directed by the care plan.<br>stants (NA)- B, NA-C and<br>wed on 5/4/16, at 2:00 p.m.<br>I not have the time to<br>prative nursing duties when the<br>s removed from those duties<br>resident cares. They all<br>d not complete the restorative<br>e time when the resident<br>on 5/5/16, at 8:12 a.m. the<br>(DON) verified the RA had<br>n the restorative program from<br>9/16 through 4/21/16, related<br>affected by low resident<br>further verified sometimes the<br>n rehab to cover for call-ins to<br>The DNS verified the census<br>onth and the RA was utilized<br>of the RA position. The DNS<br>IA's caring for the residents | F 31                |  |                               |                                     |

Facility ID: 00342

If continuation sheet Page 19 of 35

| DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM<br>CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. |  |  |  |   |                                      |                               |                            |  |  |
|--|--|--|--|---|--------------------------------------|-------------------------------|----------------------------|--|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |   |                                      | (X3) DATE SURVEY<br>COMPLETED |                            |  |  |
|  |  | 245371                                 | B. WING                                  |   |                                      | 05/05/2016                    |                            |  |  |
| NAME OF P  | ROVIDER OR SUPPLIER  |  |  |   | TREET ADDRESS, CITY, STATE, ZIP CODE |                               |                            |  |  |
| PRAIRIE  | VIEW SENIOR LIVING   | 3                                      | 250 FIFTH STREET EAST<br>TRACY, MN 56175 |   |                                      |                               |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  |   | (EACH CORRECTIVE ACTION SHOULD I     | BE                            | (X5)<br>COMPLETION<br>DATE |  |  |
|  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)<br>Continued From page 19<br>should conduct the restorative exercises during<br>cares but verified the logs indicated the<br>rehabilitation program was not documented to<br>support completion of the services.<br>During a follow-up interview with the RA-A on<br>5/5/16, at 9:18 a.m. she indicated she was asked<br>to provide personal cares for resident's today<br>instead of providing restorative care due to a<br>different staff calling in ill. The RA-A stated she is<br>unsure if she would be able to do restorative<br>program.<br>When interviewed on 5/5/16, at 9:38 a.m. the<br>DON verified the restorative aide was re-assigned<br>to work on the floor (to provide personal cares)<br>due to a NA who failed to show up for work today. |  |  | ID<br>PREFIX<br>TAG       PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)         F 318       F 318         F 323       F 323         The preparation of the following plan<br>correction for this deficiency does not<br>constitute and should not be interpret |                                      | ot                            | 6/6/16                     |  |  |

Event ID:1EW811

Facility ID: 00342

If continuation sheet Page 20 of 35

| DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 00                                     |   |  |                    |     |   |   |                            |
|---|---|--|--------------------|-----|---|---|----------------------------|
| STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                    |     | (X3) DATE SURVEY<br>COMPLETED   |   |                            |
|   |   | 245371   | B. WING            |     |   | 05/05/2016  |                            |
| NAME OF I   | PROVIDER OR SUPPLIER  |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |   |                            |
| PRAIRIE   | VIEW SENIOR LIVING  | G  |                    |     | 50 FIFTH STREET EAST<br>RACY, MN 56175  |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)   | BE  | (X5)<br>COMPLETION<br>DATE |
| F 323   | Findings include:<br>R12's care plan dat<br>diagnoses including<br>dementia, cerebrow<br>hypertension.<br>R12's care plan dat<br>at risk for aspiration<br>diet to include necta<br>liquids, including liq<br>plan goal was for R<br>over the next quarte<br>During observation<br>pass and resident of<br>trained medication<br>R12's 7:00 p.m. me<br>the following medic<br>(antipsychotic) 5 mi<br>mg- 2 tabs; and Arie<br>mg. After placing th<br>medication cup, TM<br>and mixed them in<br>transported the me<br>administer them wh<br>TMA-B elevated the<br>approximately 45 d<br>down in the bed wit<br>the bed. Subseque<br>elevated to the 45 c<br>attempted. After ac<br>medications, TMA-I<br>liquids while R12 ref | VIEW SENIOR LIVING           SUMMARY STATEMENT OF DEFICIENCIES           (EACH DEFICIENCY MUST BE PRECEDED BY FULL           REGULATORY OR LSC IDENTIFYING INFORMATION)           Continued From page 20           Findings include:           R12's care plan dated 3/24/16, identified           diagnoses including: Alzheimer's disease,           dementia, cerebrovascular disease and |                    | 323 | <ul> <li>deficiencies. The plan of correction prepared for this deficiency was exercises olely because it is required by provious of State and Federal law. Without with foregoing statement, the facility that with respect to: <ol> <li>On 5/2/2016 DON provided education to all nursing staff this wap provided in regards to giving fluid ar nutrition while in bed.</li> <li>On June 6, 2016 Speech Thera and dietary manager will provide fur education for dysphasia diets and prevention of aspiration.</li> <li>DON or designee will audit and observe staff giving residents with a consistence liquids for safe standard practice and monitor 4 episodes we for four weeks, then 2 episodes monitor two months.</li> </ol> </li> <li>The data collected will be presented Quarterly Quality Assurance commit the ED. It will be reviewed/discusse at that time the QA committee will m decision/recommendation regarding follow-up or changes.</li> </ul> | ecuted<br>risions<br>vaiving<br>states<br>as<br>nd<br>apy<br>ther<br>d<br>litered<br>d of<br>ekly<br>nthly<br>d to the<br>ttee by<br>ed and<br>nake a |                            |

If continuation sheet Page 21 of 35

|   |  | AND HUMAN SERVICES   |                   |                |   | FORM       | 05/27/2016<br>APPROVED<br>0938-0391 |
|---|--|--|-------------------|----------------|---|------------|-------------------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |  |  |                   | E CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED   |            |                                     |
|   |  | 245371   | B. WING           |                |   | 05/05/2016 |                                     |
| NAME OF I   | PROVIDER OR SUPPLIER   |  |                   |                | TREET ADDRESS, CITY, STATE, ZIP CODE  | -          |                                     |
| PRAIRIE   | VIEW SENIOR LIVING   | 3  |                   |                | 50 FIFTH STREET EAST<br>RACY, MN 56175  |            |                                     |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |                | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE       | (X5)<br>COMPLETION<br>DATE          |
| F 323   | related to R12 rece<br>lying in bed. The D0<br>that the resident's h<br>elevated to 90 degr<br>ensure the resident<br>position while admini-<br>liquids. The DON at<br>aspiration.<br>During interview with<br>5/3/16, at 3:00 p.m.<br>thickened liquids at<br>provide the liquids at<br>provide | iving thickened liquids while<br>ON stated staff should know<br>head of the bed should be<br>ees (not 45 degrees) and also<br>is maintained in an upright<br>nistering medications and/or<br>lso verified R12 was at risk for<br>th registered nurse (RN)-D on<br>RN-D stated R12 had<br>her bedside and staff should<br>to R12 while she is in a seated<br>on 5/4/16, at 10:29 a.m.<br>N)-C stated R12 was at risk<br>hould be placed in a position<br>be alert during the<br>ickened liquids. RN-C<br>ld be at risk for potential<br>ng upright. RN-C stated the<br>uidance to direct staff as to<br>should be in when laying in | F                 | 323            |   |            |                                     |

If continuation sheet Page 22 of 35

|   |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                     |   | FORM       | 05/27/2016<br>APPROVED<br>0938-0391 |
|---|---|--|---------------------|---|------------|-------------------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |   | . ,  |                     | (X3) DATE SURVEY<br>COMPLETED   |            |                                     |
|   |   | 245371   | B. WING             |   | 05/05/2016 |                                     |
| NAME OF F   | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |            |                                     |
| PRAIRIE   | VIEW SENIOR LIVING  | G  |                     | 250 FIFTH STREET EAST<br>TRACY, MN 56175  |            |                                     |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE    | (X5)<br>COMPLETION<br>DATE          |
| F 323   | reclined, while eatin<br>The curriculum did<br>foods or liquids for a<br>how to provide food<br>lying position in a graddressed the diffe<br>thickened liquids (n<br>provide instruction of<br>thickened liquids. T<br>identified in the train<br>expectation for all s<br>and/or giving liquids<br>During interview with<br>on 5/4/16 at 11:00 a<br>best practice to adm<br>any resident with a<br>position. The ST fun<br>advise anyone to ha<br>lying position wheth<br>or not. The ST state<br>practice ".<br>The facility failed to<br>were trained when a<br>to residents at risk f<br>have the the process<br>The facility further p<br>aspiration related to<br>standards of practic<br>medications and thi<br>while positioned in 1<br>483.25(I) DRUG RE | wheels) should be upright, no<br>ng.<br>not identify how to administer<br>a resident in bed but identified<br>and liquids to a resident in a<br>eri-chair. The curriculum<br>rent consistencies of<br>ectar, honey) but failed to<br>related to the administration of<br>he DON stated the standard<br>hing guide would be the<br>staff to follow when feeding<br>to residents.<br>the speech therapist (ST)<br>a.m. the ST stated it would be<br>ninister liquids and foods to<br>risk for aspiration in an upright<br>of the stated she would not<br>ave liquids or foods while in a<br>ther they were at aspiration risk<br>ed, "That would not be a safe<br>provide evidence of how staff<br>administering thickened liquids<br>for aspiration and failed to<br>as identified on the care plan.<br>blaced R12 at risk for<br>the lack of following<br>be for administering<br>ickened liquids to a resident<br>lying position in bed.<br>EGIMEN IS FREE FROM | F 323               |   |            | 6/6/16                              |
| SS=D  | UNNECESSARY D<br>Each resident's dru  | RUGS<br>g regimen must be free from  |                     |   |            |                                     |

Facility ID: 00342

If continuation sheet Page 23 of 35

|   |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                    |  |  | FORM /   | APPROVED<br>0938-0391      |  |
|---|--|---|--------------------|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |  |   |                    |  | (X3) DATE SURVEY<br>COMPLETED  |  |                            |  |
|   |  | B. WING   |                    |  | 05/05/2016   |  |                            |  |
| NAME OF I   | PROVIDER OR SUPPLIER   |   |                    | STREET ADDRESS, CITY, STATE, ZIP CODE    |  |  |                            |  |
| PRAIRIE   | VIEW SENIOR LIVING   | G   |                    | 250 FIFTH STREET EAST<br>TRACY, MN 56175 |  |  |                            |  |
| (X4) ID<br>PREFIX<br>TAG  |  |   | ID<br>PREFI<br>TAG |  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI/<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE |  |
| F 329   | Continued From page 23<br>unnecessary drugs. An unnecessary drug is any<br>drug when used in excessive dose (including<br>duplicate therapy); or for excessive duration; or<br>without adequate monitoring; or without adequate<br>indications for its use; or in the presence of<br>adverse consequences which indicate the dose<br>should be reduced or discontinued; or any<br>combinations of the reasons above.<br>Based on a comprehensive assessment of a<br>resident, the facility must ensure that residents<br>who have not used antipsychotic drugs are not<br>given these drugs unless antipsychotic drug<br>therapy is necessary to treat a specific condition<br>as diagnosed and documented in the clinical<br>record; and residents who use antipsychotic<br>drugs receive gradual dose reductions, and<br>behavioral interventions, unless clinically<br>contraindicated, in an effort to discontinue these<br>drugs. |   | F3                 | 329                                      |  |  |                            |  |
|   | by:<br>Based on interview<br>facility failed to mor<br>anti-hypertensive m<br>(R18) who received<br>medications and did<br>pressure (BP) reco<br>Findings include:<br>R18's most recent p<br>dated 3/24/16, iden<br>including: coronary  | NT is not met as evidenced<br>y and document review the<br>hitor the effectiveness of<br>hedications for 1 of 1 resident<br>I multiple anti-hypertensive<br>d not have ongoing blood<br>rdings. |                    |  | F329<br>The preparation of the following plan<br>correction for this deficiency does no<br>constitute and should not be interpre<br>as an admission nor an agreement be<br>facility of the truth of the facts alleged<br>conclusions set forth in the statement<br>deficiencies. The plan of correction<br>prepared for this deficiency was exect<br>solely because it is required by provision<br>of State and Federal law. Without we<br>the foregoing statement, the facility statement | ot<br>eted<br>by the<br>d on<br>nt of<br>cuted<br>sions<br>raiving |                            |  |

Facility ID: 00342

If continuation sheet Page 24 of 35

PRINTED: 05/27/2016
| STATEMEN                 | OF DEFICIENCIES   | KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:  |                     | TIPLE CONSTRU  |  | (X3) DAT   | . 0938-039<br>E SURVEY<br>IPLETED |  |
|--------------------------|---|--|---------------------|--|--|--|-----------------------------------|--|
|                          |   | BERTHIOMONIONIDEN.   | A. BUILDI           | NG   |  | 001  |                                   |  |
|                          |   | 245371   | B. WING             |  |  |  | 05/2016                           |  |
|                          | PROVIDER OR SUPPLIER  | G  |                     | STREET ADDF<br>250 FIFTH ST<br>TRACY, MN   |  | ODE  | E                                 |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EAC   | ROVIDER'S PLAN OF COF<br>CH CORRECTIVE ACTION<br>S-REFERENCED TO THE<br>DEFICIENCY)  | SHOULD BE  | (X5)<br>COMPLETIOI<br>DATE        |  |
| F 329                    | vascular dementia<br>This progress note<br>and plan related to<br>hypertension and th<br>acceptable blood p<br>148/88 millimeters<br>had been document<br>R18's most recent p<br>4/14/16, identified of<br>Isosorbide Mononit<br>tablet 24 hour 30 m<br>mouth daily for ang<br>mg by mouth for ess<br>Lopressor tablet 50<br>for essential hypert<br>The pharmacy cons<br>indicated the follow<br>experiencing elevat<br>although there are<br>also; has been fallin<br>following these incli<br>most recent BP's a<br>and 166/89 on 1/12<br>R18's Norvasc med<br>1/14/16, from 2.5 m<br>elevated BP's. Upd<br>and progress notes<br>not followed-up unt<br>medication increass<br>documented was 3<br>measured 148/88 m<br>documented BP rea<br>3/24/16. There was | CVA-stroke), recurrent falls,<br>and chronic kidney disease.<br>also include an assessment<br>the diagnosis of essential<br>ne physician indicated an<br>ressure (BP) range for R18 as<br>of mercury (mm Hg), which<br>ited on the monthly flow sheet.<br>physician orders dated<br>current medications as noted:<br>rate (extended release) ER<br>nilligrams (mg) 1.5 tablets by<br>ina attacks, Norvasc tablet 5<br>issential hypertension and<br>mg by mouth two times a day<br>ension.<br>sultant note dated 1/13/16,<br>ring: [R18] has been<br>ted blood pressures lately,<br>also some very low results<br>ng out of bed and BP checks<br>dents have been elevated;<br>re: 110/58 (1/13), 187/102<br>2/16.<br>dication was increased on<br>ng to 5 mg daily due to<br>on review of the BP flowsheet<br>is it was noted that R2's BP was<br>il 1/29/16, (2 week after a<br>e). The next BP reading<br>/24/16, at 3:16 a.m. and<br>nm Hg. There were no<br>adings from 1/29/16 thru<br>is no evidence documented in<br>g that ongoing BP readings | F 3                 | that with<br>1. Rea<br>pressure<br>each shi<br>for revie<br>2. Rea<br>reviewed<br>SBAR p<br>guideline<br>nursing<br>2016.<br>3. DC<br>for docu<br>weekly b<br>of reside<br>10% of r<br>The data<br>Quarterl<br>the ED.<br>at that ti<br>decision | a respect to:<br>garding R18 monito<br>es three times per d<br>ift and were reported<br>w.<br>viewed vital sign gui<br>d change of conditio<br>olicy along with conde<br>es. DON will provide<br>staff on the above a<br>DN or designee will n<br>imentation and comp<br>olood pressures and<br>ents weekly for four<br>residents weekly for four<br>residents weekly for<br>a collected will be pr<br>ly Quality Assurance<br>It will be reviewed/c<br>me the QA committed<br>/recommendation re<br>p or changes. | ay, once on<br>d to physician<br>idelines and<br>on charting and<br>dition charging<br>e education to<br>treas June 6,<br>nonitor PCC<br>pliance with<br>I monitor 20%<br>weeks, then<br>four weeks.<br>resented to the<br>e committee by<br>discussed and<br>ee will make a |                                   |  |

If continuation sheet Page 25 of 35

|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                     |   | FORM     | : 05/27/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|--|--|---------------------|---|----------|---|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · /                 | PLE CONSTRUCTION  | (X3) DAT | E SURVEY<br>IPLETED                     |
|                          |  | 245371   | B. WING             |   | 05/      | /05/2016                                |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |          |   |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G  |                     | 250 FIFTH STREET EAST<br>TRACY, MN 56175  |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE   | (X5)<br>COMPLETION<br>DATE              |
| F 329                    | ascertain R18's res<br>During an interview<br>director of nursing (<br>practice was to obta<br>unless a physician<br>The nursing assista<br>monthly on the resid<br>During a telephone<br>a.m. the facility's m<br>also R18's primary<br>like to see a BP out<br>for this age group (i<br>is the goal, otherwis<br>stroke." The MD fu<br>would require reche<br>expect a resident re<br>to have their BP mo<br>monthly. He verified<br>measurements wer<br>useful tool to evalua<br>anti-hypertensive m<br>every other day BP<br>stated, "I was not a<br>monitoring R18's B<br>stated it was difficu<br>effectiveness when<br>conducted before/a<br>administered. The<br>requested noon BP | <ul> <li>dosage increase and ponse to treatment.</li> <li>on 5/5/16, at 8:57 a.m. the (DON) indicated the facility ain monthly routine vital signs orders indicated otherwise. Interview on 5/5/16, at 9:45 edical director (MD, who was physician) stated, "I would not of the accepted high range included R18). A BP of 150/90 se it will increase the risk for orther stated an elevated BP ecking and stated he would eceiving an anti-hypertensive onitored more frequently than d that monthly BP e not frequent enough to be a ate the effectiveness of the edication, indicating daily or may be appropriate. The MD ware the facility had not been Ps more frequently." MD also It to evaluate the medication is MD indicated he had monitoring vs. early morning e residents who were receiving an arti-hypertensive</li> </ul> | F 329               | 9   |          |   |

Facility ID: 00342

If continuation sheet Page 26 of 35

|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                     |  | FORM  | 05/27/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|---|---------------------|--|---|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |  | (X3) DATE   | E SURVEY<br>PLETED                  |
|                          |  | 245371  | B. WING _           |  | 05/(  | 05/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |                                     |
| PRAIRIE                  | VIEW SENIOR LIVING   | G   |                     | 250 FIFTH STREET EAST<br>TRACY, MN 56175   |   |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETION<br>DATE          |
| F 329                    | Continued From pa  | ge 26   | F 32                | 9  |   |                                     |
| F 332<br>SS=D            |  | OF MEDICATION ERROR   | F 33                | 2  |   | 5/26/16                             |
|                          |  | sure that it is free of<br>es of five percent or greater.   |                     |  |   |                                     |
|                          | by:<br>Based on observat<br>review the facility fa<br>were administered to<br>observed during me<br>resulted in a medica<br>Findings include.<br>During observation<br>pass on 5/2/16, at 7<br>assistant (TMA)-B p<br>medications. The fo<br>up by TMA-B: Zypr<br>milligrams (mg); Tyl<br>Aricept (dementia n<br>placing the medicat<br>cup, TMA-B crushe<br>them in applesauce<br>medications into R1<br>them with a spoon t<br>bed. TMA-B elevate<br>approximately 45 de | NT is not met as evidenced<br>ion, interview and document<br>iled to ensure all medications<br>for 1 of 9 residents (R12)<br>edication administration. This<br>ation error rate of 12%.<br>of the evening medication<br>2:00 p.m. trained medication<br>prepared R12's bedtime<br>blowing medications were set<br>exa (antipsychotic) 5<br>lenol 500 mg, 2 tabs; and<br>hedication) 15 mg. After<br>ions into a plastic medication<br>d the medications and placed<br>the medications and placed<br>the medications and placed<br>the head of the bed to<br>egrees but R12 slid down<br>he bed and thus her head was<br>degree level. After |                     | <ul> <li>F332</li> <li>The preparation of the following plat correction for this deficiency does no constitute and should not be interpret as an admission nor an agreement facility of the truth of the facts allege conclusions set forth in the stateme deficiencies. The plan of correction prepared for this deficiency was exercise solely because it is required by proviof State and Federal law. Without with foregoing statement, the facility that with respect to:</li> <li>1. Upon notification of medication on 5/2/2016 by surveyor for R12, TM was reassigned off medication pass coaching and education was complete by DON on medication errors.</li> <li>2. On June 6, 2016 Speech Thera and dietary manager will provide fur education for dysphasia diets and prevention of aspiration.</li> <li>3. On May 26, 2016 and annually TMA's and licensed nursing staff with</li> </ul> | ot<br>eted<br>by the<br>ed on<br>nt of<br>ecuted<br>visions<br>vaiving<br>states<br>n error<br>MA-B<br>s until<br>eted<br>apy<br>ther |                                     |

Facility ID: 00342

If continuation sheet Page 27 of 35

PRINTED: 05/27/2016

|                          |   |  |                     |  |   | 0938-039                  |
|--------------------------|---|--|---------------------|--|---|---------------------------|
|                          | FOF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | IPLE CONSTRUCTION  |   | E SURVEY<br>PLETED        |
|                          |   | 245371   | B. WING _           |  |   | 05/2016                   |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CO  | DDE   |                           |
| PRAIRIE                  | VIEW SENIOR LIVIN   | G  |                     | 250 FIFTH STREET EAST<br>TRACY, MN 56175   |   |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)  | SHOULD BE   | (X5)<br>COMPLETIO<br>DATE |
| F 332                    | administering the n<br>noted that TMA-B s<br>(medications/apple<br>medication administ<br>located in the hallw<br>TMA-B documente<br>administration reco<br>administered the m<br>noted there was ad<br>the applesauce ren<br>used to administer<br>applesauce mixture<br>mixture as did the b<br>which contained ad<br>During interview wir<br>p.m. it was verified<br>were administered<br>verify R12 had reco<br>prescribed medicat<br>not realize she left<br>cup.<br>When interviewed of<br>director of nursing<br>aware of the obser-<br>properly trained to a<br>should ensure resid<br>prescribed.<br>During review of the<br>Dose Preparation a<br>Omnicare 2013, the<br>identified: 3. Dose<br>take all measures r<br>including, but not lin<br>Facility staff should<br>accordance with ph | nedications to R12, it was<br>set the medication cup<br>sauce) on top of the<br>stration cart. The cart was<br>vay outside of R12's room.<br>d in the medication<br>rd (MAR) that she had<br>nedications. However, it was<br>Iditional medication mixed with<br>naining in the cup. The spoon<br>the medication and<br>e contained chunks of the<br>poottom of the medication cup, | F 33                | complete a medication admirefresher course and need to pass a competency test. 4. Two TMA's will be rand by DON or designee on one pass each week for 8 weeks medication passes each momonths. The data collected will be proquarterly Quality Assurance the ED. It will be reviewed/d at that time the QA committed decision/recommendation refollow-up or changes. | o successfully<br>omly audited<br>medication<br>s, then two<br>nth for two<br>esented to the<br>committee by<br>liscussed and<br>ee will make a |                           |

Facility ID: 00342

If continuation sheet Page 28 of 35

|                          | OF DEFICIENCIES  | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA   |                     | IPLE CONSTRUCTION   |   | E SURVEY                  |  |
|--------------------------|--|---|---------------------|---|---|---------------------------|--|
|                          | OF DEFICIENCIES<br>OF CORRECTION   | IDENTIFICATION NUMBER:  |                     | NG  |   | IPLETED                   |  |
|                          |  | 245371  | B. WING _           |   | 05/   | 05/2016                   |  |
| IAME OF F                | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |   |                           |  |
| PRAIRIE                  | VIEW SENIOR LIVING   | G   |                     | 250 FIFTH STREET EAST<br>TRACY, MN 56175  |   |                           |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)  | OULD BE   | (X5)<br>COMPLETIC<br>DATE |  |
| F 332                    | could or could not b   | be crushed but did not identify ated to the administration of   | F 3                 | 32  |   |                           |  |
| F 428<br>SS=D            | related to the admir<br>applesauce.<br>483.60(c) DRUG R  | able to produce any policy<br>histration of medications in<br>EGIMEN REVIEW, REPORT<br>ON   | F 4/                | 28  |   | 6/13/16                   |  |
|                          |  | of each resident must be<br>nce a month by a licensed   |                     |   |   |                           |  |
|                          | the attending physic   | st report any irregularities to<br>cian, and the director of<br>reports must be acted upon.   |                     |   |   |                           |  |
|                          | by:  | NT is not met as evidenced  |                     | E 400   |   |                           |  |
|                          | pharmacy consultant<br>blood pressure more<br>ffectiveness for 1 of<br>who received multipr<br>medications.<br>Findings include: | of 1 resident (R18) reviewed<br>ble anti-hypertensive   |                     | F428<br>The preparation of the following<br>correction for this deficiency do<br>constitute and should not be in<br>as an admission nor an agreen<br>facility of the truth of the facts a<br>conclusions set forth in the stat<br>deficiencies. The plan of corre | es not<br>erpreted<br>nent by the<br>lleged on<br>ement of<br>ction |                           |  |
|                          | dated 3/24/16, iden<br>including: coronary<br>(high blood pressur<br>vascular disease (C   | bhysician's progress note<br>tified active diagnoses<br>artery disease, hypertension<br>e), chronic back pain, cerebral<br>CVA-stroke), recurrent falls,<br>and chronic kidney disease. |                     | <ul> <li>prepared for this deficiency was solely because it is required by of State and Federal law. With the foregoing statement, the far that with respect to:</li> <li>1. By June 13, 2016 the adm</li> </ul>  | provisions<br>out waiving<br>cility states                          |                           |  |

Facility ID: 00342

If continuation sheet Page 29 of 35

|                          |  |   | (VO) MUUTU          |   |  | 0938-039                  |
|--------------------------|--|---|---------------------|---|--|---------------------------|
|                          | FOF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION<br>G   |  | E SURVEY<br>PLETED        |
|                          |  | 245371  | B. WING             |   | 05/0   | 05/2016                   |
| NAME OF                  | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |  |                           |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G   |                     | 250 FIFTH STREET EAST<br>TRACY, MN 56175  |  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | D BE   | (X5)<br>COMPLETIO<br>DATE |
| F 428                    | This progress note<br>and plan related to<br>hypertension and th<br>acceptable blood p<br>148/88 millimeters<br>had been documer<br>R18's most recent<br>4/14/16, identified of<br>Isosorbide Mononit<br>tablet 24 hour 30 m<br>mouth daily for ang<br>mg by mouth for es<br>Lopressor tablet 50<br>for essential hypert<br>The pharmacy cons<br>indicated the follow<br>experiencing elevat<br>although there are<br>also; has been fallin<br>following these inci<br>most recent BP's a<br>and 166/89 on 1/12<br>Isosorbide Mononit<br>release medication<br>chewed".<br>R18's Norvasc med<br>1/14/16, due to elev<br>staff. Review of the<br>Norvasc had been<br>had been recorded<br>months; from 1/29/<br>BP readings docum<br>evidence documen<br>ongoing BP reading<br>determine the effect | also include an assessment<br>the diagnosis of essential<br>ne physician indicated an<br>ressure (BP) range for R18 as<br>of mercury (mm Hg), which<br>need on the monthly flow sheet.<br>physician orders dated<br>current medications as noted:<br>rrate (extended release) ER<br>nilligrams (mg) 1.5 tablets by<br>ina attacks, Norvasc tablet 5<br>ssential hypertension and<br>mg by mouth two times a day | F 423               | 8<br>director or nursing, and consulting<br>pharmacist will review and revise<br>and procedures for proper monito<br>medication usage, especially med<br>prescribed for hypertension contro<br>Nursing staff will be educated as<br>necessary to the importance of th<br>pharmacist's review. The DON or<br>designee, along with the pharmacia<br>audit medication reviews on a mo<br>basis to ensure compliance.<br>The data collected will be present<br>Quarterly Quality Assurance com<br>the ED. It will be reviewed/discus<br>at that time the QA committee will<br>decision/recommendation regard<br>follow-up or changes. | policies<br>ring of<br>lications<br>ol.<br>e<br>ist will<br>nthly<br>ed to the<br>nittee by<br>sed and<br>make a |                           |

If continuation sheet Page 30 of 35

|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                     |   | FORM     | : 05/27/2016<br>APPROVED<br>. 0938-0391 |
|--------------------------|--|--|---------------------|---|----------|---|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | TIPLE CONSTRUCTION  | (X3) DAT | TE SURVEY<br>MPLETED                    |
|                          |  | 245371   | B. WING _           |   | 05       | /05/2016                                |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE                                       |          |   |
| PRAIRIE                  | VIEW SENIOR LIVING   | 3  |                     | 250 FIFTH STREET EAST<br>TRACY, MN 56175                                    |          |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | X (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE  | (X5)<br>COMPLETION<br>DATE              |
| F 428                    | Continued From particular treatment.   | ge 30  | F 4:                | 28  |          |   |
|                          | consultant notes da<br>4/20/16 lacked any<br>related to staff mon  | ent monthly pharmacy<br>ted 2/20/16, 3/20/16 and<br>further recommendations<br>itoring the effectiveness (BP<br>rvasc medication since the<br>eased.   |                     |   |          |   |
|                          | director of nursing (<br>practice was to obta<br>unless a physician of<br>The DON verified the<br>not identified nor re- | on 5/5/16, at 8:57 a.m. the<br>DON) indicated the facility<br>ain monthly routine vital signs<br>orders indicated otherwise.<br>he pharmacy consultant had<br>commended any increase BP<br>Norvasc had been increased. |                     |   |          |   |
|                          | a.m. the pharmacy discussed with the I   | interview on 5/5/16, at 10:15<br>consultant indicated he had<br>DON and recommended<br>be sufficient monitoring for<br>d anti-hypertensive   |                     |   |          |   |
| F 441<br>SS=D            |  | I CONTROL, PREVENT   | F 44                | 41  |          | 6/6/16                                  |
|                          | Infection Control Press  | tablish and maintain an<br>ogram designed to provide a<br>comfortable environment and<br>development and transmission<br>ction.  |                     |   |          |   |
|                          | Program under which  | tablish an Infection Control   |                     |   |          |   |

Facility ID: 00342

If continuation sheet Page 31 of 35

|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                    |    |  | FORM APPROVED<br>MB NO. 0938-0391                |                            |  |
|--------------------------|--|--|--------------------|----|--|--|----------------------------|--|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |    |  | (X3) DATE  | E SURVEY<br>PLETED         |  |
|                          |  | 245371   | B. WING            |    |  | 05/0   | 05/2016                    |  |
| NAME OF                  | PROVIDER OR SUPPLIER   |  |                    |    | TREET ADDRESS, CITY, STATE, ZIP CODE   |  |                            |  |
| PRAIRIE                  | VIEW SENIOR LIVING   | G  |                    |    | 50 FIFTH STREET EAST<br>RACY, MN 56175   |  |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)  | BE   | (X5)<br>COMPLETION<br>DATE |  |
| F 441                    | in the facility;<br>(2) Decides what pr<br>should be applied to<br>(3) Maintains a reco<br>actions related to in<br>(b) Preventing Spre<br>(1) When the Infect<br>determines that a re<br>prevent the spread<br>isolate the resident.<br>(2) The facility musi-<br>communicable dise<br>from direct contact<br>direct contact will tr<br>(3) The facility musi-<br>hands after each di<br>hand washing is ince<br>professional practice<br>(c) Linens<br>Personnel must have<br>transport linens so<br>infection.<br>This REQUIREMEN<br>by:<br>Based on observat<br>review the facility fa-<br>blood glucose mete-<br>between use for 2 of<br>required blood suga<br>on the North and Co-<br>Findings include: | rocedures, such as isolation,<br>o an individual resident; and<br>ord of incidents and corrective<br>fections.<br>ead of Infection<br>ion Control Program<br>esident needs isolation to<br>of infection, the facility must<br>t prohibit employees with a<br>ase or infected skin lesions<br>with residents or their food, if<br>ansmit the disease.<br>t require staff to wash their<br>rect resident contact for which<br>dicated by accepted<br>se.<br>ndle, store, process and<br>as to prevent the spread of<br>NT is not met as evidenced<br>ion, interview and document<br>iled to ensure the multi-use<br>of 2 residents (R12, R23) who<br>ar level monitoring and resided | F 4                | 41 | F441<br>The preparation of the following plan<br>correction for this deficiency does no<br>constitute and should not be interpre<br>as an admission nor an agreement<br>facility of the truth of the facts allege<br>conclusions set forth in the statement<br>deficiencies. The plan of correction<br>prepared for this deficiency was exe<br>solely because it is required by prov | ot<br>eted<br>by the<br>ed on<br>nt of<br>ecuted |                            |  |

Facility ID: 00342

If continuation sheet Page 32 of 35

PRINTED: 05/27/2016

|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                     |  | FORM /   | 05/27/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|---------------------|--|--|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 |  | (X3) DATE  | E SURVEY<br>PLETED                  |
|                          |  | 245371   | B. WING             |  | 05/0   | 05/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER   |  | :                   | STREET ADDRESS, CITY, STATE, ZIP CODE  |  |                                     |
| PRAIRIE                  | VIEW SENIOR LIVING   | 3  |                     | 250 FIFTH STREET EAST<br>TRACY, MN 56175   |  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | ЗE   | (X5)<br>COMPLETION<br>DATE          |
| F 441                    | glucose meter (gluc<br>lancet (pricking nee<br>the medication cart<br>donned gloves, con<br>check and verbalize<br>sugar (BS) to R12.<br>sugar, TMA-B exite<br>medication cart, ren<br>placed the glucome<br>on top of the cart.<br>isopropyl alcohol wi<br>glucometer was sto<br>the glucometer with<br>finished cleansing ti<br>returned the glucom<br>basket located on to<br>administration cart<br>strips, alcohol wipes<br>When interviewed of<br>stated she always u<br>cleanse the glucom<br>scheduled to work so<br>of a TMA and freque<br>which also includes<br>testing. TMA-B state<br>prior to conducting<br>implemented the sa<br>cleansed the glucor<br>after performing the<br>TMA-B stated she h<br>anything different of<br>which were the only<br>medication cart to c<br>use. TMA-B was as<br>Central wings for th | t (TMA)-B retrieved a blood<br>cometer), test strips and a<br>dle used to obtain blood) from<br>. TMA-B entered R12's room,<br>ducted the blood sugar (BS)<br>ed the results of the blood<br>After checking R12's blood<br>d the room, walked to the<br>noved her soiled gloves and<br>ter in a plastic basket located<br>TMA-B then retrieved a 70%<br>pe from the basket where the<br>red and proceeded to cleanse<br>the alcohol wipe. After she<br>he glucometer, TMA-B<br>neter back into the plastic<br>op of the medication<br>which also stored the test | F 441               | of State and Federal law. Without w<br>the foregoing statement, the facility s<br>that with respect to:<br>1. On 5/2/2016 education to TMA-<br>was completed for disinfection proce<br>on glucometer use to follow manufac<br>cleaning and disinfecting guidelines.<br>5/3/2016 educations to remaining lic<br>nursing staff and TMA s was compl<br>for disinfection procedures on glucon<br>use to follow manufacturer cleaning<br>disinfecting guidelines.<br>2. On 5/3/2016 glucometers were<br>ordered for all residents who use<br>glucometers to prevent any sharing<br>glucometers in the future.<br>3. On June 6, 2016 DON or desig<br>will educate all licensed nursed and<br>TMA's to the manufacturers<br>recommendations on cleaning of<br>glucometers.<br>4. DON or designee will monitor prop<br>cleaning techniques for glucometers<br>auditing 3 licensed staff or TMA's we<br>for 6 weeks, then 4 licensed staff or<br>TMA's monthly for two months.<br>The data collected will be presented<br>Quarterly Quality Assurance commit<br>the ED. It will be reviewed/discussed<br>at that time the QA committee will m<br>decision/recommendation regarding<br>follow-up or changes. | states<br>-B<br>edures<br>cturer<br>. On<br>censed<br>leted<br>meter<br>and<br>of<br>per<br>s by<br>eekly<br>l to the<br>ttee by<br>ed and<br>iake a |                                     |

If continuation sheet Page 33 of 35

|                          |   | AND HUMAN SERVICES  |                     |    |   | FORM      | 05/27/2016<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|---------------------|----|---|-----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |    |   | (X3) DATE | E SURVEY<br>PLETED                  |
|                          |   | 245371  | B. WING             |    |   | 05/       | 05/2016                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                     |    | TREET ADDRESS, CITY, STATE, ZIP CODE<br>50 FIFTH STREET EAST  |           |                                     |
| PRAIRIE                  | VIEW SENIOR LIVING  | 3   |                     |    | RACY, MN 56175  |           |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | x  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE          |
| F 441                    | Continued From pa   | ge 33   | F 4                 | 41 |   |           |                                     |
|                          | director of nursing (<br>utilizing the Super S  | on 5/2/16, at 7:30 p.m. the<br>(DON) stated staff should be<br>Sani-Cloth before and after use<br>lucometer equipment to<br>ose levels.   |                     |    |   |           |                                     |
| F 465<br>SS=C            | glucometer was ide<br>manufacturer's clea<br>guidelines. The inst<br>disinfecting were id<br>handbook as follow<br>Cleaning guidelines<br>blood glucose mete<br>dampened with soa<br>(70%-80%).<br>Disinfecting guidelin<br>dilute 1 milliliter (ml<br>sodium Hypochlorit<br>achieve a 1:10 dilut<br>0.5%-0.6% sodium<br>can be used to dam<br>saturate towel). The<br>thoroughly wipe dow<br>483.70(h)<br>SAFE/FUNCTIONA | s: To clean the outside of the<br>er, use a lint-free cloth<br>apy water or isopropyl alcohol<br>nes: To disinfect the meter,<br>) household bleach (5%-6%<br>e solution) in 9 ml of water to<br>ion (finale concentration of<br>Hypochlorite). The solution<br>npen a paper towel (do not<br>en use the dampened towel to<br>wn the meter. | F 4                 | 65 |   |           | 6/3/16                              |
|                          |   | ovide a safe, functional,<br>ortable environment for<br>the public.   |                     |    |   |           |                                     |
|                          | by:<br>Based on observat  | NT is not met as evidenced tion and interview the facility the condition of the ceiling tiles   |                     |    | F465<br>The preparation of the following pla  | n of      |                                     |

Facility ID: 00342

If continuation sheet Page 34 of 35

PRINTED: 05/27/2016

|  | H AND HUMAN SERVICES<br>RE & MEDICAID SERVICES   |                   |     |  | FORM   | 05/27/2016<br>APPROVED<br>0938-0391 |
|--|--|-------------------|-----|--|--|-------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,               |     | E CONSTRUCTION   | (X3) DATE  | E SURVEY<br>PLETED                  |
|  | 245371   | B. WING           |     |  | 05/0   | 05/2016                             |
| NAME OF PROVIDER OR SUPPLIE  | R  |                   |     | TREET ADDRESS, CITY, STATE, ZIP CODE   |  |                                     |
| PRAIRIE VIEW SENIOR LIV  | NG   |                   |     | 50 FIFTH STREET EAST<br>RACY, MN 56175   |  |                                     |
| PREFIX (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)  | BE   | (X5)<br>COMPLETION<br>DATE          |
| <ul> <li>wings of the facili 101/103, 105/107 202/204, 206/208 214/216; 300 win 303/305, 306/308</li> <li>Findings include:</li> <li>During observation through 5/5/16, at bathrooms had c and/or discolored 100 wing rooms: 109/111; 200 wing rooms: 211/213, 214/216 300 wing rooms: 307/309.</li> <li>A tour was conductive director and the rest of the second through through the second through the</li></ul> | en bathrooms located on all 3<br>ty. (100 wing room #: 102/104,<br>, 109/111; 200 wing room #:<br>, 207, 210/212, 211/213,<br>gs room #: 301, 302/304,<br>, 307/309).<br>ns on 5/2/16, at 2:20 p.m.<br>: 2:00 p.m. the following resident<br>eiling tiles which were stained<br>:<br>102/104, 101/103, 105/107,<br>202/204, 206/208, 207, 210/212, | F                 | 465 | correction for this deficiency does n<br>constitute and should not be interpr<br>as an admission nor an agreement<br>facility of the truth of the facts allege<br>conclusions set forth in the stateme<br>deficiencies. The plan of correction<br>prepared for this deficiency was exe<br>solely because it is required by prov<br>of State and Federal law. Without we<br>the foregoing statement, the facility<br>that with respect to:<br>1. All ceiling tiles found to be stai<br>and/or discolored will be replaced we<br>new tiles by June 3, 2016, by<br>Maintenance Supervisor<br>2. Each quarter an inspection of<br>tiles will be conducted to identify tile<br>may need to be replaced by Mainte<br>Supervisor. An inspection work orded<br>be placed on the Direct Supply TEL<br>maintenance program for each qua<br>and monitored each quarter for two<br>quarters by ED.<br>The data collected will be presented<br>Quarterly Quality Assurance commit<br>the ED. It will be reviewed/discusse<br>at that time the QA committee will n<br>decision/recommendation regarding<br>follow-up or changes. | eted<br>by the<br>ed on<br>ent of<br>becuted<br>visions<br>waiving<br>states<br>ned<br>vith<br>ceiling<br>es that<br>nance<br>er will<br>.S<br>.rter<br>d to the<br>ittee by<br>ed and<br>nake a |                                     |

Facility ID: 00342

If continuation sheet Page 35 of 35

|                          | OF DEFICIENCIES  | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA  |                   |     | 071024  | (X3) DA  | ). 0938-039<br>TE SURVEY   |
|--------------------------|--|--|-------------------|-----|---|----------|----------------------------|
|                          | OF CORRECTION  |  | · ·               |     | MAIN BUILDING 01  | CO       | MPLETED                    |
|                          |  | 245371   | B. WING           |     |   |          | /03/2016                   |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                   |     | ET ADDRESS, CITY, STATE, ZIP COD<br>FIFTH STREET EAST   | Ε        |                            |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G  |                   |     | CY, MN 56175  |          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | IOULD BE | (X5)<br>COMPLETION<br>DATE |
| K 000                    | INITIAL COMMEN   | ٢S   | K                 | 000 |   |          |                            |
|                          | FIRE SAFETY  |  |                   |     |   |          |                            |
|                          | ALLEGATION OF (<br>DEPARTMENT'S A<br>SIGNATURE AT TH<br>PAGE OF THE CM   | OC WILL SERVE AS YOUR<br>COMPLIANCE UPON THE<br>CCEPTANCE. YOUR<br>HE BOTTOM OF THE FIRST<br>S-2567 FORM WILL BE<br>ATION OF COMPLIANCE.   |                   |     |   |          |                            |
|                          | ONSITE REVISIT<br>CONDUCTED TO<br>SUBSTANTIAL CO<br>REGULATIONS HA   | OF AN ACCEPTABLE POC, AN<br>OF YOUR FACILITY MAY BE<br>VALIDATE THAT<br>MPLIANCE WITH THE<br>AS BEEN ATTAINED IN<br>ITH YOUR VERIFICATION.   |                   |     |   |          |                            |
|                          | Minnesota Departn<br>Fire Marshal Division<br>time of this survey,<br>Center was found r<br>compliance with the<br>in Medicare/Medica<br>483.70(a), Life Safe<br>edition of National | Survey was conducted by the<br>nent of Public Safety, State<br>on, on May 03, 2016. At the<br>Prairie View Healthcare<br>not to be in substantial<br>e requirements for participation<br>aid at 42 CFR, Subpart<br>ety from Fire, and the 2000<br>Fire Protection Association<br>afety Code (LSC), Chapter 19<br>re Occupancies. |                   |     | FDA   |          |                            |
|                          | PLEASE RETURN<br>CORRECTION FO<br>DEFICIENCIES (K  | R THE FIRE SAFETY  |                   |     | LFV   |          |                            |
|                          | Health Care Fire In<br>State Fire Marshal<br>445 Minnesota Stro<br>St. Paul, MN 5510   | Division<br>eet, Suite 145   |                   | -   |   |          |                            |
|                          | By email to:   | -  |                   |     |   |          |                            |
|                          |  | DER/SUPPLIER REPRESENTATIVE'S SIGN   |                   |     | TITLE   |          | (X6) DATE                  |

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

- - - - - - - - -

|                          |   | AND HUMAN SERVICES   |  |   |          | APPROVE                   |  |
|--------------------------|---|--|--|---|----------|---------------------------|--|
| TATEMENT                 | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |  | PLE CONSTRUCTION<br>IG 01 - MAIN BUILDING 01  | (X3) DAT | E SURVEY                  |  |
|                          |   | 245371   | B. WING _                                |   | 05       | 05/03/2016                |  |
| NAME OF F                | ROVIDER OR SUPPLIER   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE   |          |                           |  |
| PRAIRIE                  | VIEW SENIOR LIVIN   | G  | 250 FIFTH STREET EAST<br>TRACY, MN 56175 |   |          |                           |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | ULD BE   | (X5)<br>COMPLETIO<br>DATE |  |
| K 000                    | Angela.Kappenma<br><mailto:angela.kap<br>THE PLAN OF CO</mailto:angela.kap<br>                                    | state.mn.us<br>hitney@state.mn.us> and   | K 00                                     | 00  |          |                           |  |
|                          | FOLLOWING INFO<br>1. A description of<br>to correct the defic   | ORMATION:<br>what has been, or will be, done   |  |   |          |                           |  |
|                          | 3. The name and/c<br>responsible for cor  | or title of the person<br>rection and monitoring to<br>ence of the deficiency.   |  |   |          |                           |  |
|                          | in 1965, is one-sto<br>basement, is fully f   | ncare Center was constructed<br>ry in height, has a partial<br>fire sprinkler protected and was<br>of Type II(111) construction.   | 1  |   |          |                           |  |
|                          | detection in the co<br>corridors which is in<br>department notificat<br>rooms are equipped<br>alarms. The facilit | ire alarm system with smoke<br>rridors and spaces open to the<br>monitored for automatic fire<br>ation. Additionally, all resident<br>ed with battery-operated smoke<br>by has a capacity of 55 beds<br>of 43 at time of the survey. |  |   |          |                           |  |
| K 025                    | NOT MET as evide  | tt 42 CFR, Subpart 483.70(a) is<br>enced by:<br>AFETY CODE STANDARD  | K 02                                     | 25  |          | 5/31/16                   |  |
| SS=D                     | Smoke barriers sh<br>least a one half ho<br>constructed in acc  | all be constructed to provide at<br>our fire resistance rating and<br>ordance with 8.3. Smoke<br>ermitted to terminate at an   | 1 02                                     |   |          |                           |  |

Event ID: 1EW821

Facility ID: 00342

If continuation sheet Page 2 of 4

|                          |   | E & MEDICAID SERVICES   |  |  | DATE SURVEY  |  |
|--------------------------|---|---|--|--|--|--|
|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                                      |  | COMPLETED  |  |
|                          |   | 245371  | B. WING                                  |  | 05/03/2016   |  |
| AME OF F                 | ROVIDER OR SUPPLIER   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE  |  |  |
| PRAIRIE                  | VIEW SENIOR LIVIN   | IG  | 250 FIFTH STREET EAST<br>TRACY, MN 56175 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETIO<br>DATE  |  |
| K 025                    | Continued From p  | age 2   | K 02                                     | 5  |  |  |
|                          | fire-rated glazing of<br>steel frames.<br>8.3, 19.3.7.3, 19.3<br>This STANDARD<br>Smoke barriers sl<br>least a one half ho<br>constructed in acc<br>barriers shall be p<br>atrium wall. Windo<br>fire-rated glazing of<br>steel frames.<br>8.3, 19.3.7.3, 19.3<br>FINDINGS INCLU<br>During Facility Ins<br>between the hours<br>open penetrations<br>above the lay-in of<br>Barrier.<br>This was also obs<br>Environmental Se | is not met as evidenced by:<br>nall be constructed to provide at<br>our fire resistance rating and<br>ordance with 8.3. Smoke<br>ermitted to terminate at an<br>ows shall be protected by<br>or by wired glass panels and<br>.7.5<br>DE:<br>pection on May 03, 2016,<br>a of 09:00 AM and 12:30 PM,<br>around cables were observed<br>eiling on the North Wing Smoke<br>erved by the Director of<br>rvices. |  | K025<br>The preparation of the following plan of<br>correction for this deficiency does not<br>constitute and should not be interpreter<br>as an admission nor an agreement by<br>facility of the truth of the facts alleged of<br>conclusions set forth in the statement of<br>deficiencies. The plan of correction<br>prepared for this deficiency was execut<br>solely because it is required by provision<br>of State and Federal law. Without waits<br>the foregoing statement, the facility stat<br>that with respect to:<br>1. On May 31, 2016 the open<br>penetration around cables which were<br>observed above the lay-in ceiling on the<br>North Wing Smoke Barrier was filled we<br>fire protection sealant that is rated for a<br>least one half hour fire resistance.<br>The data collected will be presented to<br>Quarterly Quality Assurance committee<br>the ED. It will be reviewed/discussed a<br>at that time the QA committee will mak<br>decision/recommendation regarding<br>follow-up or changes. | d<br>he<br>n<br>of<br>ed<br>ons<br>ring<br>tes<br>e<br>ith<br>ith<br>the<br>by<br>ond<br>e a |  |
| K 050<br>SS=D            |   | AFETY CODE STANDARD   | K 05                                     | 0  | 6/3/16   |  |
|                          | signal and simulat<br>conditions. Fire dr<br>times under varyir<br>on each shift. The<br>and is aware that<br>routine. Responsi   | ion of emergency fire<br>ills are held at unexpected<br>ng conditions, at least quarterly<br>staff is familiar with procedures<br>drills are part of established<br>bility for planning and<br>s assigned only to competent   |  |  |  |  |

Event ID: 1EW821

Facility ID: 00342

If continuation sheet Page 3 of 4

|                          |  | AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                     | -   | FORM   | 05/27/2016<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|---------------------|---|--|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION<br>G 01 - MAIN BUILDING 01   | (X3) DATE  | SURVEY<br>PLETED                    |
|                          |  | 245371   | B. WING             |   | 05/0   | 3/2016                              |
| NAME OF F                | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |  |                                     |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G  |                     | 250 FIFTH STREET EAST<br>TRACY, MN 56175  |  |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY)  | D BE   | (X5)<br>COMPLETION<br>DATE          |
| K 050                    | Where drills are co<br>6:00 AM a coded a<br>instead of audible a<br>18.7.1.2, 19.7.1.2<br>This STANDARD i<br>Fire drills include t<br>signal and simulatic<br>conditions. Fire drill<br>times under varying<br>on each shift. The<br>and is aware that d<br>routine. Responsib<br>conducting drills is<br>persons who are qu<br>Where drills are co<br>6:00 AM a coded a<br>instead of audible a<br>18.7.1.2, 19.7.1.2<br>FINDINGS INCLUI<br>During Facility Doc<br>2016, between the<br>12:30 PM, docume<br>the night shift (10p<br>conducted during t<br>the 4th quarter (Oc | ualified to exercise leadership.<br>nducted between 9:00 PM and<br>nnouncement may be used<br>alarms.<br>s not met as evidenced by:<br>he transmission of a fire alarm<br>on of emergency fire<br>Is are held at unexpected<br>g conditions, at least quarterly<br>staff is familiar with procedures<br>rills are part of established<br>ility for planning and<br>assigned only to competent<br>ualified to exercise leadership.<br>nducted between 9:00 PM and<br>nnouncement may be used<br>alarms.<br>DE:<br>umentation Review on May 03,<br>hours of 09:00 AM and<br>entation review revealed that<br>m-6am) fire drill was not<br>he 3rd quarter (Jul-Sep) and<br>it-Dec) of 2015.<br>erved by the Director of<br>vices. | K 05                | K050<br>The preparation of the following p<br>correction for this deficiency does<br>constitute and should not be inter<br>as an admission nor an agreemen<br>facility of the truth of the facts alle<br>conclusions set forth in the staten<br>deficiencies. The plan of correction<br>prepared for this deficiency was e<br>solely because it is required by pr<br>of State and Federal law. Without<br>the foregoing statement, the facilit<br>that with respect to:<br>1. By June 3, 2016 all fire drills<br>required shifts will be verified and<br>on the Direct Supply TELS monther<br>maintenance program.<br>2. ED will monitor monthly for 6<br>to ensure correct shift or fire drill<br>complete.<br>The data collected will be present<br>Quarterly Quality Assurance com<br>the ED. It will be reviewed/discuss<br>at that time the QA committee will<br>decision/recommendation regard<br>follow-up or changes. | not<br>preted<br>at by the<br>ged on<br>hent of<br>on<br>xecuted<br>ovisions<br>t waiving<br>ty states<br>and<br>placed<br>ly<br>6 months<br>has been<br>red to the<br>mittee by<br>sed and<br>I make a<br>ing |                                     |
| FORM CMS-2               | 567(02-99) Previous Version  | s Obsolete Event ID: 1EW82   | 21                  | Facility ID: 00342 If conti   | nuation she  | et Page 4 of 4                      |



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Prairie View Senior Living May 19, 2016 Page 2

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,

Kumala Fiske Downing

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

| Minneso                  | ta Department of He  | alth   |                         |  |                   |                          |
|--------------------------|--|--|-------------------------|--|-------------------|--------------------------|
|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|                          |  | 00342  | B. WING                 |  | 05/0              | 5/2016                   |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S          | STATE, ZIP CODE  |                   |                          |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G 250 FIFTH<br>TRACY, M  | I STREET EA<br>IN 56175 | AST  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 2 000                    | Initial Comments   |  | 2 000                   |  |                   |                          |
|                          | *****ATTE  | NTION*****   |                         |  |                   |                          |
|                          | NH LICENSING   | CORRECTION ORDER   |                         |  |                   |                          |
|                          | 144A.10, this correct<br>pursuant to a surver<br>found that the defic<br>herein are not corrected shall  | Minnesota Statute, section<br>ction order has been issued<br>y. If, upon reinspection, it is<br>iency or deficiencies cited<br>ected, a fine for each violation<br>be assessed in accordance<br>ines promulgated by rule of<br>artment of Health.  |                         |  |                   |                          |
|                          | corrected requires of<br>requirements of the<br>number and MN Ru<br>When a rule contain<br>comply with any of<br>lack of compliance.<br>re-inspection with a<br>result in the assess | hether a violation has been<br>compliance with all<br>a rule provided at the tag<br>ule number indicated below.<br>Ins several items, failure to<br>the items will be considered<br>Lack of compliance upon<br>any item of multi-part rule will<br>ment of a fine even if the item<br>uring the initial inspection was |                         |  |                   |                          |
|                          | that may result from<br>orders provided that<br>the Department wit   | hearing on any assessments<br>n non-compliance with these<br>at a written request is made to<br>hin 15 days of receipt of a<br>ent for non-compliance.   |                         |  |                   |                          |
|                          | receipt of State lice<br>the Minnesota Dep<br>Informational Bullet<br>http://www.health.s<br>obul.htm The Stat<br>delineated on the a  | participate in the electronic<br>nsure orders consistent with<br>artment of Health<br>in 14-01, available at<br>tate.mn.us/divs/fpc/profinfo/inf<br>e licensing orders are   |                         |  |                   |                          |
| ABORATOR                 | epartment of Health<br>7 DIRECTOR'S OR PROVIE<br>ically Signed   | DER/SUPPLIER REPRESENTATIVE'S SIGI   | NATURE                  | TITLE  |                   | (X6) DATE<br>05/26/16    |

If continuation sheet 1 of 41

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                          | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |  |
|--------------------------|--|---|--------------------------|--|---------------------------------|-------------------------|--|
|                          |  | 00342   | B. WING                  |  | 05/                             | 05/05/2016              |  |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, ST         | TATE, ZIP CODE   |                                 |                         |  |
| PRAIRIE                  | VIEW SENIOR LIVIN  |   | H STREET EAS<br>MN 56175 | ST   |                                 |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 000                    | Continued From pa  | ge 1  | 2 000                    |  |                                 |                         |  |
|                          | you electronically.<br>is necessary for Sta<br>enter the word "corr<br>text. You must then<br>State licensure pro-<br>completion date, th  | Ith orders being submitted to<br>Although no plan of correction<br>ate Statutes/Rules, please<br>rected" in the box available for<br>indicate in the electronic<br>cess, under the heading<br>e date your orders will be<br>lectronically submitting to the<br>nent of Health.  |                          |  |                                 |                         |  |
|                          | Department's staff<br>the following correct<br>Please indicate in y<br>correction that you   | 5/5/16, surveyors of this<br>visited the above provider and<br>tion orders are issued.<br>Your electronic plan of<br>have reviewed these orders,<br>e when they will be completed.  |                          |  |                                 |                         |  |
| 2 265                    | MN Rule 4658.008<br>Resident Health Sta  | 5 Notification of Chg in<br>atus  | 2 265                    |  |                                 | 6/6/16                  |  |
|                          | policies to guide sta<br>physicians, physicia<br>practitioners, and if<br>legal representative<br>member of a reside<br>accident, or death.<br>nursing services, an<br>attending physician<br>development of the | ast develop and implement<br>aff decisions to consult<br>an assistants, and nurse<br>known, notify the resident's<br>or an interested family<br>ent's acute illness, serious<br>At a minimum, the director of<br>and the medical director or an<br>must be involved in the<br>se policies. The policies must<br>address at least the<br>tion times for: |                          |  |                                 |                         |  |
|                          |  | involving the resident which<br>I has the potential for requiring<br>on;  |                          |  |                                 |                         |  |
|                          |  | change in the resident's r psychosocial status, for   |                          |  |                                 |                         |  |

If continuation sheet 2 of 41

|                          | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                        | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED<br>05/05/2016 |                         |
|--------------------------|---|---|------------------------|--|---|-------------------------|
|                          |   | 00342   | B. WING                |  |   |                         |
| AME OF F                 | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY,          | STATE, ZIP CODE  |   |                         |
| RAIRIE                   | VIEW SENIOR LIVIN   | G   | H STREET E<br>MN 56175 | AST  |   |                         |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | OULD BE                                     | (X5)<br>COMPLET<br>DATE |
| 2 265                    | Continued From pa   | age 2   | 2 265                  |  |   |                         |
|                          |   | ration in health, mental, or<br>s in either life-threatening<br>al complications;   |                        |  |   |                         |
|                          | example, a need to  | Iter treatment significantly, for<br>discontinue an existing form<br>adverse consequences, or to<br>of treatment;   |                        |  |   |                         |
|                          | D. a decision resident from the n   | to transfer or discharge the<br>oursing home; or  |                        |  |   |                         |
|                          | E. expected ar  | nd unexpected resident deaths   |                        |  |   |                         |
|                          | by:<br>Based on interview<br>facility failed to not<br>blood pressure rec   | tent is not met as evidenced<br>and document review the<br>ify the physician of elevated<br>ordings for 1 of 6 residents<br>r unnecessary drugs.  |                        | Completed  |   |                         |
|                          | dated 3/24/16, ider<br>including: coronary<br>(high blood pressu<br>vascular disease (0<br>vascular dementia<br>This progress note<br>and plan related to<br>hypertension and t<br>acceptable blood p<br>148/88 millimeters | physician's progress note<br>ntified active diagnoses<br>artery disease, hypertension<br>re), chronic back pain, cerebra<br>CVA-stroke), recurrent falls,<br>and chronic kidney disease.<br>also include an assessment<br>the diagnosis of essential<br>he physician indicated an<br>pressure (BP) range for R18 as<br>of mercury (mm Hg), which<br>need on the monthly flow sheet. |                        |  |   |                         |
|                          | 4/14/16, identified Isosorbide Mononi   | physician orders dated<br>current medications as noted:<br>trate (extended release) ER<br>nilligrams (mg) 1.5 tablets by  |                        |  |   |                         |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |  |
|--------------------------|--|---|-------------------------|--|---------------------------------|-------------------------|--|
|                          |  | 00342   | B. WING                 |  | 05/                             | 05/05/2016              |  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S          | TATE, ZIP CODE   |                                 |                         |  |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G 250 FIFTH<br>TRACY, M   | I STREET EA<br>IN 56175 | ST   |                                 |                         |  |
| (X4) ID<br>PREFIX<br>TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 265                    | Continued From pa  | age 3   | 2 265                   |  |                                 |                         |  |
|                          | mouth daily for ang mg by mouth for es   | ina attacks, Norvasc tablet 5<br>sential hypertension and<br>mg by mouth two times a day  |                         |  |                                 |                         |  |
|                          | multiple documenter<br>155/84 mm Hg to 2<br>evidence there had<br>monitoring initiated<br>dosage was increas<br>was ordered. There<br>physician had been<br>4/12/16, BP measu<br>accordance with the<br>procedure which di<br>>210 mm Hg imme<br>documented evider<br>acknowledging a pa<br>pressures nor docu | f falls in April 2016 with<br>ed post fall BP's ranging from<br>219/108 mm Hg. There was no<br>l been any additional BP<br>when the BP medication<br>sed on 1/14/16; Norvasc 5 mg<br>e was also no evidence the<br>nimmediately notified of the<br>iring 219/108 mm Hg in<br>e Change in Condition (SBAR)<br>rected to report a systolic BP<br>ediately. There was no<br>nce in R18's record<br>attern of elevated blood<br>umented evaluation of whether<br>gimen was effective. |                         |  |                                 |                         |  |
|                          | a.m. the facility's m<br>also R18's primary<br>like to see a BP our<br>for this age group (<br>150/90 is the goal,<br>risk for stroke." Th<br>unaware of R18's e<br>he would expect to<br>some labs or chang<br>aware. The MD furt<br>would require reche<br>expect a resident re                              | interview on 5/5/16, at 9:45<br>edical director (MD, who was<br>physician) stated, "I would not<br>t of the accepted high range<br>which included R18). A BP of<br>otherwise it will increase the<br>e MD further verified he was<br>elevated BP reading and stated<br>review a BP flow sheet, run<br>ge medications had he been<br>ther stated an elevated BP<br>ecking and stated he would<br>eceiving an anti-hypertensive<br>onitored more frequently than                    |                         |  |                                 |                         |  |
|                          | monthly. The MD s<br>facility had not been<br>frequently." MD als  | tated, "I was not aware the<br>n monitoring R18's BPs more<br>so stated the time of day the<br>e BP recording for R18 could   |                         |  |                                 |                         |  |

|                          | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE<br>A. BUILDING: | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED    |                         |  |
|--------------------------|--|--|-------------------------------|--|----------------------------------|-------------------------|--|
|                          |  |  |                               |  |                                  |                         |  |
|                          |  | 00342  | B. WING                       |  | 05/                              | 05/05/2016              |  |
| IAME OF F                | PROVIDER OR SUPPLIER   |  | DDRESS, CITY, S               |  |                                  |                         |  |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G  | H STREET EA<br>MN 56175       | ST   |                                  |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |  |
| 2 265                    | Continued From pa  | age 4  | 2 265                         |  |                                  |                         |  |
|                          | determine when the is administered.  | e anti-hypertensive medication   |                               |  |                                  |                         |  |
|                          | director of nursing staff were to follow   | v on 5/5/16, at 8:57 a.m. the<br>(DON) indicated the nursing<br>the facility's protocol for<br>on (SBAR) to report changes in  |                               |  |                                  |                         |  |
|                          | (SBAR) directed st<br>nurse practitioner of<br>systolic BP>210 m<br>the SBAR tool was  | dure titled Change in Condition<br>aff to immediately notify the<br>or MD re., blood pressure,<br>mHg. The procedure indicated<br>to be used by the nurse caring<br>h a change in condition.   |                               |  |                                  |                         |  |
|                          | The director of nurs<br>develop, review, an<br>procedures to ensu<br>physician are notifie<br>nursing (DON) or d<br>appropriate staff or<br>The director of nurs | THOD OF CORRECTION:<br>sing (DON) or designee could<br>ind/or revise policies and<br>ure responsible parties and the<br>ed of changes. The director of<br>lesignee could educate all<br>in the policies and procedures.<br>sing (DON) or designee could<br>g systems to ensure ongoing |                               |  |                                  |                         |  |
|                          | TIME PERIOD FO<br>(21) Days  | R CORRECTION: Twenty-one   |                               |  |                                  |                         |  |
| 2 565                    | MN Rule 4658.040<br>Plan of Care; Use  | 5 Subp. 3 Comprehensive  | 2 565                         |  |                                  | 6/6/16                  |  |
|                          |  | omprehensive plan of care<br>I personnel involved in the<br>t.   |                               |  |                                  |                         |  |
|                          |  |  |                               |  |                                  |                         |  |

STATE FORM

1EW811

If continuation sheet 5 of 41

| TATEMEN                  | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | LE CONSTRUCTION  |             | E SURVEY<br>PLETED      |
|--------------------------|---|--|---------------------|--|-------------|-------------------------|
|                          |   | 00342  | B. WING             |  | 05/05/2016  |                         |
| AME OF F                 | PROVIDER OR SUPPLIER  |  | DRESS. CITY.        | STATE, ZIP CODE  |             | 00,2010                 |
|                          |   | 250 FIFTI  | I STREET E          |  |             |                         |
| RAIRIE                   | VIEW SENIOR LIVIN   | G TRACY, I   | MN 56175            |  |             |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CC<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa   | age 5  | 2 565               |  |             |                         |
|                          | by:<br>Based on observat<br>review, the facility f<br>directed by the writ<br>residents (R10, R1<br>rehabilitation and re   | ent is not met as evidenced<br>ion, interview and document<br>failed to provide services as<br>ten plan of care for 3 of 3<br>3, R25) reviewed for<br>estorative needs, and who had<br>onal range of motion (ROM). |                     | Completed  |             |                         |
|                          | Findings include:   |  |                     |  |             |                         |
|                          |   |  |                     |  |             |                         |
|                          | was seated in a wh<br>noted to have a con<br>which he stated ha   | on 5/2/16, at 2:22 p.m. R10<br>eelchair in his room. R10 was<br>ntracted left hand and arm<br>d been contracted for a long<br>perienced a cardiovascular   |                     |  |             |                         |
|                          | an activities of daily<br>performance deficit<br>and dementia. The<br>had limited mobility<br>would maintain abil<br>staff, or 2 staff and<br>maintain his curren<br>plan identified R10<br>program that includ<br>(1) Active range of<br>Omnicycle (Exercise | f motion (ROM) utilizing the   |                     |  |             |                         |
|                          | (3) Place feet up o   | n black stool for 5 minutes.<br>stand up to 5 minutes if   |                     |  |             |                         |

|                          | NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE<br>A. BUILDING: _ |  |               | E SURVEY<br>PLETED      |
|--------------------------|---|--|---------------------------------|--|---------------|-------------------------|
|                          |   | 00342  | B. WING                         |  | 05/           | 05/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY, S                 | TATE, ZIP CODE   |               |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN   |  | H STREET EA<br>MN 56175         | ST   |               |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa   | age 6  | 2 565                           |  |               |                         |
|                          | pull up and use of posture.<br>During review of the the month of April 2 log identified the for utilizing the Omnic, for the month and a use of the EZ stand the month. The remwere documented and/or was unavail During review of R for the month of Maidentified: (1) received the month of Maidentified: (1) received the month and exercises with use opportunities for the work and/or was not ava Documentation on past 6 months (Derevealed R10 had program as directed When interviewed restorative aide (R. Omnicycle 3-5 time extremity and lowe the EZ stand daily. pulled the restorative was short on the flewould be assigned versus providing restated rehab service census remained la R13 had diagnoses. | 10's restorative nursing logs<br>arch 2016, documentation<br>ved active range of motion<br>ycle-3 out of 31 opportunities<br>(2) received 5 minutes<br>of the EZ stand-3 of 31<br>e month. The remaining days<br>that R10 had either refused<br>ailable.<br>R10's restorative logs for the<br>cember 2015-May 2016)<br>not received the restorative<br>ed by the care plan.<br>on 5/4/16, at 1:04 p.m.<br>A)-A stated R10 should use the<br>es/week and have upper<br>r extremity exercises while in<br>RA-A stated the facility had<br>ve position from the schedule<br>vas low in April and May 2016.<br>were many times when staffing<br>oor, the restorative person<br>to providing personal cares<br>estorative aide services. RA-A<br>ces ceased for awhile when the |                                 |  |               |                         |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                         |  |
|--------------------------|---|--|-------------------------|--|-------------------------------|-------------------------|--|
|                          |   | 00342  | B. WING                 |  | 05/                           | 05/05/2016              |  |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, S         | TATE, ZIP CODE   |                               |                         |  |
| PRAIRIE                  | VIEW SENIOR LIVIN   | (  | H STREET EA<br>MN 56175 | ST   |                               |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TION SHOULD BE                | (X5)<br>COMPLET<br>DATE |  |
| 2 565                    | Continued From pa   | age 7  | 2 565                   |  |                               |                         |  |
|                          |   | systemic lupus, lumbar<br>lementia and osteoporosis.   |                         |  |                               |                         |  |
|                          | was seated in her table. R13 was not contractures. R13  | on 5/2/16, at 5:28 p.m. R13<br>wheelchair at the dining room<br>ed to have bilateral hand<br>was unable to open her left<br>her right hand to pull her<br>Im of her hand.  |                         |  |                               |                         |  |
|                          | identified R13 had<br>to a history of 2nd<br>and osteoporosis.<br>R13 would maintai<br>ambulating 25 feet<br>and would maintain<br>through the review | 13's care plan dated 2/12/16, it<br>limited physical mobility related<br>lumbar compression fracture<br>The care plan goal identified<br>n level of mobility by<br>through the next review date<br>n current level of function<br>date. The care plan for R13<br>ving restorative rehabilitation |                         |  |                               |                         |  |
|                          | interventions:<br>(1) Active range of<br>identified R13 wou<br>following: Seated<br>exercises with 1 pc<br>Maintenance/welln                          | motion (ROM) program<br>Id complete any of the<br>pilateral lower extremity (BLE)<br>bund weight.<br>ess/restorative therapy:  |                         |  |                               |                         |  |
|                          | Follow exercise sh<br>as needed for ROM<br>(BUE).<br>(2) PROM/splint ca   | ram as patient tolerates.<br>eet. Use Omnicycle arm bike<br>A of bilateral upper extremities<br>re: Use bilateral resting hand<br>afternoon and between meals.   |                         |  |                               |                         |  |
|                          | Sheep skin palm p<br>wash cloth or wate<br>bilateral hands for<br>for extension. Goa  | rotectors on at night. Warm<br>r basin before PROM of<br>10-20 repetitions on each hand<br>I: Decrease flexion   |                         |  |                               |                         |  |
|                          | for the month of Ap   | 13's restorative nursing logs<br>oril 2016, documentation<br>ived restorative services for   |                         |  |                               |                         |  |

| STATEMEN                 | ta Department of He<br>T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|---|---|-------------------------|--|--------------------------------|-------------------------|
|                          |   | 00040   | B. WING                 |  |                                |                         |
|                          |   | 00342   |                         |  | 05/                            | 05/2016                 |
| NAME OF F                | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, S         |  |                                |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN   | G   | H STREET EA<br>MN 56175 | 51   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa   | ige 8   | 2 565                   |  |                                |                         |
|                          | month. The remain<br>documented that R<br>unavailable.<br>During review of R<br>for month of March<br>identified she rece<br>active range of mot<br>the Omnicycle 0 ou<br>month. The remain<br>documented that R<br>unavailable.<br>Documentation rev<br>for the past 6 mont<br>2016) indicated R1<br>restorative program<br>When interviewed of<br>stated R13 should h<br>days/week.<br>R25 had diagnoses<br>dated 4/8/16, includ<br>depression, right fe<br>partial repair (4/201<br>humeral fracture wi<br>post-herpatic neura<br>the right third and fe<br>During observation<br>was noted have he<br>with contracture wi<br>R25 was noted to v<br>left hand and feet v<br>resting on her lap.<br>During review of R2<br>identified that R25<br>The care plan ident<br>of mobility through<br>following interventio | t of 30 opportunities for the<br>ing days of the month were<br>13 either refused and/or was<br>2016, documentation<br>ived restorative services for<br>tion to BUE and BLE utilizing<br>at of 31 opportunities for the<br>ing days of the month were<br>13 either refused and/or was<br>iewed on the restorative logs<br>hs (December 2015-May<br>3 had not received a<br>n as directed by the care plan.<br>on 5/4/16, at 1:04 p.m. RA-A<br>use the Omnicycle 3-5 times a<br>ave AROM to bilateral hands 5<br>s identified on the care plan<br>ding: heart failure, anxiety,<br>emoral neck fracture with<br>15), osteoporosis, history of<br>ith decreased mobility,<br>algia, and history of injury to<br>ourth fingers related to fall.<br>on 5/5/16, at 9:46 a.m. R25<br>r right hand folded in he lap<br>hile seated in the dining room.<br>wheel the wheelchair with her<br>while her right hand remained<br>25's care plan dated 4/18/16, it<br>had limited physical mobility.<br>tified R25 would maintain level<br>the next review date with the<br>ons in the nursing rehabilitation |                         |  |                                |                         |
| nnesota De               | program:  | ogram with pink therapy-putty   |                         |  |                                |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE<br>A. BUILDING: _ |  | (X3) DATE SURVEY<br>COMPLETED |                         |
|--------------------------|--|---|---------------------------------|--|-------------------------------|-------------------------|
|                          |  | 00342   | B. WING                         |  | 05/                           | 05/2016                 |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, ST                | TATE, ZIP CODE   |                               |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN  | ( -   | H STREET EA<br>MN 56175         | ST   |                               |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE                | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa  | age 9   | 2 565                           |  |                               |                         |
|                          | hand x 5 minutes.<br>maintenance of to<br>hand.<br>(2) Active ROM Pro<br>10-15 minutes for I<br>pain complaints. The<br>program was to may<br>with one assist limit<br>a history of 2nd lun<br>osteoporosis.<br>During review of R<br>for the month of Ap-<br>identified she rece<br>active range of mo<br>out of 30 opportunit<br>ROM exercises to<br>for the month. The<br>were documented<br>unavailable and/or | 0 each way. Digi-flexors right<br>The goal was identified as<br>apply hand splint on the right<br>ogram with use of Omnicycle<br>egs. May vary according to any<br>he goal identified for the<br>aintain strength for transfers<br>ted physical mobility related to<br>nbar compression fracture and<br>25's restorative nursing logs<br>oril 2016, documentation<br>vived restorative services for<br>tion utilizing the Omnicycle 2<br>ties for the month and received<br>her hands 0 of 30 opportunities<br>remaining days of the month<br>that R10 either refused or was<br>was left undocumented.<br>25's restorative nursing logs | 1                               |  |                               |                         |
|                          | for the month of Ma<br>identified she recein<br>active ROM utilizin<br>opportunities for the<br>exercises to her has<br>the month. The rerivere documented<br>unavailable, or was  | arch 2016, documentation<br>ved restorative services for<br>g the Omnicycle 4 out of 30<br>e month and received ROM<br>ands 0 of 30 opportunities for<br>naining days of the month<br>that R10 either refused or was<br>s left undocumented.  |                                 |  |                               |                         |
|                          | for the past 6 mont<br>2016) indicated R2<br>restorative program<br>When nursing assi<br>NA-F were intervie<br>they stated they did  | viewed on the restorative logs<br>ths (December 2015-May<br>25 had not received a<br>n as directed by the care plan.<br>stants (NA)- B, NA-C and<br>wed on 5/4/16, at 2:00 p.m.<br>d not have the time to<br>orative nursing duties when the  |                                 |  |                               |                         |

| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                     | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED   |                         |
|--------------------------|--|--|-------------------------|---|---------------------------------|-------------------------|
|                          |  | 00342  | B. WING                 |   | 05/                             | 05/2016                 |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, S         | TATE, ZIP CODE  |                                 |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G  | H STREET EA<br>MN 56175 | ST  |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa  | age 10   | 2 565                   |   |                                 |                         |
|                          | verified the NA's di   | resident cares. They all<br>id not complete the restorative<br>he time when the resident   |                         |   |                                 |                         |
|                          | director of nursing<br>been removed from<br>the time period 3/2<br>to staffing changes<br>census. The DON<br>RA was pulled from<br>perform NA cares.<br>was low the past m<br>on the floor instead<br>further stated the N<br>should conduct the<br>cares but verified t | on 5/5/16, at 8:12 a.m. the<br>(DON) verified the RA had<br>in the restorative program from<br>9/16 through 4/21/16, related<br>a affected by low resident<br>further verified sometimes the<br>in rehab to cover for call-ins to<br>The DNS verified the census<br>nonth and the RA was utilized<br>d of the RA position. The DNS<br>NA's caring for the residents<br>a restorative exercises during<br>he logs indicated the<br>ram was not documented to<br>in of the services. |                         |   |                                 |                         |
|                          | 5/5/16, at 9:18 a.m<br>to provide persona<br>instead of providing<br>different staff callin  | interview with the RA-A on<br>a she indicated she was asked<br>a cares for resident's today<br>g restorative care due to a<br>a g in ill. The RA-A stated she is<br>d be able to do restorative  |                         |   |                                 |                         |
|                          | DON verified the re<br>to work on the floo   | on 5/5/16, at 9:38 a.m. the<br>estorative aide was re-assigned<br>r (to provide personal cares)<br>ailed to show up for work today.  |                         |   |                                 |                         |
|                          | The director of nur<br>review and revise p<br>to ensuring the car<br>resident is followed  | THOD OF CORRECTION:<br>sing (DON) or designee could<br>policies and procedures related<br>re plan for each individual<br>d. The director of nursing or<br>velop a system to educate staff  |                         |   |                                 |                         |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED<br>05/05/2016 |                         |
|--------------------------|---|---|-------------------------|--|---|-------------------------|
|                          |   | 00342   | B. WING                 |  |   |                         |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AL   | DRESS, CITY, S          | STATE, ZIP CODE  |   |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN   | G   | H STREET E/<br>MN 56175 | AST  |   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRC<br>DEFICIENCY) | LD BE                                       | (X5)<br>COMPLET<br>DATE |
| 2 565                    | Continued From pa   | ge 11   | 2 565                   |  |   |                         |
|                          |   | itoring system to ensure staff<br>as directed by the written plan   |                         |  |   |                         |
|                          | TIME PERIOD FOR<br>(21) days.   | R CORRECTION: Twenty-one  |                         |  |   |                         |
|                          |   | HOD OF CORRECTION:  |                         |  |   |                         |
| 2 570                    | MN Rule 4658.040<br>Plan of Care; Revis   | 5 Subp. 4 Comprehensive<br>ion  | 2 570                   |  |   | 6/6/16                  |
|                          | care must be review<br>interdisciplinary tea<br>physician, a registe<br>for the resident, and<br>disciplines as deter<br>and, to the extent p<br>participation of the<br>guardian or chosen<br>quarterly and within | A comprehensive plan of<br>wed and revised by an<br>m that includes the attending<br>red nurse with responsibility<br>d other appropriate staff in<br>mined by the resident's needs,<br>practicable, with the<br>resident, the resident's legal<br>representative at least<br>seven days of the revision of<br>resident assessment required<br>subpart 3, item B. |                         |  |   |                         |
|                          | by:<br>Based on observati<br>review the facility fa   | ent is not met as evidenced<br>on, interview and document<br>iled to revise the care plan for<br>2, R2) reviewed for accidents  |                         | Completed  |   |                         |

1EW811

If continuation sheet 12 of 41

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         |   | (X3) DATE SURVEY<br>COMPLETED   |                         |
|--------------------------|---|---|-------------------------|---|---------------------------------|-------------------------|
|                          |   | 00342   | B. WING                 |   | 05/                             | 05/2016                 |
| AME OF F                 | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, S         | TATE, ZIP CODE  |                                 |                         |
| RAIRIE                   | VIEW SENIOR LIVIN   | G   | H STREET EA<br>MN 56175 | ST  |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 570                    | Continued From pa   | age 12  | 2 570                   |   |                                 |                         |
|                          | and who received t risk for aspiration/c  | hickened liquids and were at hoking.  |                         |   |                                 |                         |
|                          | Findings include:   |   |                         |   |                                 |                         |
|                          | R12 had diagnoses identified on the care plan<br>dated 3/24/16, that included: Alzheimer's disease,<br>dementia, cerebrovascular disease and<br>hypertension.   |   | ,                       |   |                                 |                         |
|                          | risk for aspiration a<br>which included nec<br>liquids, including ne<br>bedside. The care   | ted 3/24/16, identified R12 at<br>and identified a prescribed diet<br>tar consistency thickened<br>ectar thickened liquids at<br>plan goal was for R12 to be<br>wer the next quarter.   |                         |   |                                 |                         |
|                          | pass and resident of<br>trained medication<br>R12's 7:00 p.m. me<br>the following medic<br>(anti-psychotic) 5 m<br>mg- 2 tabs; and Ari<br>mg. After placing th<br>medication cup, TM<br>and mixed them in<br>transported the me<br>administer them wh<br>TMA-B elevated the<br>approximately 45 d<br>down in the bed witt<br>the bed. Subseque<br>elevated to the 45 c<br>attempted. After ac | of the evening medication<br>cares on 5/2/16, at 7:00 p.m.<br>assistant (TMA)-B prepared<br>edications. TMA-B prepared<br>cations for R12: Zyprexa<br>nilligrams (mg); Tylenol 500<br>cept (dementia medication) 15<br>me medications in a plastic<br><i>IA</i> -B crushed the medications<br>applesauce. TMA-B then<br>idications into R12's room to<br>nile R12 was lying in bed.<br>e head of the bed to<br>legrees. However, R12 slid<br>th her head toward the foot of<br>ently, R12's head was not<br>degree angle the TMA-B had<br>dministration of these prepared |                         |   |                                 |                         |
|                          | liquids while R12 r   | B administered thickened<br>emained lying on her back in<br>ess than a 45 degree angle.   |                         |   |                                 |                         |
|                          | Immediately after the partment of Health  | he noted observation, at  |                         |   |                                 |                         |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |                                  | E SURVEY<br>PLETED      |
|--------------------------|--|---|-------------------------|--|----------------------------------|-------------------------|
|                          |  | 00342   | B. WING                 |  | 05/                              | 05/2016                 |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, S         | TATE, ZIP CODE   |                                  |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G   | H STREET EA<br>MN 56175 | ST   |                                  |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 570                    | approximately 7:15<br>(DON) was intervier<br>related to R12 recei-<br>lying in bed. The D<br>that the resident's le<br>elevated to 90 deg-<br>ensure the residen<br>position while admi-<br>liquids. The DON a<br>aspiration.<br>When interviewed<br>registered nurse (F<br>for aspiration and s<br>upright and should<br>administration of the<br>reiterated R12 wou<br>aspiration if not sitt<br>the care plan had re<br>staff guidance relat<br>R12 should be whe<br>administration of lice<br>prevent aspiration.<br>Diagnoses listed on<br>12/21/15, included:<br>(CA) with aphasia a<br>disease, failure to the<br>The significant chan<br>Set (MDS) assess<br>R2 receives a med<br>severely impaired of<br>R2 as receiving the<br>total assistance with<br>living (ADL).<br>R2's plan of care d | <ul> <li>b p.m., the director of nursing wed about the observation eiving thickened liquids while ON stated staff should know head of the bed should be rees (not 45 degrees) and also t is maintained in an upright inistering medications and/or also verified R12 was at risk for on 5/4/16, at 10:29 a.m. RN)-C stated R12 was at risk for on 5/4/16, at 10:29 a.m. RN)-C stated R12 was at risk should be positioned sitting be alert during the tickened liquids. RN-C and be at risk for potential ing upright. RN-C confirmed not been revised to include ted to the appropriate position en lying in bed during the quids and/or medications to</li> <li>n R2's plan of care dated to the appropriate position en lying in bed during the quids and/or medications to</li> <li>n R2's plan of care dated to hemiparesis, Alzheimer's thrive, dysphasia and anorexia.</li> <li>nge in status Minimum Data ment dated 2/17/16, indicated chanically altered diet and has cognition. The MDS identified to her activities of daily</li> </ul> |                         |  |                                  |                         |
| nesota D                 | identified: (1) Nect   | rovide nectar thickened liquids   |                         |  |                                  |                         |

|                          | DIT DEPARTMENT OF HE<br>NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | (X2) MULTIPLE CONSTRUCTION A. BUILDING:  |                                 | E SURVEY<br>PLETED      |
|--------------------------|---|--|-------------------------|--|---------------------------------|-------------------------|
|                          |   | 00342  | B. WING                 |  | 05/                             | 05/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, ST         | TATE, ZIP CODE   |                                 |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN   | G  | H STREET EA<br>MN 56175 | ST   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 570                    | of choice with meal<br>The plan of care has<br>the change in cons<br>from nectar to a ho<br>The nursing progre<br>identified that R2 has<br>had been provided<br>documentation indi<br>feeding R2 related<br>sheet for the kitche<br>indicated a (3) threat<br>to use honey thicked<br>who received thicked<br>kitchen and nectar<br>out and honey thick<br>Review of the hosp<br>identified that R2's<br>now on honey thick<br>need to stop feedin<br>When interviewed of<br>dietary manager (D<br>changed the thicke<br>nectar to a honey c<br>concerns during me<br>feeding.<br>SUGGESTED MET<br>DON or designee c<br>procedures or facili<br>plan development f<br>liquids. Appropriate<br>regarding any chan<br>could develop a sys<br>to ensure revisions | ls, with meds and with snacks.<br>ad not been updated to include<br>istency of the thickened liquids |                         |  |                                 |                         |

|                          | Ita Department of He<br>TOF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                        | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                         |
|--------------------------|---|--|------------------------|---|-------------------------------|-------------------------|
|                          |   | 00342  | B. WING                |   | 05/                           | 05/2016                 |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY,          | STATE, ZIP CODE   |                               |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN   | G  | H STREET E<br>MN 56175 | AST   |                               |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | IOULD BE                      | (X5)<br>COMPLET<br>DATE |
| 2 830                    | Continued From pa   | ige 15   | 2 830                  |   |                               |                         |
| 2 830                    | MN Rule 4658.052<br>Proper Nursing Ca   | 0 Subp. 1 Adequate and re; General   | 2 830                  |   |                               | 6/6/16                  |
|                          | receive nursing car<br>custodial care, and<br>individual needs an<br>the comprehensive<br>plan of care as des<br>4658.0405. A nurs<br>of bed as much as<br>written order from t | general. A resident must<br>e and treatment, personal and<br>supervision based on<br>id preferences as identified in<br>resident assessment and<br>scribed in parts 4658.0400 and<br>ing home resident must be out<br>possible unless there is a<br>he attending physician that the<br>ain in bed or the resident<br>in bed. |                        |   |                               |                         |
|                          | by:<br>Based on observati<br>review the facility fa<br>liquids and medicat<br>safe manner to pre  | ent is not met as evidenced<br>ion, interview and document<br>ailed to ensure thickened<br>tions were administered in a<br>vent aspiration for 1 of 3<br>iewed who were at risk for  |                        | Completed   |                               |                         |
|                          | Findings include:   |  |                        |   |                               |                         |
|                          | diagnoses including   | ted 3/24/16, identified<br>g: Alzheimer's disease,<br>vascular disease and   |                        |   |                               |                         |
|                          | at risk for aspiration<br>diet to include necta<br>liquids, including liq   | ted 3/24/16, identified R12 as<br>n and identified a prescribed<br>ar consistency thickened<br>juids at the bedside. The care<br>12 to be free of aspiration   |                        |   |                               |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | E CONSTRUCTION   |              | E SURVEY<br>PLETED      |
|--------------------------|--|---|-------------------------|--|--------------|-------------------------|
|                          |  | 00342   | B. WING                 |  | 05/          | 05/2016                 |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, S         | TATE, ZIP CODE   |              |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G   | H STREET EA<br>MN 56175 | ST   |              |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | Continued From pa  | age 16  | 2 830                   |  |              |                         |
|                          | over the next quart  | er.   |                         |  |              |                         |
|                          | pass and resident of<br>trained medication<br>R12's 7:00 p.m. me<br>the following medic<br>(antipsychotic) 5 m<br>mg- 2 tabs; and Ari<br>mg. After placing th<br>medication cup, TM<br>and mixed them in<br>transported the me<br>administer them wi<br>TMA-B elevated th<br>approximately 45 c<br>down in the bed wi<br>the bed. Subseque<br>elevated to the 45 c<br>attempted. After a<br>medications, TMA-<br>liquids while R12 r<br>bed. positioned at l | of the evening medication<br>cares on 5/2/16, at 7:00 p.m.<br>assistant (TMA)-B prepared<br>edications. TMA-B prepared<br>eations for R12: Zyprexa<br>illigrams (mg); Tylenol 500<br>icept (dementia medication) 15<br>ne medications in a plastic<br><i>M</i> A-B crushed the medications<br>applesauce. TMA-B then<br>edications into R12's room to<br>hile R12 was lying in bed.<br>e head of the bed to<br>legrees. However, R12 slid<br>th her head toward the foot of<br>ently, R12's head was not<br>degree angle the TMA-B had<br>dministration of these prepared<br>B administered thickened<br>emained lying on her back in<br>less than a 45 degree angle. |                         |  |              |                         |
|                          | approximately 7:15<br>(DON) was intervieured<br>related to R12 receipting in bed. The D<br>that the resident's lelevated to 90 deg<br>ensure the residen<br>position while administration  | he noted observation, at<br>5 p.m., the director of nursing<br>ewed about the observation<br>eiving thickened liquids while<br>ON stated staff should know<br>nead of the bed should be<br>rees (not 45 degrees) and also<br>t is maintained in an upright<br>inistering medications and/or<br>also verified R12 was at risk for  |                         |  |              |                         |
|                          | 5/3/16, at 3:00 p.m<br>thickened liquids a   | th registered nurse (RN)-D on<br>. RN-D stated R12 had<br>t her bedside and staff should<br>to R12 while she is in a seated   |                         |  |              |                         |

|                          | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED   |                         |
|--------------------------|--|--|-------------------------|--|---------------------------------|-------------------------|
|                          |  | 00342  | B. WING                 |  | 05/                             | 05/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AL  | DDRESS, CITY, S         | TATE, ZIP CODE   |                                 |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G  | H STREET EA<br>MN 56175 | ST   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | position.<br>When interviewed or<br>registered nurse (F<br>for aspiration and s<br>sitting upright and b<br>administration of th<br>reiterated R12 wou<br>aspiration if not sitt<br>care plan lacked gu<br>which position R12<br>bed during adminis<br>medications.<br>During interview wi<br>a.m. the surveyor r<br>related to the admin<br>The DON submitte<br>curriculum (Hartma<br>1994), which identi<br>should feed residen<br>the following:<br>8. Properly position<br>a. Usually the pro<br>90 degree angle. T<br>problems. Residen | on 5/4/16, at 10:29 a.m.<br>N)-C stated R12 was at risk<br>hould be placed in a position<br>be alert during the<br>ickened liquids. RN-C<br>ld be at risk for potential<br>ing upright. RN-C stated the<br>uidance to direct staff as to<br>should be in when laying in<br>tration of liquids or<br>th the DON on 5/4/16, at 10:40<br>equested the facility policy<br>nistration of thickened liquids.<br>d the nursing assistant training<br>un's Nursing Assistant Care,<br>fied how nursing assistants<br>nts. The curriculum identified<br>ing residents for eating.<br>oper positioning is upright, at a<br>his helps prevent swallowing<br>ts who use geri-chairs<br>wheels) should be upright, no |                         |  |                                 |                         |
|                          | foods or liquids for<br>how to provide food<br>lying position in a g<br>addressed the diffe<br>thickened liquids (r<br>provide instruction<br>thickened liquids. T<br>identified in the trai   | not identify how to administer<br>a resident in bed but identified<br>d and liquids to a resident in a<br>eri-chair. The curriculum<br>rent consistencies of<br>lectar, honey) but failed to<br>related to the administration of<br>The DON stated the standard<br>ning guide would be the<br>staff to follow when feeding   |                         |  |                                 |                         |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                          | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |
|--------------------------|--|--|--------------------------|--|---------------------------------|-------------------------|
|                          |  | 00342  | B. WING                  |  | 05/                             | 05/2016                 |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, ST          | ATE, ZIP CODE  |                                 |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G  | H STREET EAS<br>MN 56175 | ST   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 830                    | Continued From pa  | age 18   | 2 830                    |  |                                 |                         |
|                          | on 5/4/16 at 11:00 a<br>best practice to adu<br>any resident with a<br>position. The ST fu<br>advise anyone to h<br>lying position wheth                         | th the speech therapist (ST)<br>a.m. the ST stated it would be<br>minister liquids and foods to<br>risk for aspiration in an upright<br>rther stated she would not<br>ave liquids or foods while in a<br>ner they were at aspiration risk<br>ed, "That would not be a safe |                          |  |                                 |                         |
|                          | were trained when<br>to residents at risk<br>have the the proces<br>The facility further<br>aspiration related to<br>standards of praction<br>medications and th | provide evidence of how staff<br>administering thickened liquids<br>for aspiration and failed to<br>ss identified on the care plan.<br>placed R12 at risk for<br>the lack of following<br>ce for administering<br>ickened liquids to a resident<br>lying position in bed.  |                          |  |                                 |                         |
|                          | director of nursing<br>and re-educate all<br>procedures to ensu<br>issues; including th<br>properly monitored  | THOD OF CORRECTION: The<br>or her designee could review<br>staff on the policies and<br>ure that all resident's health<br>ickened liquids offered are<br>. The director of nursing or her<br>velop monitoring systems to<br>mpliance.                                      |                          |  |                                 |                         |
|                          | TIME PERIOD FOI<br>(21) days.  | R CORRECTION: Twenty-one   |                          |  |                                 |                         |
| 2 895                    | MN Rule 4658.052<br>Motion   | 5 Subp. 2.B Rehab - Range of   | 2 895                    |  |                                 | 6/6/16                  |
|                          | that is directed tow   | motion. A supportive program<br>ard prevention of deformities<br>and range of motion must be   |                          |  |                                 |                         |
|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | ealth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                       | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|-----------------------|--|-------------------------------|
|                          |   | 00342  | B. WING               |  | 05/05/2016                    |
| IAME OF F                | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY,          | STATE, ZIP CODE  |                               |
| PRAIRIE                  | VIEW SENIOR LIVIN   | IG 250 FIFTH<br>TRACY, M   | istreet e<br>/N 56175 | AST  |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE COMPLET                  |
| 2 895                    | Continued From pa   | age 19   | 2 895                 |  |                               |
|                          | comprehensive res<br>of nursing services<br>development of a r<br>provides that:          | maintained. Based on the<br>sident assessment, the director<br>must coordinate the<br>nursing care plan which  |                       |  |                               |
|                          | receives appropria  | th a limited range of motion<br>te treatment and services to<br>notion and to prevent further<br>of motion.  |                       |  |                               |
|                          | by:<br>Based on observat<br>review the facility fa<br>treatment and serv                  | ient is not met as evidenced<br>tion, interview and document<br>ailed to provide the assessed<br>rices for 3 of 3 residents (R10,<br>ed who had limited range of                                 |                       | Completed  |                               |
|                          | Findings include:   |  |                       |  |                               |
|                          |   |  |                       |  |                               |
|                          | was seated in a wh<br>noted to have a co<br>which he stated ha                            | n on 5/2/16, at 2:22 p.m. R10<br>neelchair in his room. R10 was<br>ntracted left hand and arm<br>id been contracted for a long<br>perienced a cardiovascular                                     |                       |  |                               |
|                          | an activities of daily<br>performance defici<br>and dementia. The<br>had limited mobility | ed 3/29/16, identified R10 had<br>y living (ADL) self care<br>t related to CVA, hemiplegia<br>e care plan also indicated R10<br>y, with a goal the resident<br>lity to transfer with assist of 2 |                       |  |                               |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>NOF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE<br>A. BUILDING: | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|--|---|-------------------------------|--|--------------------------------|-------------------------|
|                          |  | 00342   | -<br>B. WING                  |  | 05/05/2016                     |                         |
|                          | PROVIDER OR SUPPLIER   |   | DRESS, CITY, ST               |  | 05/                            | 05/2010                 |
|                          |  | 250 FIFTH   |                               |  |                                |                         |
| PRAIRIE                  | E VIEW SENIOR LIVIN  | G TRACY, N  | N 56175                       |  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIV<br>CROSS-REFERENCED TO TI<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 895                    | Continued From pa  | ige 20  | 2 895                         |  |                                |                         |
|                          | maintain his curren<br>plan identified R10<br>program that includ<br>(1) Active range of<br>Omnicycle (Exercis<br>(2) Stretching of bo<br>hamstrings.<br>(3) Place feet up o<br>(4) Standing in EZ<br>cooperative to work<br>pull up and use of le<br>posture.<br>During review of the<br>the month of April 2<br>log identified the fo<br>utilizing the Omnicy<br>for the month and (<br>use of the EZ stand<br>the month. The rem<br>were documented t<br>and/or was unavails<br>During review of R <sup>-1</sup><br>for the month of Ma<br>identified: (1) receiv<br>utilizing the Omnicy<br>for the month and (<br>exercises with use<br>opportunities for the<br>were documented t<br>and/or was not ava<br>Documentation on<br>past 6 months (Dec<br>revealed R10 had r<br>program as directed<br>When interviewed of<br>restorative aide (RA<br>Omnicycle 3-5 time<br>extremity and lower | <ul> <li>motion (ROM) utilizing the se bike).</li> <li>oth Lower extremities and both</li> <li>n black stool for 5 minutes.</li> <li>stand up to 5 minutes if</li> <li>k on the use of arms to</li> <li>egs for weight bearing and</li> <li>e restorative nursing logs for</li> <li>2016, documentation on R10's</li> <li>llowing data: (1) active ROM</li> <li>vcle- 5 out of 30 opportunities</li> <li>2) 5 minutes exercises with</li> <li>d -4 out of 30 opportunities for</li> <li>naining days of the month</li> <li>that R10 had either refused</li> <li>able.</li> <li>10's restorative nursing logs</li> <li>arch 2016, documentation</li> <li>vcle-3 out of 31 opportunities</li> <li>2) received 5 minutes</li> <li>of the EZ stand-3 of 31</li> <li>e month. The remaining days</li> <li>that R10 had either refused</li> <li>ilable.</li> <li>R10's restorative logs for the</li> <li>cember 2015-May 2016)</li> <li>not received the restorative</li> </ul> |                               |  |                                |                         |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | CONSTRUCTION   |                | E SURVEY<br>PLETED      |  |
|--------------------------|---|--|---------------------|--|----------------|-------------------------|--|
|                          |   | 00342  | B. WING             |  | 05/            | 05/2016                 |  |
| AME OF I                 | PROVIDER OR SUPPLIER  |  | DDRESS, CITY, ST    | ATE, ZIP CODE  |                | 10/2010                 |  |
| RAIRIF                   | VIEW SENIOR LIVIN   | G 250 FIFT   | H STREET EA         |  |                |                         |  |
|                          |   | IRACY,   | MN 56175            |  |                |                         |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TION SHOULD BE | (X5)<br>COMPLET<br>DATE |  |
| 2 895                    | Continued From pa   | age 21   | 2 895               |  |                |                         |  |
|                          | when the census w<br>RA-A stated there w<br>was short on the flow<br>would be assigned<br>versus providing re-<br>stated rehab service<br>when the census re-<br>R13 had diagnoses<br>dated 2/12/16, inclu-<br>major depression, s-<br>vertebral fracture, o<br>During observation<br>was seated in her w<br>table. R13 was note<br>contractures. R13 | s identified on the care plan<br>uding adult failure to thrive,<br>systemic lupus, lumbar<br>dementia and osteoporosis.<br>on 5/2/16, at 5:28 p.m. R13<br>wheelchair at the dining room<br>ed to have bilateral hand<br>was unable to open her left<br>her right hand to pull her                        |                     |  |                |                         |  |
|                          | identified R13 had<br>to a history of 2nd I<br>and osteoporosis.<br>R13 would maintain<br>ambulating 25 feet<br>and would maintain<br>through the review<br>identified the follow<br>interventions:   | 13's care plan dated 2/12/16, it<br>limited physical mobility related<br>lumbar compression fracture<br>The care plan goal identified<br>n level of mobility by<br>through the next review date<br>n current level of function<br>date. The care plan for R13<br><i>r</i> ing restorative rehabilitation |                     |  |                |                         |  |
|                          | identified R13 woul<br>following: Seated b<br>exercises with 1 po<br>Maintenance/wellno<br>nursing rehab prog<br>Follow exercise sho<br>as needed for ROM<br>(BUE).   | motion (ROM) program<br>ld complete any of the<br>bilateral lower extremity (BLE)<br>bund weight.<br>ess/restorative therapy:<br>irram as patient tolerates.<br>eet. Use Omnicycle arm bike<br><i>I</i> of bilateral upper extremities<br>are: Use bilateral resting hand                                |                     |  |                |                         |  |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>NOF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                |                     |  |                                 | E SURVEY<br>PLETED      |
|--------------------------|--|--|---------------------|--|---------------------------------|-------------------------|
|                          |  | 00342  | B. WING             |  | 05/                             | 05/2016                 |
|                          | PROVIDER OR SUPPLIER   |  | DRESS, CITY, S      |  | 05/                             | 05/2010                 |
|                          | PROVIDER OR SUPPLIER   |  | I STREET EA         |  |                                 |                         |
| PRAIRIE                  | E VIEW SENIOR LIVIN  |  | AN 56175            |  |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ITEMENT OF DEFICIENCIES<br>( MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 895                    | Continued From pa  | ge 22  | 2 895               |  |                                 |                         |
|                          | Sheep skin palm pr<br>wash cloth or water<br>bilateral hands for f<br>for extension. Goal<br>contractures of BUI<br>During review of R<br>for the month of Ap<br>identified R13 recei<br>active range of mot<br>the Omnicycle 4 our<br>month. The remain<br>documented that R<br>unavailable.<br>During review of R<br>for month of March<br>identified she rece<br>active range of mot<br>the Omnicycle 0 our<br>month. The remain<br>documented that R<br>unavailable.<br>Documentation rev<br>for the past 6 mont<br>2016) indicated R11<br>restorative program<br>When interviewed of<br>stated R13 should he<br>days/week.<br>R25 had diagnoses<br>dated 4/8/16, includ<br>depression, right fe<br>partial repair (4/201<br>humeral fracture wi<br>post-herpatic neura<br>the right third and fe<br>During observation<br>was noted have he |  |                     |  |                                 |                         |

Minnesota Department of Health STATE FORM

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| STATEMEI                 | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     |  |                                | E SURVEY<br>PLETED      |
|--------------------------|---|---|---------------------|--|--------------------------------|-------------------------|
|                          |   | 00342   | B. WING             |  | 05/                            | 05/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AL   | DRESS, CITY, S      | TATE, ZIP CODE   |                                |                         |
| PRAIRIF                  | VIEW SENIOR LIVIN   |   | H STREET EA         | ST   |                                |                         |
|                          | I   | IRACY, I  | MN 56175            |  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ITEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIV<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 895                    | Continued From pa   | ige 23  | 2 895               |  |                                |                         |
|                          | left hand and feet w<br>resting on her lap.<br>During review of R2<br>identified that R25 f<br>The care plan ident<br>of mobility through<br>following intervention<br>program:<br>(1) Active ROM Pro-<br>exercises (with peg-<br>pushing/pulling x 10<br>hand x 5 minutes.<br>maintenance of to a<br>hand.<br>(2) Active ROM Pro-<br>10-15 minutes for le<br>pain complaints. The<br>program was to ma<br>with one assist limit<br>a history of 2nd lum<br>osteoporosis.<br>During review of R2<br>for the month of Ap-<br>identified she rece<br>active range of mot<br>out of 30 opportunit<br>ROM exercises to her<br>for the month. The<br>were documented t<br>unavailable and/or<br>During review of R2<br>for the month of Ma-<br>identified she recein<br>active ROM utilizing<br>opportunities for the<br>exercises to her ha<br>the month. The rem | wheel the wheelchair with her<br>while her right hand remained<br>25's care plan dated 4/18/16, it<br>had limited physical mobility.<br>tified R25 would maintain level<br>the next review date with the<br>ons in the nursing rehabilitation<br>ogram with pink therapy-putty<br>is removed). Right hand<br>0 each way. Digi-flexors right<br>The goal was identified as<br>apply hand splint on the right<br>ogram with use of Omnicycle<br>egs. May vary according to any<br>he goal identified for the<br>aintain strength for transfers<br>ted physical mobility related to<br>obar compression fracture and<br>25's restorative nursing logs<br>ril 2016, documentation<br>ived restorative services for<br>tion utilizing the Omnicycle 2<br>ties for the month and received<br>her hands 0 of 30 opportunities<br>remaining days of the month<br>that R10 either refused or was<br>was left undocumented.<br>25's restorative services for<br>g the Omnicycle 4 out of 30<br>e month and received ROM<br>nds 0 of 30 opportunities for<br>naining days of the month<br>that R10 either refused or was |                     |  |                                |                         |

|   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |  |  |   | E SURVEY<br>PLETED  |
|---|--|--|--|---|---|
|   | 00342  | B. WING  |  | 05/   | 05/2016   |
| IDER OR SUPPLIER  | STREET AI  | DDRESS, CITY, ST   | TATE, ZIP CODE   |   |   |
| W SENIOR LIVIN  | (  |  | ST   |   |   |
| (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG  | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO  | TION SHOULD BE  | (X5)<br>COMPLET<br>DATE   |
| available, or was<br>cumentation rev<br>the past 6 mont<br>16) indicated R2<br>torative program<br>en nursing assis<br>-F were interview<br>y stated they did<br>blement the rest<br>torative aide wa<br>assist them with<br>ified the NA's di-<br>grams during th<br>isus was low.<br>The nen interviewed of<br>ector of nursing<br>en removed from<br>time period 3/2<br>staffing changes<br>isus. The DON<br>was pulled from<br>form NA cares.<br>Is low the past m<br>the floor instead<br>her stated the N<br>buld conduct the<br>es but verified th<br>abilitation progra-<br>port completion<br>ring a follow-up<br>/16, at 9:18 a.m<br>provide personal<br>tead of providing<br>erent staff callin<br>sure if she would | s left undocumented.<br>iewed on the restorative logs<br>hs (December 2015-May<br>5 had not received a<br>n as directed by the care plan.<br>stants (NA)- B, NA-C and<br>wed on 5/4/16, at 2:00 p.m.<br>d not have the time to<br>orative nursing duties when the<br>s removed from those duties<br>resident cares. They all<br>d not complete the restorative<br>e time when the resident<br>on 5/5/16, at 8:12 a.m. the<br>(DON) verified the RA had<br>n the restorative program from<br>9/16 through 4/21/16, related<br>affected by low resident<br>further verified sometimes the<br>n rehab to cover for call-ins to<br>The DNS verified the census<br>ionth and the RA was utilized<br>of the RA position. The DNS<br>IA's caring for the residents<br>restorative exercises during<br>he logs indicated the<br>am was not documented to<br>o of the services.   |  |  |   |   |
|   | DEFICIENCIES<br>ORRECTION<br>IDER OR SUPPLIER<br>W SENIOR LIVIN<br>SUMMARY ST/<br>(EACH DEFICIENC<br>REGULATORY OR L<br>Intinued From para<br>available, or was<br>cumentation rev<br>the past 6 mont<br>16) indicated R2<br>torative program<br>nen nursing assi<br>-F were intervie<br>y stated they did<br>olement the rest<br>torative program<br>nen nursing assi<br>-F were intervier<br>y stated they did<br>olement the rest<br>torative aide wa<br>assist them with<br>ified the NA's di<br>ograms during the<br>sus was low.<br>men interviewed from<br>time period 3/2<br>staffing changes<br>nsus. The DON<br>was pulled from<br>form NA cares.<br>s low the past m<br>the floor instead<br>ther stated the N<br>build conduct the<br>res but verified the<br>abilitation program<br>the folor instead<br>ther stated the N<br>port completion<br>ring a follow-up<br>/16, at 9:18 a.m<br>provide persona<br>tead of providing<br>erent staff callin | IDER OR SUPPLIER OBJECTION NUMBER:<br>IDER OR SUPPLIER STREET AL<br>W SENIOR LIVING 250 FIFT<br>TRACY, I<br>SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)<br>Intinued From page 24<br>available, or was left undocumented.<br>cumentation reviewed on the restorative logs<br>the past 6 months (December 2015-May<br>16) indicated R25 had not received a<br>torative program as directed by the care plan.<br>then nursing assistants (NA)- B, NA-C and<br>-F were interviewed on 5/4/16, at 2:00 p.m.<br>y stated they did not have the time to<br>belement the restorative nursing duties when the<br>torative aide was removed from those duties<br>assist them with resident cares. They all<br>ified the NA's did not complete the restorative<br>grams during the time when the resident<br>hsus was low.<br>The nursing (DON) verified the RA had<br>en removed from the restorative program from<br>time period 3/29/16 through 4/21/16, related<br>staffing changes affected by low resident<br>hsus. The DON further verified sometimes the<br>was pulled from rehab to cover for call-ins to<br>form NA cares. The DNS verified the census<br>s low the past month and the RA was utilized<br>the floor instead of the RA position. The DNS<br>ther stated the NA's caring for the residents<br>but verified the logs indicated the<br>uabilitation program was not documented to<br>port completion of the services.<br>ring a follow-up interview with the RA-A on<br>/16, at 9:18 a.m. she indicated she was asked<br>provide personal cares for resident's today<br>tead of providing restorative care due to a<br>erent staff calling in ill. The RA-A stated she is<br>sure if she would be able to do restorative | DEFICIENCIES<br>ORRECTION       (X1) PROVIDER/SUPPLIER/CLA<br>IDENTIFICATION NUMBER:       (X2) MULTIPLE<br>A. BUILDING:<br> | DEFICIENCIES<br>ORRECTION         (M1)         PROVIDER/SUPPLIER/CLA<br>IDENTIFICATION NUMBER:         (X2)         MULTIPLE CONSTRUCTION<br>A. BUILDING:           03342         B. WING | DEFICIENCIES<br>ORRECTION       (X) PROVIDERSUPPLIENCUA<br>IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING:       (X3) DATA<br>A. BUILDING:         00342       B. WING       05/         UDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         W SENOR LIVING       250 FIFTH STREET EAST<br>TRACY, NM 56175         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST EE PROCEEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       ID<br>PROVIDER'S PLAN OF CORRECTION<br>(EACH DEFICIENCY MUST EE PROCEEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDER'S PLAN OF CORRECTION<br>(EACH DEFICIENCY MUST EE PROCEEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDER'S PLAN OF CORRECTION<br>(EACH DEFICIENCY)         Transpace       2895 |

| STATEMEN                 | ota Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                      | CONSTRUCTION   |                                | E SURVEY<br>PLETED      |
|--------------------------|--|---|----------------------|--|--------------------------------|-------------------------|
|                          |  | 00342   | B. WING              |  | 05/                            | 05/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET ADD  | DRESS, CITY, S       | TATE, ZIP CODE   |                                |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G 250 FIFTH<br>TRACY, M   | STREET EA<br>N 56175 | ST   |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 2 895                    | DON verified the re<br>to work on the floor<br>due to a NA who fa<br>SUGGESTED MET<br>director of nursing of<br>residents at risk for<br>assure they are rec<br>treatment/services<br>range of motion. The<br>designee, could con<br>delivery of care; to<br>services are implen<br>decline in range of  | storative aide was re-assigned<br>(to provide personal cares)<br>iled to show up for work today.<br>THOD OF CORRECTION: The<br>pr designee, could review all<br>limited range of motion to<br>eiving the necessary<br>to prevent further limitation in<br>ne director of nursing or<br>nduct random audits of the<br>ensure appropriate care and<br>nented; to reduce the risk of a   | 2 895                |  |                                |                         |
| 21390                    | Subp. 4. Policies a<br>control program mu<br>procedures which p<br>A. surveillance<br>collection to identify<br>residents;<br>B. a system for<br>control of outbreaks<br>C. isolation and<br>reduce risk of trans<br>D. in-service en<br>prevention and con<br>E. a resident he<br>immunization progr<br>defined in part 465<br>procedures of resid<br>the prevention and<br>F. the developm | D Subp. 4 A-I Infection Control<br>and procedures. The infection<br>ist include policies and<br>provide for the following:<br>based on systematic data<br>a nosocomial infections in<br>to detection, investigation, and<br>s of infectious diseases;<br>d precautions systems to<br>mission of infectious agents;<br>ducation in infection<br>trol;<br>ealth program including an<br>am, a tuberculosis program as<br>8.0810, and policies and<br>ent care practices to assist in<br>treatment of infections;<br>nent and implementation of<br>olicies and infection control | 21390                |  |                                | 5/5/16                  |

| STATEMEN                 | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                        | LE CONSTRUCTION   |        | E SURVEY<br>PLETED      |
|--------------------------|---|---|------------------------|---|--------|-------------------------|
|                          |   | 00342   | B. WING                |   | 05/    | 05/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY,           | STATE, ZIP CODE   |        |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN   | G 250 FIFTH<br>TRACY, M   | I STREET E<br>IN 56175 | AST   |        |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE | (X5)<br>COMPLET<br>DATE |
| 21390                    | practices, including<br>defined in part 465<br>G. a system fo<br>products which affe<br>disinfectants, antise<br>incontinence produ<br>I. methods for<br>current standards of<br>This MN Requirem<br>by:<br>Based on observat<br>review the facility fa<br>blood glucose mete<br>between use for 2 of<br>required blood suga<br>on the North and C<br>Findings include:           | a tuberculosis program as<br>3.0815;<br>r reviewing antibiotic use;<br>r review and evaluation of<br>ect infection control, such as<br>eptics, gloves, and<br>cts; and<br>maintaining awareness of<br>of practice in infection control.<br>ent is not met as evidenced<br>ion, interview and document<br>ailed to ensure the multi-use<br>er was properly sanitized<br>of 2 residents (R12, R23) who<br>ar level monitoring and resided<br>entral wings.  | 21390                  | Completed   |        |                         |
|                          | medication assistant<br>glucose meter (gluc<br>lancet (pricking neet<br>the medication cart<br>donned gloves, cort<br>check and verbalize<br>sugar (BS) to R12.<br>sugar, TMA-B exite<br>medication cart, rep<br>placed the glucometer<br>on top of the cart.<br>isopropyl alcohol w<br>glucometer was sto<br>the glucometer with<br>finished cleansing to<br>returned the glucom | on 5/2/16, at 7:00 p.m. trained<br>ht (TMA)-B retrieved a blood<br>cometer), test strips and a<br>edle used to obtain blood) from<br>t. TMA-B entered R12's room,<br>hducted the blood sugar (BS)<br>ed the results of the blood<br>After checking R12's blood<br>ed the room, walked to the<br>moved her soiled gloves and<br>eter in a plastic basket located<br>TMA-B then retrieved a 70%<br>ipe from the basket where the<br>bred and proceeded to cleanse<br>in the alcohol wipe. After she<br>the glucometer, TMA-B<br>neter back into the plastic<br>op of the medication |                        |   |        |                         |

| STATEMEN                 | ta Department of He   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         |  |                                 | E SURVEY<br>PLETED      |
|--------------------------|---|---|-------------------------|--|---------------------------------|-------------------------|
|                          |   | 00342   | B. WING                 |  | 05/                             | 05/2016                 |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET AL   | DDRESS, CITY, S         | TATE, ZIP CODE   |                                 |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN   | G   | H STREET EA<br>MN 56175 | ST   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21390                    | Continued From pa   | -   | 21390                   |  |                                 |                         |
|                          | administration cart which also stored the test strips, alcohol wipes and lancets.   |   |                         |  |                                 |                         |
|                          | stated she always of<br>cleanse the glucom<br>scheduled to work<br>of a TMA and freque<br>which also includes<br>testing. TMA-B state<br>prior to conducting<br>implemented the state<br>cleansed the gluco<br>after performing the<br>TMA-B stated she<br>anything different of<br>which were the only<br>medication cart to of<br>use. TMA-B was a<br>Central wings for the<br>checking the blood<br>R12 and R23. | on 5/2/16, at 7:15 p.m. TMA-B<br>uses the alcohol wipes to<br>neter. TMA-B stated she is<br>several days/week in the role<br>uently administers medications,<br>s conducting blood glucose<br>ted she had checked R23's BS<br>R12's blood sugar and had<br>ame procedure. She had<br>meter with the alcohol wipe<br>e blood glucose check for R23.<br>had not been instructed to use<br>other than the alcohol wipes<br>y item available on the<br>cleanse the glucometer after<br>assigned to the North and<br>ne evening, which included<br>sugar levels for 2 residents, |                         |  |                                 |                         |
|                          | director of nursing<br>utilizing the Super  | on 5/2/16, at 7:30 p.m. the<br>(DON) stated staff should be<br>Sani-Cloth before and after use<br>lucometer equipment to<br>ose levels.   | )                       |  |                                 |                         |
|                          | glucometer was ide<br>manufacturer's clea<br>guidelines. The ins<br>disinfecting were ic<br>handbook as follow  | or disinfecting the Arkray blood<br>entified by the DON as the<br>aning and disinfecting<br>tructions for cleaning and<br>dentified in the device<br>vs:<br>s: To clean the outside of the  |                         |  |                                 |                         |
|                          | blood glucose mete<br>dampened with soa<br>(70%-80%).   | er, use a lint-free cloth<br>apy water or isopropyl alcohol<br>nes: To disinfect the meter,   |                         |  |                                 |                         |

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                          | CONSTRUCTION  |                                   | E SURVEY<br>IPLETED     |
|--------------------------|--|---|--------------------------|---|-----------------------------------|-------------------------|
|                          |  | 00342   | B. WING                  |   | 05/                               | 05/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, ST          | TATE, ZIP CODE  |                                   |                         |
| PRAIRIE                  | VIEW SENIOR LIVING   |   | H STREET EAS<br>MN 56175 | ST  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21390                    | sodium Hypochlorit<br>achieve a 1:10 dilut<br>0.5%-0.6% sodium<br>can be used to dam<br>saturate towel). The<br>thoroughly wipe dow<br>SUGGESTED MET<br>The director of nurs<br>related to the stand<br>the glucometer betw<br>conduct periodic au<br>implemented consis<br>audit could be repo<br>committee.  | ) household bleach (5%-6%<br>e solution) in 9 ml of water to<br>ion (finale concentration of<br>Hypochlorite). The solution<br>open a paper towel (do not<br>en use the dampened towel to   | 21390                    |   |                                   |                         |
| 21530                    | A. The drug regim<br>reviewed at least m<br>currently licensed b<br>This review must be<br>Appendix N of the S<br>Surveyor Procedure<br>Requirements in Lo<br>the Department of H<br>Health Care Finance<br>This standard is im<br>available through th<br>system. It is not su<br>B. The pharma<br>irregularities to the<br>and the attending p<br>must be acted upor | o A.B.C Drug Regimen Review<br>en of each resident must be<br>onthly by a pharmacist<br>y the Board of Pharmacy.<br>e done in accordance with<br>State Operations Manual,<br>es for Pharmaceutical Service<br>ong-Term Care, published by<br>Health and Human Services,<br>ing Administration, April 1992.<br>corporated by reference. It is<br>ne Minitex interlibrary loan<br>bject to frequent change.<br>cist must report any<br>director of nursing services<br>hysician, and these reports<br>n by the time of the next<br>poner, if indicated by the |                          |   |                                   | 6/13/16                 |

| STATEMEN                 | ta Department of He<br>IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | LE CONSTRUCTION  |             | E SURVEY<br>PLETED      |
|--------------------------|--|---|---------------------|--|-------------|-------------------------|
|                          |  | 00342   | B. WING             |  | 05/         | 05/2016                 |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY,        | STATE, ZIP CODE  |             |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN  | G   | I STREET E          | AST  |             |                         |
|                          |  | TRACY, M  | IN 56175            | 1  |             | 1                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE | (X5)<br>COMPLET<br>DATE |
| 21530                    | Continued From pa  | age 29  | 21530               |  |             |                         |
|                          | report and the sign<br>of nursing services<br>C. If the attend<br>with the pharmacis<br>not provide adequa<br>pharmacist believe<br>being adversely aff<br>refer the matter to<br>if the medical direct<br>physician. If the m<br>the attending physi<br>justification for the<br>physician does not<br>must be referred for<br>assessment and a<br>by part 4658.0070.<br>the medical direct<br>must refer the mat | acceptance or rejection of the<br>sing or initialing by the director<br>and the attending physician.<br>ding physician does not concur<br>it's recommendation, or does<br>ate justification, and the<br>es the resident's quality of life is<br>fected, the pharmacist must<br>the medical director for review<br>stor is not the attending<br>edical director determines that<br>ician does not have adequate<br>order and if the attending<br>change the order, the matter<br>or review to the quality<br>ssurance committee required<br>If the attending physician is<br>or, the consulting pharmacist<br>ter directly to the quality<br>ssurance committee. |                     |  |             |                         |
|                          | by:<br>Based on interview<br>pharmacy consulta<br>blood pressure mo<br>effectiveness for 1<br>who received multi<br>medications.<br>Findings include:<br>R18's most recent   | of 1 resident (R18) reviewed<br>ple anti-hypertensive<br>physician's progress note  |                     | Completed  |             |                         |
|                          | including: coronary<br>(high blood pressu<br>vascular disease (<br>vascular dementia   | ntified active diagnoses<br>r artery disease, hypertension<br>re), chronic back pain, cerebral<br>CVA-stroke), recurrent falls,<br>and chronic kidney disease.<br>also include an assessment  |                     |  |             |                         |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE<br>A. BUILDING: _ | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |
|--------------------------|--|---|---------------------------------|--|---------------------------------|-------------------------|
|                          |  | 00342   | B. WING                         |  | 05/                             | 05/2016                 |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, S                  | TATE, ZIP CODE   |                                 |                         |
| PRAIRIE                  | VIEW SENIOR LIVING   | G 250 FIFTH<br>TRACY, M   | STREET EA                       | ST   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21530                    | and plan related to<br>hypertension and th<br>acceptable blood pu<br>148/88 millimeters of<br>had been documen<br>R18's most recent p<br>4/14/16, identified of<br>Isosorbide Mononit<br>tablet 24 hour 30 m<br>mouth daily for ang<br>mg by mouth for es<br>Lopressor tablet 50<br>for essential hyperto<br>The pharmacy cons<br>indicated the follow<br>experiencing elevat<br>although there are a<br>also; has been fallin<br>following these incide<br>most recent BP's at<br>and 166/89 on 1/12<br>Isosorbide Mononit<br>release medication<br>chewed".<br>R18's Norvasc med<br>1/14/16, due to elev<br>staff. Review of the<br>Norvasc had been in<br>had been recorded<br>months; from 1/29/<br>BP readings docum<br>evidence document<br>ongoing BP reading<br>determine the effect | the diagnosis of essential<br>ne physician indicated an<br>ressure (BP) range for R18 as<br>of mercury (mm Hg), which<br>ted on the monthly flow sheet.<br>obysician orders dated<br>current medications as noted:<br>rate (extended release) ER<br>illigrams (mg) 1.5 tablets by<br>ina attacks, Norvasc tablet 5<br>sential hypertension and<br>mg by mouth two times a day | 21530                           |  |                                 |                         |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA<br>AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |   | CONSTRUCTION             |  | (X3) DATE SURVEY<br>COMPLETED |                         |
|--|---|---|--------------------------|--|-------------------------------|-------------------------|
|  | of oonneonon  | DENTITIOATION NOMBER.   | A. BUILDING: _           |  |                               |                         |
| 00342  |   | B. WING   |                          | 05/  | 05/2016                       |                         |
| NAME OF F  | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, S          | TATE, ZIP CODE   |                               |                         |
| PRAIRIE  | VIEW SENIOR LIVING  |   | TH STREET EA<br>MN 56175 | ST   |                               |                         |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE                 | (X5)<br>COMPLET<br>DATE |
| 21530  | Continued From pa   | ge 31   | 21530                    |  |                               |                         |
|  | consultant notes da<br>4/20/16 lacked any<br>related to staff mon   | ent monthly pharmacy<br>ated 2/20/16, 3/20/16 and<br>further recommendations<br>itoring the effectiveness (BP<br>rvasc medication since the<br>eased. |                          |  |                               |                         |
|  | During an interview on 5/5/16, at 8:57 a.m. the<br>director of nursing (DON) indicated the facility<br>practice was to obtain monthly routine vital signs<br>unless a physician orders indicated otherwise.<br>The DON verified the pharmacy consultant had<br>not identified nor recommended any increase BP<br>monitoring after the Norvasc had been increased. |   |                          |  |                               |                         |
|  | a.m. the pharmacy discussed with the  | interview on 5/5/16, at 10:15<br>consultant indicated he had<br>DON and recommended<br>be sufficient monitoring for<br>d anti-hypertensive            |                          |  |                               |                         |
|  | The administrator, of<br>consulting pharmac<br>policies and proced<br>medication usage, of<br>prescribed for hype<br>could be educated<br>importance of the p<br>or designee, along   | harmacist's review. The DON<br>with the pharmacist, could<br>views on a regular basis to  |                          |  |                               |                         |
|  | TIME PERIOD FOR<br>days.  | R CORRECTION: Thirty (30)   |                          |  |                               |                         |
| 21535  | MN Rule4658.1315<br>Drug Usage; Gener   | Subp.1 ABCD Unnecessary   | 21535                    |  |                               | 6/6/16                  |

| STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         00342 |   | Ealth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                         |
|---|---|--|-------------------------|--|-------------------------------|-------------------------|
|   |   | 00342  | B. WING                 |  | 05/05/2016                    |                         |
| IAME OF F   | PROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY, S         | TATE, ZIP CODE   |                               |                         |
| PRAIRIE   | VIEW SENIOR LIVIN   | G  | H STREET EA<br>MN 56175 | AST  |                               |                         |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE                   | (X5)<br>COMPLET<br>DATE |
| 21535   | Continued From pa   | age 32   | 21535                   |  |                               |                         |
|   | must be free from a<br>unnecessary drug i<br>A. in excessive<br>therapy;<br>B. for excessive<br>C. without ade<br>D. in the prese<br>which indicate the a<br>discontinued.<br>In addition to the o<br>part 4658.1310, th<br>with provisions in th<br>Code of Federal Re<br>483.25 (1) found in<br>Operations Manual<br>Long-Term Care Fa<br>Department of Hea<br>Health Care Finand<br>This standard is ind<br>available through th | quate indications for its use; or<br>ence of adverse consequences<br>dose should be reduced or<br>drug regimen review required in<br>the nursing home must comply<br>he Interpretive Guidelines for<br>egulations, title 42, section<br>a Appendix P of the State<br>I, Guidance to Surveyors for<br>acilities, published by the<br>alth and Human Services,<br>cing Administration, April 1992.<br>corporated by reference. It is<br>he Minitex interlibrary Ioan<br>ate Law Library. It is not | 1                       |  |                               |                         |
|   | This MN Requirement is not met as evidenced<br>by:<br>Based on interview and document review the<br>facility failed to monitor the effectiveness of<br>anti-hypertensive medications for 1 of 1 resident<br>(R18) who received multiple anti-hypertensive<br>medications and did not have ongoing blood<br>pressure (BP) recordings.<br>Findings include:   |  |                         | Completed  |                               |                         |
|   | dated 3/24/16, ider including: coronary   | physician's progress note<br>ntified active diagnoses<br>rartery disease, hypertension<br>re), chronic back pain, cerebra  | I                       |  |                               |                         |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:         00342 |  | ealth<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | CONSTRUCTION   |                                 | E SURVEY<br>PLETED      |
|---|--|--|-------------------------|--|---------------------------------|-------------------------|
|   |  | 00342  | B. WING                 |  | 05/                             | 05/2016                 |
| NAME OF   | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, S         | TATE, ZIP CODE   |                                 |                         |
| PRAIRIE   | VIEW SENIOR LIVIN  | (  | H STREET EA<br>MN 56175 | ST   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21535   | vascular disease (0<br>vascular dementia<br>This progress note<br>and plan related to<br>hypertension and th<br>acceptable blood p<br>148/88 millimeters<br>had been documer<br>R18's most recent<br>4/14/16, identified of<br>Isosorbide Mononit<br>tablet 24 hour 30 m<br>mouth daily for ang<br>mg by mouth for es<br>Lopressor tablet 50<br>for essential hypert<br>The pharmacy con<br>indicated the follow<br>experiencing eleva<br>although there are<br>also; has been falli<br>following these inci | CVA-stroke), recurrent falls,<br>and chronic kidney disease.<br>also include an assessment<br>the diagnosis of essential<br>he physician indicated an<br>ressure (BP) range for R18 as<br>of mercury (mm Hg), which<br>the on the monthly flow sheet.<br>physician orders dated<br>current medications as noted:<br>trate (extended release) ER<br>hilligrams (mg) 1.5 tablets by<br>the attacks, Norvasc tablet 5<br>ssential hypertension and<br>0 mg by mouth two times a day |                         |  |                                 |                         |
|   | 1/14/16, from 2.5 n<br>elevated BP's. Upg<br>and progress notes<br>not followed-up unt<br>medication increas<br>documented was 3<br>measured 148/88 r<br>documented BP re<br>3/24/16. There was  | dication was increased on<br>ng to 5 mg daily due to<br>on review of the BP flowsheet<br>is it was noted that R2's BP was<br>iil 1/29/16, (2 week after a<br>e). The next BP reading<br>/24/16, at 3:16 a.m. and<br>nm Hg. There were no<br>adings from 1/29/16 thru<br>is no evidence documented in<br>ig that ongoing BP readings  | 5                       |  |                                 |                         |

Minnesota Department of Health STATE FORM

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If continuation sheet 34 of 41

| STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         00342 |  |  |                         | CONSTRUCTION   |                                   | E SURVEY<br>PLETED      |
|---|--|--|-------------------------|--|-----------------------------------|-------------------------|
|   |  | 00342  | B. WING                 |  | 05/                               | 05/2016                 |
| NAME OF F   | PROVIDER OR SUPPLIER   | STREET AI  | DDRESS, CITY, S         | TATE, ZIP CODE   |                                   |                         |
| PRAIRIE   | VIEW SENIOR LIVIN  | G  | H STREET EA<br>MN 56175 | ST   |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21535   | Continued From pa  | age 34   | 21535                   |  |                                   |                         |
|   | ascertain R18's res  | sponse to treatment.   |                         |  |                                   |                         |
|   | director of nursing<br>practice was to obt<br>unless a physician<br>The nursing assista<br>monthly on the resi<br>During a telephone<br>a.m. the facility's m<br>also R18's primary<br>like to see a BP ou<br>for this age group (<br>is the goal, otherwi<br>stroke." The MD fu<br>would require rech<br>expect a resident m<br>to have their BP m<br>monthly. He verifier<br>measurements we<br>useful tool to evalu<br>anti-hypertensive n<br>every other day BP<br>stated, "I was not a<br>monitoring R18's B<br>stated it was difficu<br>effectiveness when<br>conducted before/a<br>administered. The<br>requested noon BF | re not frequent enough to be a<br>ate the effectiveness of the<br>nedication, indicating daily or<br>may be appropriate. The MD<br>ware the facility had not been<br>Ps more frequently." MD also<br>lit to evaluate the medication<br>of the BP recordings are<br>after the medication is<br>MD indicated he had<br>of monitoring vs. early morning<br>e residents who were receiving |                         |  |                                   |                         |
|   | The administrator,<br>consulting pharmac<br>policies and proced<br>medication usage,   | THOD OF CORRECTION:<br>director of nursing (DON) and<br>cist could review and revise<br>dures for proper monitoring of<br>especially medications<br>ertension control. Nursing staff   |                         |  |                                   |                         |

| STATEME                  | Dta Department of He<br>NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                         | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED     |                         |
|--------------------------|--|--|-------------------------|---|-----------------------------------|-------------------------|
| 00342                    |  | 00342  | B. WING                 |   | 05/                               | /05/2016                |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, ST         | TATE, ZIP CODE  |                                   |                         |
| PRAIRIE                  | E VIEW SENIOR LIVING   | G  | H STREET EA<br>MN 56175 | ST  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21535                    | Continued From pa  | ge 35  | 21535                   |   |                                   |                         |
|                          | or designee, along   | harmacist's review. The DON<br>with the pharmacist, could<br>views on a regular basis to   |                         |   |                                   |                         |
|                          | TIME PERIOD FOF<br>days.   | R CORRECTION: Thirty (30)  |                         |   |                                   |                         |
| 21545                    | MN Rule 4658.1320  | A.B.C Medication Errors  | 21545                   |   |                                   | 5/26/16                 |
|                          | percent as describe<br>Guidelines for Code<br>42, section 483.25<br>the State Operation<br>Surveyors for Long<br>incorporated by refe<br>purposes of this pa<br>(1) a discrepan<br>prescribed and wha<br>administered to res<br>(2) the adminis<br>medications.<br>B. It is free of a<br>error. A significant<br>(1) an error v<br>discomfort or jeopa<br>safety; or<br>(2) medication<br>requires the medica<br>be titrated to a spec<br>medication error co<br>precipitate a reoccu<br>toxicity. All medicat<br>prescribed. An inc | on error rate is less than five<br>ed in the Interpretive<br>e of Federal Regulations, title<br>(m), found in Appendix P of<br>is Manual, Guidance to<br>-Term Care Facilities, which is<br>erence in part 4658.1315. For<br>rt, a medication error means:<br>ncy between what was<br>at medications are actually<br>idents in the nursing home; or<br>stration of expired |                         |   |                                   |                         |

| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                      | LE CONSTRUCTION (>  | (3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|----------------------|---|------------------------------|
|                          | 00342   |  | B. WING              |   | 05/05/2016                   |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY,         | STATE, ZIP CODE   |                              |
| PRAIRIE                  | VIEW SENIOR LIVIN   | (4   | HSTREETE<br>MN 56175 | AST   |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE COMPLET                   |
| 21545                    | resident reactions r<br>physician or the ph<br>resident or the resid<br>designated represe<br>must be made in th<br>C. All medication<br>prescribed. An inci-<br>report must be filed<br>occurs. Any signifi-<br>resident reactions r<br>physician or the ph<br>resident or the resid<br>designated represe | Ige 36<br>must be reported to the<br>ysician's designee and the<br>dent's legal guardian or<br>entative and an explanation<br>be resident's clinical record.<br>ons are administered as<br>ident report or medication error<br>of for any medication error that<br>cant medication errors or<br>must be reported to the<br>ysician's designee and the<br>dent's legal guardian or<br>entative and an explanation<br>be resident's clinical record. | 21545                |   |                              |
|                          | by:<br>Based on observation<br>review the facility factorial were administered<br>residents (R12) observation.  | ent is not met as evidenced<br>ion, interview and document<br>ailed to ensure all medications<br>without error for 1 of 9<br>served during medication  |                      | Completed   |                              |
|                          | pass on 5/2/16, at assistant (TMA)-B<br>medications. The four by TMA-B: Zype<br>milligrams (mg); Ty<br>Aricept (dementia r<br>placing the medication<br>them in applesauce<br>medications into R<br>them with a spoon   | of the evening medication<br>7:00 p.m. trained medication<br>prepared R12's bedtime<br>blowing medications were set<br>rexa (antipsychotic) 5<br>denol 500 mg, 2 tabs; and<br>nedication) 15 mg. After<br>tions into a plastic medication<br>ed the medications and placed<br>be. TMA-B transported the<br>12's room and administered<br>to R12. R12 remained lying in<br>ed the head of the bed to  |                      |   |                              |

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | E CONSTRUCTION  |                                | E SURVEY<br>PLETED      |
|--------------------------|--|---|-------------------------|---|--------------------------------|-------------------------|
|                          | 00342  |   | B. WING                 |   | 05/05/2016                     |                         |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AI   | DDRESS, CITY, S         | TATE, ZIP CODE  |                                |                         |
| PRAIRIE                  | VIEW SENIOR LIVIN  | (-  | H STREET EA<br>MN 56175 | ST  |                                |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
|                          | toward the foot of t<br>not raised to the 45<br>administering the n<br>noted that TMA-B s<br>(medications/apple<br>medication adminis<br>located in the hallw<br>TMA-B documente<br>administered the m<br>noted there was ac<br>the applesauce rem<br>used to administer<br>applesauce mixture<br>mixture as did the l<br>which contained ac | legrees but R12 slid down<br>he bed and thus her head was<br>5 degree level. After<br>nedications to R12, it was<br>set the medication cup<br>isauce) on top of the<br>stration cart. The cart was<br>vay outside of R12's room.<br>d in the medication<br>ord (MAR) that she had<br>nedications. However, it was<br>Iditional medication mixed with<br>naining in the cup. The spoon<br>the medication and<br>e contained chunks of the<br>bottom of the medication cup,<br>dditional residue.<br>th TMA-B on 5/2/16, at 7:10<br>that not all of the medications |                         |   |                                |                         |
|                          | verify R12 had rece<br>prescribed medicat<br>not realize she left<br>cup.<br>When interviewed<br>director of nursing<br>aware of the obser<br>properly trained to<br>should ensure resid<br>prescribed.<br>During review of th   | and consequently could not<br>eived the full dose of the<br>tions. TMA-B indicated she did<br>so much medication in the<br>on 5/2/16, at 7:30 p.m. the<br>services (DON) was made<br>vation and stated staff were<br>administer medications and<br>dents receive the full dosing as<br>e facility policy for, General   |                         |   |                                |                         |
|                          | Dose Preparation a<br>Omnicare 2013, the<br>identified: 3. Dose<br>take all measures r<br>applicable law, incl   | and Medication Administration,<br>e following guidance was<br>Preparation: Facility should<br>required by facility policy and<br>uding, but not limited to the<br>lity staff should crush oral  |                         |   |                                |                         |

| STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         00342 |  |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   | E SURVEY<br>PLETED              |                         |
|---|--|--|---|---|---------------------------------|-------------------------|
|   |  | B. WING  |   | 05/   | 05/2016                         |                         |
| IAME OF I   | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, S                         | TATE, ZIP CODE  |                                 |                         |
| PRAIRIE   | VIEW SENIOR LIVIN  | G  | H STREET EA<br>MN 56175                 | AST   |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| 21545   | Continued From pa  | ige 38   | 21545                                   |   |                                 |                         |
|   | guidelines as set for<br>identified which me<br>crushed but did not<br>related to the admin<br>medications in appl   | able to produce a policy related   |   |   |                                 |                         |
|   | applesauce.<br>SUGGESTED MET<br>The Director of Nur<br>involved staff as to<br>medication adminis<br>conduct periodic au<br>compliance adminis<br>medication pass. | THOD FOR CORRECTION:<br>rsing could re-educate the<br>proper procedure for following<br>stration. She could also<br>udits to ensure staff<br>ster all medications during the                                       |   |   |                                 |                         |
|   | TIME PERIOD FOR<br>days.   | R CORRECTION: Seven (7)  |   |   |                                 |                         |
| 21685   |  | eration, & Maintenance   | 21685                                   |   |                                 | 6/3/16                  |
|   | including walls, floc<br>systems, and equip<br>continuous state of<br>with regard to the h<br>well-being of the re   | blant. The physical plant,<br>brs, ceilings, all furnishings,<br>brent must be kept in a<br>good repair and operation<br>lealth, comfort, safety, and<br>esidents according to a written<br>be and repair program. |   |   |                                 |                         |
|   | by:<br>Based on observat   | ent is not met as evidenced<br>ion and interview the facility<br>ne condition of the ceiling tiles   |   | Completed   |                                 |                         |

| ta Department of He<br>T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,  |   | (X3) DATE SURVEY<br>COMPLETED  |  |
|--|--|--|---|--|--|
|  | 00342  | B. WING  | /ING  |  | 05/2016  |
| PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, S  | TATE, ZIP CODE  |  |  |
| VIEW SENIOR LIVIN  | G  | -  | ST  |  |  |
| (EACH DEFICIENC)   | MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG  | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1   | TION SHOULD BE<br>THE APPROPRIATE  | (X5)<br>COMPLET<br>DATE  |
| for 15 of 17 resider<br>wings of the facility<br>101/103, 105/107,<br>202/204, 206/208, 2<br>214/216; 300 wing<br>303/305, 306/308, 3<br>Findings include:<br>During observation:<br>through 5/5/16, at 2<br>bathrooms had ceil<br>and/or discolored:<br>100 wing rooms: 10<br>109/111;<br>200 wing rooms: 20<br>211/213, 214/216; a<br>300 wing rooms: 30<br>307/309.<br>A tour was conduct<br>director and the reg<br>11:39 a.m. It was con<br>ceiling tiles in resid<br>water damage relativents and melting.<br>stated on 5/5/16, at<br>system located on the<br>been inspected sind<br>company.<br>SUGGESTED MET<br>The director of nurse<br>educate staff regard | at bathrooms located on all 3<br>. (100 wing room #: 102/104,<br>109/111; 200 wing room #:<br>207, 210/212, 211/213,<br>room #: 301, 302/304,<br>307/309).<br>s on 5/2/16, at 2:20 p.m.<br>2:00 p.m. the following resident<br>ing tiles which were stained<br>02/104, 101/103, 105/107,<br>02/204, 206/208, 207, 210/212<br>and<br>01, 302/304, 303/305, 306/308<br>ed with the maintenance<br>gional director on 5/5/16, at<br>onfirmed the stains on the<br>ent bathrooms were a result of<br>ted to snow getting into the<br>The maintenance director<br>: 11:45 a.m. the ventilation<br>the roof of the building had not<br>ce 2014 by the ventilation<br>THOD OF CORRECTION:<br>sing (DON) or designee, could<br>ding the importance of a safe,  | ,<br>,<br>F  | DEFICIENC   | (Υ)  |  |
|  | PROVIDER OR SUPPLIER<br>VIEW SENIOR LIVIN<br>SUMMARY STA<br>(EACH DEFICIENCC<br>REGULATORY OR L<br>Continued From par<br>for 15 of 17 resider<br>wings of the facility<br>101/103, 105/107,<br>202/204, 206/208, 2<br>214/216; 300 wing<br>303/305, 306/308, 3<br>Findings include:<br>During observations<br>through 5/5/16, at 2<br>bathrooms had ceil<br>and/or discolored:<br>100 wing rooms: 10<br>109/111;<br>200 wing rooms: 20<br>211/213, 214/216; a<br>300 wing rooms: 30<br>307/309.<br>A tour was conduct<br>director and the reg<br>11:39 a.m. It was conduct<br>director and the reg<br>10:30 a.m. It was conduct<br>director and th | OF CORRECTION         IDENTIFICATION NUMBER:           00342         00342           PROVIDER OR SUPPLIER         STREET AI           VIEW SENIOR LIVING         250 FIFT<br>TRACY,           SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)           Continued From page 39           for 15 of 17 resident bathrooms located on all 3<br>wings of the facility. (100 wing room #: 102/104,<br>101/103, 105/107, 109/111; 200 wing room #:<br>202/204, 206/208, 207, 210/212, 211/213,<br>214/216; 300 wing room #: 301, 302/304,<br>303/305, 306/308, 307/309).           Findings include:           During observations on 5/2/16, at 2:20 p.m.<br>through 5/5/16, at 2:00 p.m. the following resident<br>bathrooms had ceiling tiles which were stained<br>and/or discolored:           100 wing rooms: 102/104, 101/103, 105/107,<br>109/111;           200 wing rooms: 202/204, 206/208, 207, 210/212<br>211/213, 214/216; and<br>300 wing rooms: 301, 302/304, 303/305, 306/308<br>307/309.           A tour was conducted with the maintenance<br>director and the regional director on 5/5/16, at<br>11:39 a.m. It was confirmed the stains on the<br>ceiling tiles in resident bathrooms were a result of<br>water damage related to snow getting into the<br>vents and melting. The maintenance director<br>stated on 5/5/16, at 11:45 a.m. the ventilation<br>system located on the roof of the building had not<br>been inspected since 2014 by the ventilation<br>company.           SUGGESTED METHOD OF CORRECTION:<br>The director of nursing (DON) or designee, could<br>educate staff regarding the importance of a safe,<br>clean, functional and homelike environment. The<br>DON or designee, could coordinate with | OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00342       B. WING | OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING:       00342     B. WING       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       VIEW SENIOR LIVING     250 FIFTH STREET EAST<br>TRACY, MN 56175       SUMMARY STATEMENT OF DEFICIENCIES     D<br>PROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES     D<br>PROVIDER OF CORPORT       Continued From page 39     21685       for 15 of 17 resident bathrooms located on all 3<br>wings of the facility. (100 wing room #: 102/104,<br>101/103, 105/107, 109/111; 200 wing room #:<br>202/204, 206/208, 207, 210/212, 211/213,<br>202/204, 206/208, 207, 210/212, 211/213,<br>214/216; 300 wing room #: 301, 302/304,<br>303/305, 306/308, 307/309).       Findings include:       During observations on 5/2/16, at 2:20 p.m.<br>through 5/5/16, at 2:00 p.m. the following resident<br>bathrooms had ceiling tiles which were stained<br>and/or discolored:       100 wing rooms: 202/204, 206/208, 207, 210/212,<br>211/213, 214/216; and<br>300 wing rooms: 202/204, 206/208, 207, 210/212,<br>211/213, 214/216; and<br>300 wing rooms: 202/204, 203/305, 306/308,<br>307/309.       A tour was conducted with the maintenance<br>director and the regional director on 5/5/16, at<br>11:39 a.m. It was confirmed the stains on the<br>ceiling tiles in resident bathrooms were a result of<br>water damage related to snow getting into the<br>vents and meting. The maintenance director<br>stated on 5/5/16, at 11:45 a.m. the ventilation<br>system located on the roof of the building had not<br>been inspected since 2014 by the ventilation<br>company.       SUGGESTED METHOD OF CORRECTION:<br>The director of nursing (DON) or designee, could<br>educate staff regarding the importance of a safe,<br>clean, functional and homelike environm | OF CORRECTION     IDENTIFICATION NUMBER:     A BUILDING:     COM       00342     B. WING     05/       ROVIDER OR SUPPLER     STREET ADDRESS, CITY, STATE, 2/P CODE       VIEW SENIOR LIVING     250 FIFTH STREET EAST<br>TRACY, MN 56175       SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY ON LSC DENTIFYING INFORMATION)     ID<br>PREFX<br>TAG     PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)       Continued From page 39     21685       for 15 of 17 resident bathrooms located on all 3<br>wings of the facility. (100 wing room #: 102/104,<br>101/103, 105/107, 109/111; 200 wing room #: 102/104,<br>101/103, 105/107, 109/111; 200 wing room #: 201/204,<br>202/204, 206/208, 207, 210/212, 211/213,<br>214/216; 300 wing room #: 301, 302/304,<br>303/305, 306/308, 307/309).       Findings include:       During observations on 5/2/16, at 2:20 p.m.<br>through 5/5/16, at 2:00 p.m. the following resident<br>bathrooms had ceiling tiles which were stained<br>and/or discolored:       100 wing rooms: 102/104, 101/103, 105/107,<br>109/111;       200 wing rooms: 301, 302/304, 303/305, 306/308,<br>307/309.       A tour was conducted with the maintenance<br>director and the regional director on 5/5/16, at<br>11:39 a.m. It was confirmed the stains on the<br>ceiling tiles in resident bathrooms were a result of<br>water damage related to snow getting into the<br>vents and melling. The maintenance director<br>stated on 5/5/16, at 11:45 a.m. the ventilation<br>company.       SUGGESTED METHOD OF CORRECTION:<br>The director of nursing (DON) or designee, could<br>educate staff regarding the importance of a safe,<br>clean, functional and homelike envi |

Minnesota Department of Health STATE FORM

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If continuation sheet 40 of 41

| TATEMENT OF DEFICIENCIES<br>ND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                                     | (X2) MULTIPLE CONSTRUCTION A. BUILDING:                   |                          | (X3) DATE SURVEY<br>COMPLETED                            |                 |                 |
|--|-------------------------------------|---|--------------------------|--|-----------------|-----------------|
|  |                                     |   |                          |  |                 |                 |
|  |                                     | 00342   | B. WING                  |  | 05/             | 05/2016         |
| AME OF F   | PROVIDER OR SUPPLIER                |   | DDRESS, CITY, ST         |  |                 |                 |
| RAIRIE   | VIEW SENIOR LIVIN                   | ( -   | H STREET EAS<br>MN 56175 | ST   |                 |                 |
| (X4) ID  |                                     | ATEMENT OF DEFICIENCIES                                   | ID                       | PROVIDER'S PLAN OF                                       |                 | (X5)            |
| PRÉFIX<br>TAG  | (EACH DEFICIENC)<br>REGULATORY OR L | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG            | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | THE APPROPRIATE | COMPLET<br>DATE |
| 21685  | Continued From pa                   | age 40  | 21685                    |  |                 |                 |
|  | environment is mai                  | ntained to the extent possible.                           |                          |  |                 |                 |
|  | TIME PERIOD FOI<br>(21) days.       | R CORRECTION: Twenty-one                                  |                          |  |                 |                 |
|  |                                     |   |                          |  |                 |                 |
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