Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 16, 2025

Administrator
The Green Prairie Rehabilitation Center
800 Second Avenue Northwest
Plainview, MN 55964

RE: CCN: 245345
Cycle Start Date: October 31, 2024

Dear Administrator:

On January 10, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 25, 2024

Administrator
The Green Prairie Rehabilitation Center
800 Second Avenue Northwest
Plainview, MN 55964

RE: CCN: 245345
Cycle Start Date: October 31, 2024

Dear Administrator:

On October 31, 2024, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 January 31, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by May 1, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 On 10/28/24 to 10/31/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		12/4/24

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

Electronically Signed | 12/04/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 688	Continued From page 1 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review the facility failed to perform range of motion or ambulation (walking) as ordered for 2 of 2 residents (R14, R6) reviewed for restorative therapy programs. Findings include: R14's quarterly MDS dated 10/10/24, indicated R14 was cognitively intact, and diagnoses included stroke and hemiplegia or hemiparesis (loss of some or all ability to use one side of the body). R14 had functional limitation in range of motion to one side of the upper and lower extremities. R14 needed maximal assistance and dependent on staff for all mobility. R14's care plan dated 4/23/20, indicated impaired mobility related to stroke and resulted left side paresis. Interventions included two times a day when laying down range of motion (ROM) movements with left lower extremity (LLE), hip flexion/abduction and knee flexion for 20 repetitions. R14's Occupational Therapy (OT) Discharge Summary dated 6/5/20, indicated a ROM program had been made and given to nursing to follow. R14's passive range of motion (PROM) program from 10/1/24 - 10/28/24, indicated ten times documented not applicable (NA) and thirty-one	F 688	Plan of Correction □ F688 Please accept the following as the facility□s credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Based on interview, observation and record review the facility failed to perform range of motion or ambulation (walking) as ordered for 2 of 2 residents (R14, R6) reviewed for restorative therapy programs. Green Prairie Rehabilitation Center does ensure that a resident with limited mobility receives the appropriate services, equipment, and assistance to maintain or improve mobility with maximum practicable independence unless it is unavoidable. Corrective Action and Measures taken to ensure that the issue will be corrected and will not occur further □ - Policies and procedures regarding providing range of motion (ROM) have been reviewed and are appropriate. - All resident recommendations for ROM	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 688	Continued From page 2 times no charting was entered. During an interview on 10/28/24 at 3:48 p.m., R14 stated the staff did ROM on her LLE sometimes, but wished they did it more often because the LLE starts to hurt. During interview on 10/30/24 at 7:36 a.m., nurse assistant (NA)-B stated R14 was on a ROM program performed twice a day, with morning cares and then when R14 went to bed at night. After the ROM program was complete it would be documented in R14's record. NA-B reviewed R14's documentation and acknowledged areas with an NA as well as missing documentation. NA-B stated an unawareness of why somebody would mark NA on this resident's charting. NA-B was unaware of staff ability to not be able to complete the ROM program for R14. During an interview on 10/30/24 at 8:10 a.m., the therapy director (TD) stated a ROM program would be set up by the therapy department if therapy felt it would help keep the resident at a certain level and not get worse. Therapy set up the program and then nursing made sure it was completed. The TD reviewed R14's OT notes and verified on 6/5/20 R14 had been discharged from therapy with a ROM program in place. During an interview on 10/30/24 at 1:34 p.m., the director of nursing (DON) stated therapy communicates ROM programs with a "therapy to nursing communication form". The form is given to the unit coordinator to enter into the electronic medical record. Nursing assistants document completion of the ROM program in the electronic medical record. The DON stated they do not check completion of documentation unless a	F 688	and splint/brace application have been reviewed and care plans have been adjusted to reflect any changes. - Immediate verbal staff education was received on 10/29/24 on the importance of appropriate documentation and completion of ROM programs when assigned. Staff reminded to report to licensed staff when programs are unable to be completed per plan of care for further documentation and interventions. - Nursing staff will be re-educated pertaining to completion of ROM and appropriate documentation on 12/17/24 at their staff meeting. - DON or designee will audit compliance of operation weekly X 4 weeks, monthly X 3 months, and quarterly thereafter. Audit results will be reviewed by QAPI committee in quarterly QAPI for further recommendations. - Social Services Director or designee will follow up with residents to assure compliance of operations weekly X 4 weeks, monthly X 3 months, and quarterly thereafter. - Audit results will be reviewed by QAPI committee for further recommendations. Audits: - DON or RN Manager to Audit POC - SS to Audit Resident Responses Completion Date: 12/04/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 688	Continued From page 3 concern is reported. The DON reviewed R14's record acknowledged there were several times since 10/1/24, no documentation was completed. The DON stated they would expect nursing staff to complete assigned ROM programs and report if unable to complete. R6 R6's quarterly MDS dated 8/14/24, indicated R6 was cognitively intact, had impaired range of motion to both arms and no impairment to either leg. R6 required substantial assist for toileting, showering, and activities of daily living (ADLs), partial/moderate assist sitting to standing and supervision/touch assist for ambulation/walking. R6's diagnosis list included rheumatoid arthritis (disorder of the joints causing deformity and decreased function), difficulty walking, muscle weakness, and chronic pain syndrome. R6's care plan indicated impaired mobility related to weakness due to rheumatoid arthritis. Interventions included walk to and from the bathroom with 1 assist and gait belt and walk from room to activities department with walker, gait belt and wheelchair to follow. During an interview on 10/28/24 at 2:05 p.m., R6 stated they are supposed to ambulate daily however "lucky" to ambulate once a week. During interview on 10/29/24 at 1:20 p.m., R6 stated they were not offered to walk on 10/28/24. R6 reported occasional refusals due to discomfort but would walk at least 5 times a week if offered. R6 stated they must use their legs to get around	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 688	Continued From page 4 in their wheelchair because of the arthritis in their hands. R6 indicated they had the opportunity to use a motorized wheelchair and declined for fear of losing use of their legs. During observation and interview on 10/29/24 at 1:46 p.m., R6 was observed walking in the hall with the assistance. Nursing assistant (NA)-A stated R6 is on a daily walking program to and from the activity department. NA-A stated R6 "goes through phases" of refusing to ambulate. NA-A stated if R6 refuses staff document "refused" in the electronic medical record. NA-A stated "not applicable" would be documented if there was no time to assist R6 to walk. The only time documentation would be left blank is if staff forgot to document. During interview on 10/30/24 at 8:26 a.m., registered nurse (RN)-A stated therapy sets up ambulation programs. The nursing assistants document completion of walking programs in electronic medical record. RN-A stated R6's acceptance of walking is mood dependent. During interview on 10/20/24 at 8:39 a.m., physical therapist (PT)-A reported seeing R6 multiple times since admission for leg strengthening, walking program, and transfers/home exercise program. PT-A reported walking programs are communicated to nursing staff via therapy communication form. There is a binder containing all walking programs on the unit. PT-A stated they informally check in with residents on occasion however the therapy director does formalized check-ins at IDT (interdisciplinary team) meetings weekly. During interview on 10/30/24 at 8:58 a.m., the	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 688	Continued From page 5 therapy director (TD) stated a Therapy to Nursing Communication form is filled out when restorative/walking programs are developed. Completion of program is documented in electronic medical record by the nursing assistants. TD confirmed R6's walking program included walking to and from the activity room daily. TD spoke to R6 on 10/2/24 and confirmed R6 reported walking program has been "inconsistent". After speaking to R6, the TD compiled all walking programs onto one form and placed it in the linen rooms down each hall as a reminder for nursing staff to complete each program. Walking programs are also on nursing assistant care sheets. The therapy director stated R6 could experience increased weakness if walking program isn't completed consistently. The TD provided a document titled "walking programs" that listed all residents in the facility on walking programs with detailed instructions of the program. The form indicated R6 was to use platform walker to walk to bathroom for toileting needs and walk to activity room and back. During interview with NA-B and NA-C on 10/30/24 at 10:07 a.m., NA-B stated they would document "not applicable" if the resident was unable to transfer safely when attempting a walk. NA-B indicated performing R6's walking program was "hit and miss" and dependent on who was on duty for that day. NA-C stated R6 does not usually refuse to walk. Review of R6's walking program from 7/1/24 - 10/28/24 indicated the following: Out of 31 opportunities from 7/1/24-7/31/24, R8 walked twice and refused 10 times. "Not applicable" was documented 9 times and 10	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 688	Continued From page 6 opportunities lacked documentation. Out of 31 opportunities from 8/1/24-8/31/24, R8 walked 4 times and refused 9 times. Five opportunities were documented "not applicable" and 13 opportunities lacked documentation. Out of 30 opportunities from 9/1/24-9/30/24, R8 walked once and refused 7 times. Eight opportunities were documented "not applicable" and 14 opportunities lacked documentation. Out of 28 opportunities from 10/1/24-10/28/24, R8 walked 7 times and refused 4 times. "Not applicable" was documented for 5 opportunities and 14 opportunities lacked documentation. During interview on 10/30/24 at 10:41 a.m., the director of nursing (DON) stated therapy communicates walking programs by filling out "therapy to nursing communication form". The form is given to the unit coordinator to enter into the electronic medical record. Nursing assistants document completion of walking program in the electronic medical record. Nursing assistants fill out communication form if residents have difficulty performing tasks. The DON stated they do not check completion of documentation unless a concern is reported. The DON stated they would expect nursing staff to complete assigned walking programs and report if unable to complete. Facility restorative/maintenance therapy program policy was requested but not provided.	F 688		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3)	F 809		12/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 809	Continued From page 7 §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer and/or provide a suitable and nourishing snack after dinner and before bedtime when there were more than 14 hours between the evening and morning meals. This had the potential to affect all residents in the facility who would require a snack. Findings include: The facility provided a survey preparation binder which included an undated flyer titled Mealtimes: Breakfast - 8:00 a.m. Lunch - 12:00 p.m. Dinner - 5:00 p.m. During an observation on 10/29/24 at 2:08 p.m., a	F 809	Plan of Correction □ F809 Please accept the following as the facility□s credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Based on interview and document review, the facility failed to offer and/or provide a suitable and nourishing snack after dinner and before bedtime when there were more than 14 hours between the evening and morning meals. This had the potential to affect all residents in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 809	Continued From page 8 wicker basket was on the counter in the resident dining room. The basket contained applesauce, granola bars, pudding, animal crackers and rice krispie bars. In the refrigerator on a tray were half sandwiches in plastic bags, pieces of fruit, and a squeeze container of jelly. During an interview on 10/30/24, at 6:55 a.m., dietary aide (DA)-A stated dietary staff made peanut butter sandwiches for residents who didn't eat much for meals and were hungry later. DA-A stated the sandwiches were for any resident. During an interview on 10/30/24 at 12:35 p.m., dietary manager (DM) was aware there should not be more than 14 hours between the evening and morning meals but was not aware the facility exceeded those hours. DM was aware a substantial snack was required for residents when there were more than 14 hours between the evening and morning meals but could not state what would be considered a substantial snack. During a telephone interview on 10/30/24 at 1:55 p.m., registered dietician (RD) stated she was not aware of the length of time between the evening and morning meals. When informed it was 15 hours, RD stated, residents should receive a substantial snack which would include a protein and a carbohydrate. RD was aware dietary staff made some peanut butter sandwiches and kept them in a refrigerator for staff to access but did know it they were offered to each resident, adding she had not reviewed the facility snack process recently. During an interview on 10/31/2024 at 10:43 a.m., the director of nursing (DON) and administrator were both aware there were 15 hours between	F 809	facility who would require a snack. Green Prairie Rehabilitation Center does ensure that a resident that requires/requests a snack between dinner and before breakfast the next day will have one available when requested. Policies and procedures regarding providing a substantial snack when scheduled mealtimes are more than 14 hours apart have been reviewed and are appropriate. All snacks that are available to residents have been reviewed to assure the facility is providing substantial snacks for those residents who offer this request. Corrective Action and Measures taken to ensure that the issue will be corrected and will not occur further □ - Immediate verbal staff education was received on 10/30/24 on the facility policy regarding passing of snacks on the evening shift between the dinner meal and morning meal. Staff were reminded to report to a licensed staff member when snack passing is unable to be completed per policy for further documentation and interventions needed to ensure residents are receiving a substantial snack per policy. - Staff were educated on appropriate documentation of snack acceptance on all three shifts in POC. - Nursing staff will be re-educated pertaining to the requirements of fulfilling the snack policy and appropriate documentation of snacks received on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 809	Continued From page 9 the evening and morning meals. Neither were aware residents should receive a substantial snack consisting of a carbohydrate and a protein. The administrator stated peanut butter sandwiches were always available to residents, and indicated a substantial snack was not offered to or provided to residents. The DON added the residents were not offered nor did they receive a substantial snack after the dinner meal and before bedtime. The facility Meal Times policy dated 9/2012, indicated it was policy to serve meals to meet the standards of the surveying agencies specifying no more than 14 hours between the evening meal of one day and the breakfast meal of the next day. Meal times would be: a. Breakfast (the space was blank) b. Noon (the space was blank) c. Evening (the space was blank) The hospitality services manager was responsible to monitor the system to assure adherence to this schedule. All staff were responsible for following this schedule.	F 809	12/17/24 at their staff meeting. - DON or designee will audit the compliance of operation weekly X 4 weeks, monthly X 3 months, then quarterly thereafter. - Audit results will be reviewed by QAPI committee for further recommendations. - SS or designee will follow up with residents to assure compliance of operations weekly X 4 weeks, monthly X 3 months, then quarterly thereafter. - Audit results will be reviewed by QAPI committee for further recommendations. Audits: - DON or RN Manager to Audit POC - SS to Audit Resident Responses Completion Date: 12/04/2024	
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-	F 825		12/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 825	Continued From page 10 §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide physical therapy and occupational therapy as ordered for 1 of 1 resident (R5) reviewed for therapy services. Findings include: R5's Admission Record undated, identified R5 was admitted to the facility on 7/12/22. Diagnoses included Epilepsy (A neurological disorder that causes seizures) and quadriplegia (is the paralysis of both arms and legs due). R5's quarterly Minimum Data Set (MDS) dated 10/10/24, identified R5 was nonverbal and unable to determine cognitive status. The MDS identified R5 had impairments to both upper and lower extremities, could not ambulate, and was dependent on staff for all cares. R5's discharge instructions and active order summary from R5's former LTC facility, dated and signed 7/7/22, identified R5 was discharged to Green Prairie Rehab Center. The order summary report indicated occupational therapy (OT) and physical therapy (PT) were to evaluate and treat as indicated after admitted to the facility. The	F 825	Plan of Correction □ F825 Please accept the following as the facility□s credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Based on observation, interview and record review, the facility failed to provide physical therapy and occupational therapy as ordered for 1 of 1 resident (R5) reviewed for therapy services. Green Prairie Rehabilitation Center does ensure that admitting a resident with physical therapy, occupational therapy or speech therapy orders will receive the appropriate services, equipment, and assistance to maintain or improve their functional abilities with maximum practicable independence unless it is unavoidable. Policies and procedures regarding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 825	Continued From page 11 order summary also indicated nursing to ensure passive range of motion (PROM) was completed to left ankle, left knee, and left hip daily with AM cares. R5's active Order Summary Reported dated 7/13/22 (from current facility) lacked orders for therapy or a PROM program. During an interview on 10/30/24 at 8:10 a.m., the occupational therapist (OT) stated new admissions with orders for therapy services would be evaluated by therapy staff within 48 hours of admission. OT was aware R5 had orders at the time of admission for OT and PT, but the decision was made not to perform the evaluations and treat as ordered because of a payor source concern. There also were no orders received to discontinue the therapy orders after the decision was made not to offer therapy to R5. During an interview on 10/30/24 at 1:34 p.m., the director of nursing (DON) confirmed the discharge orders from R5's prior LTC facility were also the admission orders for Green Prairie Rehab Center. She also confirmed R5 had therapy orders and PROM orders at time of admission, but the orders were never started. The DON also confirmed the therapy orders and PROM orders were never entered into R5's EMR because there was a "payor source issue" and therapy was not going to perform the evaluation, so the orders were not needed. The provider should have been contacted and orders obtained to discontinue the therapy orders if they were not needed. During an interview on 10/31/24 at 8:54 a.m., the administrator stated she expected all new	F 825	assuring physician orders are entered and followed through upon admission to Green Prairie Rehabilitation Center. If orders are not applicable or unable to be fulfilled through Green Prairie Rehabilitation Center an updated order from a provider will be obtained on the day of admission to reflect or discontinue orders if appropriate. If the facility is unable to provide appropriate services, the facility will obtain the required services from an outside resource that is a provider of specialized rehabilitative services. Corrective Action and Measures taken to ensure that the issue will be corrected and will not occur further □ - Immediate verbal staff education was received on 10/29/24 regarding appropriate documentation of physician orders upon admission. Staff have been reminded to seek discontinuation orders from a provider if the orders are not applicable to residents or if the orders are unable to be fulfilled. - Nursing staff will be re-educated on 12/17/24 at their staff meeting pertaining to completion of physician orders upon admission and appropriate documentation of physician orders if unable to complete them. - DON or designee will audit compliance of operation weekly X 4 weeks, monthly X 3 months, and quarterly thereafter. - Audit results will be reviewed by QAPI committee for further recommendations. Audit form: DON or RN Manager to audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 825	Continued From page 12 admission orders would be entered into the EMR by staff, and followed until new orders were obtained that overrode the prior orders. The facility therapy policy was requested but not provided.	F 825	admission orders entry into PCC. Completion Date: 12/04/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	**800 SECOND AVENUE NORTHWEST** **PLAINVIEW, MN 55964**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/29/2024. At the time of this survey, THE GREEN PRAIRIE REHABILITATION CENTER found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 12/04/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	**800 SECOND AVENUE NORTHWEST** **PLAINVIEW, MN 55964**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. THE GREEN PRAIRIE REHABILITATION CENTER is a 2 story building, with partial basement The building was constructed at (3) different times. The original building was constructed in 1968 and was determined to be of Type II (222) construction.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	**800 SECOND AVENUE NORTHWEST** **PLAINVIEW, MN 55964**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 In 1992, addition was constructed to the (Dining Kitchen area) that was determined to be of Type II (222) construction. Another addition was added in 2005 to the chapel area that was determined to be of Type II (222) Because the original building and the (2) addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. 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 50 beds and had a census of 29 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for	K 374		12/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	**800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 3 swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test, maintain and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/29/2024 between 9:30 AM and 1:30 PM, it was revealed by observation that the smoke barrier door assemblies located in the Basement of the facility exhibited an airgap(s) greater than 1/8 inch, which would allow the passage of smoke. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 374	Plan of Correction - 0374 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Green Prairie Rehabilitation Center ensures that smoke barrier doors are tested, maintained and inspected to remain in compliance with the Life Safety Code sections 19.3.7 and 8.5.4. Corrective Action and Measures taken to ensure that the issue has been corrected and will not occur further – - Immediate verbal staff education was given to Maintenance Director and Maintenance Assistant on 10/29/24 regarding smoke barrier doors. - Maintenance Director sealed the identified air gaps to ensure no gaps greater than 1/8 inch on 11/01/2024. - Maintenance Director and Administrator will perform fire door inspections quarterly. - Facility will review fire door inspection findings in Quarterly QAPI. Completion date: 11/1/2024	
K 918	Electrical Systems - Essential Electric Syste	K 918		12/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	**800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918 SS=F	Continued From page 4 CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff	K 918	Plan of Correction — 0918	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	**800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 5 interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 8.3, 8.4, 8.4.2(2). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/29/2024 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that 2-of-10 monthly generator run tests identified the unit did not achieve 30% of the nameplate rating - thus requiring annual 2-hour load-bank testing. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 918	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Green Prairie Rehabilitation Center does ensure that the generator and associated equipment is capable of supplying sufficient service within 10 seconds at greater than 30% of the nameplate rating. Corrective Action and Measures taken to ensure that the issue will be corrected and will not occur further – - The facility completed a full-load bank test on 11/14/2024, with Generator System Services, Inc. to confirm the capability for life safety and critical branches. - Immediate verbal staff education was given to Maintenance Director and Maintenance Assistant on 10/29/24 regarding generator testing. - Maintenance Director or designee will audit the compliance of operation monthly X 3 months, then quarterly thereafter. - Audit results will be reviewed quarterly by QAPI committee for further recommendations. Completion date: 11/14/2024	