

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 1T5G
Facility ID: 00650

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245482		3. NAME AND ADDRESS OF FACILITY (L3) PRAIRIE MANOR CARE CENTER			4. TYPE OF ACTION: <u>7</u> (L8)	
2.STATE VENDOR OR MEDICAID NO. (L2) 122343700		(L4) 220 THIRD STREET NORTHWEST			1. Initial 3. Termination 5. Validation 7. On-Site Visit	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7)			2. Recertification 4. CHOW 6. Complaint 9. Other	
6. DATE OF SURVEY 06/29/2015 (L34)		01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA			8. Full Survey After Complaint	
8. ACCREDITATION STATUS: <u> </u> (L10)		02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF			FISCAL YEAR ENDING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC			09/30	
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY IS CERTIFIED AS:				
From (a) :		X A. In Compliance With <u> </u> And/Or Approved Waivers Of The Following Requirements:				
To (b) :		Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit				
12.Total Facility Beds 52 (L18)		Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director				
13.Total Certified Beds 52 (L17)		<u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size				
		<u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room				
		B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12)				
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS	
18 SNF 18/19 SNF 19 SNF ICF IID					1861 (e) (1) or 1861 (j) (1): (L15)	
52						
(L37) (L38) (L39) (L42) (L43)						

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

17. SURVEYOR SIGNATURE		Date :	18. STATE SURVEY AGENCY APPROVAL		Date:
<u>Gary Nederhoff, Unit Supervisor</u>		07/01/2015	<u>Kamala Fiske-Downing, Enforcement Specialist</u>		07/01/2015
		(L19)			(L20)

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

19. DETERMINATION OF ELIGIBILITY		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : <u> </u>	
<input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 2. Facility is not Eligible (L21)					
22. ORIGINAL DATE OF PARTICIPATION 05/01/1987 (L24)		23. LTC AGREEMENT BEGINNING DATE (L41)		26. TERMINATION ACTION: (L30)	
		24. LTC AGREEMENT ENDING DATE (L25)		VOLUNTARY <u>00</u> INVOLUNTARY	
25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS		01-Merger, Closure 05-Fail to Meet Health/Safety	
		A. Suspension of Admissions: (L44)		02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement	
		B. Rescind Suspension Date: (L45)		03-Risk of Involuntary Termination OTHER	
				04-Other Reason for Withdrawal 07-Provider Status Change	
				00-Active	
28. TERMINATION DATE: (L28)		29. INTERMEDIARY/CARRIER NO. 03001 (L31)		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE 06/18/2015 (L33)		DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245482

July 1, 2015

Mr. Richard Feeney, Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, Minnesota 55917

Dear Mr. Feeney:

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 18, 2015 the above facility is certified for or recommended for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 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,

A handwritten signature in black ink that reads "Kamala Fiske-Downing".

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 1, 2015

Mr. Richard Feeney, Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, Minnesota 55917

RE: Project Number S5482025

Dear Mr. Feeney:

On May 28, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 14, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 29, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 22, 2015 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 14, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 18, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 14, 2015, effective June 18, 2015 and therefore remedies outlined in our letter to you dated May 28, 2015, 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,

A handwritten signature in cursive script that reads "Kamala Fiske-Downing".

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

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245482	(Y2) Multiple Construction A. Building _____ B. Wing _____	(Y3) Date of Revisit 6/29/2015
Name of Facility PRAIRIE MANOR CARE CENTER	Street Address, City, State, Zip Code 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917	

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0279	Correction Completed 06/18/2015	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # 483.20(d), 483.20(k)(1)		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

Reviewed By _____	Reviewed By GPN/kfd	Date: 07/01/2015	Signature of Surveyor: 10160	Date: 06/29/2015
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 5/14/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245482	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 6/22/2015
Name of Facility PRAIRIE MANOR CARE CENTER	Street Address, City, State, Zip Code 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917	

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC <u>K0050</u>	Correction Completed 06/06/2015	ID Prefix _____ Reg. # NFPA 101 LSC <u>K0062</u>	Correction Completed 06/05/2015	ID Prefix _____ Reg. # NFPA 101 LSC <u>K0144</u>	Correction Completed 06/18/2015
ID Prefix _____ Reg. # NFPA 101 LSC <u>K0147</u>	Correction Completed 06/06/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By <u>PS/kfd</u>	Date: <u>07/01/2015</u>	Signature of Surveyor: _____ 25822	Date: <u>06/22/2015</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>5/13/2015</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right; margin-left: 20px;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245482	(Y2) Multiple Construction A. Building 02 - CHAPEL B. Wing	(Y3) Date of Revisit 6/22/2015
Name of Facility PRAIRIE MANOR CARE CENTER	Street Address, City, State, Zip Code 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917	

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC <u>K0050</u>	Correction Completed 06/06/2015	ID Prefix _____ Reg. # NFPA 101 LSC <u>K0062</u>	Correction Completed 06/05/2015	ID Prefix _____ Reg. # NFPA 101 LSC <u>K0144</u>	Correction Completed 06/18/2015
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By PS/kfd	Date: 07/01/2015	Signature of Surveyor: 25822	Date: 06/22/2015
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/13/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 4738

May 28, 2015

Mr. Richard Feeney, Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, Minnesota 55917

RE: Project Number S5482025

Dear Mr. Feeney:

On May 14, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not

attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 23, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 23, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 14, 2015 (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

Prairie Manor Care Center

May 26, 2015

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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 14, 2015 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

Prairie Manor Care Center

May 26, 2015

Page 6

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Kamala Fiske-Downing".

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

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

PRINTED: 06/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245482	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2015
NAME OF PROVIDER OR SUPPLIER PRAIRIE MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		6/18/15	

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

TITLE

(X6) DATE

Electronically Signed

06/05/2015

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

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NAME OF PROVIDER OR SUPPLIER PRAIRIE MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	Continued From page 1 by: Based on observation, interview, and document review, the facility failed to develop a care plan that included dental care and treatment for 1 of 1 resident (R16) reviewed for dental care. Findings include: R16's care plan was reviewed and did not include an oral/dental care focus which would have identified dental problems and instructions for staff on how and when to provide oral/dental care. R16 was observed and interviewed on 5/11/15, at 5:56 p.m. Looking at teeth it was noted that R16 had at least one broken front tooth. R16 confirmed he had broken teeth and stated he had been to the dentist but could not recall when. R16 was admitted to the facility on 5/31/13 according to the facility admission record. R16's annual Minimum Data Set (MDS) dated 4/2/15 indicated severe cognitive impairment with a Brief Interview for Mental Status score of 6 and required extensive assistance of one staff member for personal hygiene. The MDS also indicated R16 had obvious or likely cavities or broken natural teeth, which had triggered a Care Assessment Area (CAA) that required a plan of care for oral/dental care. R16's CAA for dental problems indicated oral/dental care had been included in the care plan. The CAA further indicated R16's cognitive deficit contributed to oral/dental problems, had decreased mobility that would limit the ability to perform personal hygiene, and had been administered antidepressant medications that would cause dry mouth that could potentially cause build-up of oral bacteria. The rationale for including a dental focus on the care plan read, "Oral assessment completed today 4/5/2015TEETH: natural/no dentures (left bottom 2nd to last molar obvious decay and broken)(Front top	F 279	Prairie Manor Care Center uses the results of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident's needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents' right to refuse cares/services. The care plan related policies/procedures and the staff responsibilities for development and revision of the comprehensive plans of care were reviewed and found appropriate. At the time of admission, a temporary care plan is implemented that addresses the residents' need for assistance with activities of daily living; the interdisciplinary care plan is developed within seven days after completion of the comprehensive assessment. During the mandatory educational sessions, the nursing staff will be reminded 1) of the facility policies for care plan implementation/reviews/updates 2) that the residents' care plans must be current at all times 3) that care plans must continue to address the residents' oral hygiene and dental care needs and 4) the nursing assistant care reference sheets (Kardex) should include instructions for		

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F 279	<p>Continued From page 2</p> <p>teeth mostly just little buds/roots with obvious decay) (2nd to last back upper molar is missing) (2 lower back right molars are missing)Plaque and tarter present throughout ...Denies pain/discomfort ..."</p> <p>R16's Kardex (abbreviated care plan primarily used by nursing assistants) also did not include an oral/dental care focus.</p> <p>During an interview on 5/13/15, at 11:35 a.m. director of nursing (DON) verified oral/dental care had not been included in R16's care plan. DON stated oral/dental care should have been included in the care plan.</p> <p>Facility policy Oral Assessment Policy last updated 3/26/14 included, "Resident's dental status will be addressed in their care plan."</p> <p>Facility policy Care Plan Policy last updated 8/13/12 included, "A care plan will be developed for each resident identifying the needs of each individual resident. Each resident care plan will address every specific area of care for each resident."</p>	F 279	<p>oral/dental hygiene.</p> <p>Resident number 16 was admitted the facility May 31, 2013. The comprehensive admission assessment identified dental issues which were subsequently evaluated by a registered nurse. The resident received assistance with routine oral/dental hygiene according to facility policy. The resident's comprehensive care plan and the care reference sheets used by the certified nursing assistants were updated to include oral/dental care. Due to advanced dementia, the resident's condition declined and he died at the facility May 26, 2015.</p> <p>All care plans and nursing assistant care reference sheets have been reviewed to ensure that oral/dental care is addressed. At the time of admission, quarterly, and with significant change in condition, the interdisciplinary care team will continue to review residents' oral care dependencies and need for dental services. The MDS Coordinator will monitor the records of all new residents for appropriate dental/oral plans of care for the next three months, if noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the next Quality Assessment and Assurance Committee meeting.</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/05/2015

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K 000	<p>Continued From page 1 St Paul, MN 55101-5145, or</p> <p>By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. <p>This facility will be surveyed as two separate buildings. Prairie Manor Care Center is a 1-story building. The original building was constructed in 1970 and was determined to be of Type II(111) construction, with a partial basement. In 1984, addition was constructed and was determined to be of Type II(111) construction.</p> <p>The facility is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.</p> <p>The facility has a capacity of 56 beds and had a census of 43 at the time of the survey.</p> <p>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:</p>	K 000		

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K 050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 43 residents.</p> <p>Findings include:</p> <p>On facility tour between 8:15 AM and 10:45 AM on 05/13/2015, the review of the fire drill documentation for the past 12 months (May 2014 to April 2015) revealed the following:</p> <ol style="list-style-type: none"> The fire drills did not sufficiently vary the times that the drills were conducted on the following shifts: Evening: 1842, 2030, 1824 and 2058 hours Night: 0130, 0115 and 0030 hours Fire drill was missed in the 2nd quarter of 2014/2015 	K 050	<p>Fire drills are held with sufficient frequency to familiarize staff with the drill procedures. Drills will be held once per quarter on each shift at no less than 1.5 hour intervals. A tracking log is being used to verify that fire drills are held quarterly on each shift and at unexpected times under varying conditions.</p> <p>The Environmental Service Director will be responsible for scheduling the fire drills to meet regulatory requirements. The administrator will monitor the scheduling of fire drills monthly for six months and randomly thereafter.</p>	6/6/15

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K 050	Continued From page 3	K 050		
K 062 SS=D	<p>These deficient practices were confirmed by the Facility Maintenance Director (SB) at the time of discovery.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-4.1.4. This deficient practice could affect all 43 residents.</p> <p>Findings include:</p> <p>On facility tour between 8:15 AM and 10:45 AM on 05/13/2015, observation revealed that the spare sprinkler head box does not contain 2 of each type of sprinkler head in the facility.</p> <p>This deficient practice was confirmed by the Facility Maintenance Director (SB) at the time of discovery.</p>	K 062	<p>The sprinkler head storage box contained an extra sprinkler head of the type used in residential facilities. During the inspection this extra sprinkler head was misinterpreted as the facility not having two spare sprinkler heads for the type used in the long-term care facility.</p> <p>The Environmental Services Director removed the misplaced residential sprinkler head from the sprinkler storage box and did a tour of the facility with the contracted sprinkler company representative to ensure proper sprinkler heads were in place. Quick Response Sprinklers are used in the facility and the proper amount and type of sprinkler heads are in the sprinkler head storage box.</p>	6/5/15
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised</p>	K 144		6/18/15

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K 144	<p>Continued From page 4</p> <p>under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6.4.2 and 6-4.2.2. The deficient practice could affect all 43 residents.</p> <p>Findings include:</p> <p>On facility tour between 8:15 AM and 10:45 AM on 05/13/2015, documentation review of the monthly generator logs and the generator did not meet one of the following:</p> <ul style="list-style-type: none"> a. loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer or b. under load of 30 percent or more of the nameplate rating of generator or c. 2 hour load bank test (first 30 minutes - 25%, next 30 minutes - 50%, and last 1 hour - 75%) <p>No annual load bank test since 04/25/2014.</p> <p>This deficient practice was confirmed by the Facility Maintenance Director (SB) at the time of discovery.</p>	K 144	<p>The Generator System Services has agreed to perform the Annual Load Bank Test to meet NFPA 101 Life Safety Code requirements during the week of June 8, 2015. The required load test will be added to the generator preventive maintenance schedule.</p> <p>The Environmental Services Director will monitor compliance with boiler inspections and load test requirements.</p>	

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K 147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA 101 - 19.5.1, 9.1.2, 1999 NFPA 70 and 2007 MSFC. The deficient practice could affect 15 out of 48 residents.</p> <p>Findings include:</p> <p>On facility tour between 8:15 AM and 10:45 AM on 05/13/2015, observation revealed, that the following was found:</p> <ol style="list-style-type: none"> 1. The circuit breaker panels are block in rooms #9, #22 and #64 2. Extension cords in use in resident rooms #18 and #41 3. Extension cord in use in staff break room powering the refrigerator <p>These deficient practices were confirmed by the Facility Maintenance Director (SB) at the time of discovery.</p> <p>*TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.</p>	K 147	<ol style="list-style-type: none"> 1) The portable utility carts blocking access to the circuit breaker panels in rooms # 9, #22 and #64 were relocated. Signs have been placed in the storage rooms informing staff not to place equipment in front of the circuit breaker panels. 2) The extension cords in resident rooms #18 and #41 were removed. The safety committee will review options for ensuring regulatory compliance and resident satisfaction with the operation of their personal electrical equipment. A reminder that extension cords are not to be used in resident rooms will be included in the monthly newsletter that is distributed to resident and families. 3) The extension cord used to power the refrigerator in the staff break room has been removed. To eliminate the need for an extension cord, a new outlet box and outlet was installed behind the refrigerator June 3, 2015. <p>Compliance will be monitored by the Environmental Services Director.</p>	6/6/15

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

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Prairie Manor Care Center 1991 chapel addition is a 1-story building with no basement. The 1991 chapel addition was determined to be of Type V (111) construction. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 43 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050		6/6/15

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K 050	<p>Continued From page 2</p> <p>varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 43 residents.</p> <p>Findings include:</p> <p>On facility tour between 8:15 AM and 10:45 AM on 05/13/2015, the review of the fire drill documentation for the past 12 months (May 2014 to April 2015) revealed the following:</p> <ol style="list-style-type: none"> The fire drills did not sufficiently vary the times that the drills were conducted on the following shifts: Evening: 1842, 2030, 1824 and 2058 hours Night: 0130, 0115 and 0030 hours Fire drill was missed in the 2nd quarter of 2014/2015 	K 050	<p>Fire drills are held with sufficient frequency to familiarize staff with the drill procedures. Drills will be held once per quarter on each shift at no less than 1.5 hour intervals. A tracking log is being used to verify that fire drills are held quarterly on each shift and at unexpected times under varying conditions.</p> <p>The Environmental Service Director will be responsible for scheduling the fire drills to meet regulatory requirements. The administrator will monitor the scheduling of fire drills monthly for six months and randomly thereafter.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245482	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - CHAPEL B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2015
NAME OF PROVIDER OR SUPPLIER PRAIRIE MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917	
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K 050	Continued From page 3 These deficient practices were confirmed by the Facility Maintenance Director (SB) at the time of discovery.	K 050		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-4.1.4. This deficient practice could affect all 43 residents. Findings include: On facility tour between 8:15 AM and 10:45 AM on 05/13/2015, observation revealed that the spare sprinkler head box does not contain 2 of each type of sprinkler head in the facility. This deficient practice was confirmed by the Facility Maintenance Director (SB) at the time of discovery.	K 062		6/5/15
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	The sprinkler head storage box contained an extra sprinkler head of the type used in residential facilities. During the inspection this extra sprinkler head was misinterpreted as the facility not having two spare sprinkler heads for the type used in the long-term care facility. The Environmental Services Director removed the misplaced residential sprinkler head from the sprinkler storage box and did a tour of the facility with the contracted sprinkler company representative to ensure proper sprinkler heads were in place. Quick Response Sprinklers are used in the facility and the proper amount and type of sprinkler heads are in the sprinkler head storage box.	6/18/15

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K 144	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6.4.2 and 6-4.2.2. The deficient practice could affect all 43 residents.</p> <p>Findings include:</p> <p>On facility tour between 8:15 AM and 10:45 AM on 05/13/2015, documentation review of the monthly generator logs and the generator did not meet one of the following:</p> <ul style="list-style-type: none"> a. loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer or b. under load of 30 percent or more of the nameplate rating of generator or c. 2 hour load bank test (first 30 minutes - 25%, next 30 minutes - 50%, and last 1 hour - 75%) <p>No annual load bank test since 04/25/2014.</p> <p>This deficient practice was confirmed by the Facility Maintenance Director (SB) at the time of discovery.</p>	K 144	<p>The Generator System Services has agreed to perform the Annual Load Bank Test to meet NFPA 101 Life Safety Code requirements during the week of June 8, 2015. The required load test will be added to the generator preventive maintenance schedule.</p> <p>The Environmental Services Director will monitor compliance with boiler inspections and load test requirements.</p>	

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K 144	Continued From page 5 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		