DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2020

Administrator
Prairie View Senior Living
250 Fifth Street East
Tracy, MN 56175

RE: CCN: 245371
Cycle Start Date: April 7, 2020

Dear Administrator:

On June 2, 2020, the Minnesota Department(s) of Health 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
April 28, 2020

Administrator
Prairie View Senior Living
250 Fifth Street East
Tracy, MN 56175

SUBJECT: SURVEY RESULTS
CCN: 245371
Cycle Start Date: Cycle Start Date: April 7, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On April 7, 2020, a survey was completed at your facility by the Minnesota Department of Health completed a COVID-19 Focused Survey at Prairie View Senior Living to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the April 7, 2020 survey. Prairie View Senior Living may choose to delay submission of a POC until after the survey and enforcement suspensions have been lifted. The provider will have ten days

from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC 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; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 7, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and

- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Prairie View Senior Living may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Kamala Fiske-Downing

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Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245371	A. BUILDING _____ B. WING _____	04/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 4/6/20, through 4/7/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is requires, it is required that the facilty acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 4/6/20, through 4/7/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be 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. Upon receipt of an acceptable electronic POC, an 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 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		5/8/20

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

Electronically Signed | 05/08/2020

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F 880	Continued From page 1 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 2 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to cancel group activities and ensure employees were actively screened at the point of entry for symptoms of COVID-19 according to Centers for Disease Control (CDC) and Centers for Medicare and medicaid Services (CMS) guidelines for COVID-19. This had the potential to affect all 42 residents.	F 880	F880 - Group Activities The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed	

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F 880	Continued From page 3 Finding include Observation and interview on 4/6/20 at 12:10 a.m., with the social service director (S) identified the main entrance of the facilty for was used for visitors and the south entry door for staff. All staff were to go to the nurses station to be screened. The nurses station was located in the central area of the facilty next to the dining area and day room. 14 residents were seated at dining tables for lunch. 1 resident was being assisted with eating. The facilty had not discontinued group activites but tried to limit group activities to less than 10 residnets at at time while practicing social distancing. Observation on 4/6/20 at 1:30 p.m., of the south entrance identified the exterior door opened to a short corridor. A time clock was located on the wall outside the kitchen. That corridor led to the dining area. The dining area was central to the building and was adjacent to the main entrance, the TV area, and the nurse station. Observation on 4/6/20 at 2:25 p.m., dietary assistant (DA)-a entered the facility through the designated doorway and walked to the nurse station. DA-A took his own temperature and recorded the information on the staff COVID-19 screening sheet and proceeded to the kitchen to begin his shift. Interview on 4/6/20 at 2:25 p.m., with the director of nursing (DON) identified staff were expected to have the nurse screen actively staff for symptoms of COVID-19 at the start of the shift. No formal audits had been completed to identify if the screening process was being followed by staff.	F 880	solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. On 4/6/2020 observation of 10 residents seated throughout the dining room and tables playing bingo and practicing social distancing. 2. On 4/7/2020 Interdisciplinary team and community life staff were educated on the need to no longer have any type of communal activity even while practicing social distancing; Activities needed to be complete with residents in their own rooms until social distancing guidelines are update to permit by the MNDOH and or CDC. 3. The Executive Director or designee will complete audits twice per week for two weeks then once per week for two weeks on all residents who participate in activities ensure no communal activities occur until MNDOH and or CDC permit this within their guidelines. 4. The data collected will be presented to the QAPI committee by the DNS. The data collected will be reviewed/discussed at the regularly scheduled QAA meeting. At this time the QAA Committee will make the decision/recommendation regarding any follow-up studies. F880 - Staff Screenings The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on	

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F 880	Continued From page 4 Observation on 4/6/20 2:30 p.m., identified 10 residents were seated throughout the dining tables in the dining room, and TV area playing BINGO. Interview with the administrator on 4/6/20, at 3:20 p.m. identified he received CMS memos and was aware of the guideline to cancel all group activities and actively screen staff at the point of entry. The facilty had not canceled group activities at the present time to have less disruption to their daily routines, however, group activities were to be limited to 10 residents to ensure they were socially distanced. Review of the 3/19/20, COVID-19 Employee Screening guidelines identified all employees were to be screened for fever and acute respiratory illness prior to clocking in for their shifts by a team member. There was no mention that was to occur at the point of entry. Review of the 3/19/20, New Updates on the COVID-19 Procedures policy identified group activites were to be limited to 10 residents and were to be spaced six feet apart. There was no indication the policy had been updated in accordance with CDC and CMS guidance to cancel all group activities.	F 880	conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. 4/6/2020 Observation occurred of staff being screened at nurses' station after entering the facility and walking through the dinning area. 2. Staff screen location was immediately moved to the staff entrance to ensure all staff screening are completed at point of entry and no staff needed to walk through facility to complete their screening. 3. The DON or designee will complete two audits per week of one month of staff screenings and documentation to ensure compliance. 5. The data collected will be presented to the QAPI committee by the DNS. The data collected will be reviewed/discussed at the regularly scheduled QAA meeting. At this time the QAA Committee will make the decision/recommendation regarding any follow-up studies.	