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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8G2N

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00778

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245244**
2.STATE VENDOR OR MEDICAID NO.
(L2) **278525100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH SYSTEM - LONG PRAIRIE**
(L4) **20 NINTH STREET SOUTHEAST**
(L5) **LONG PRAIRIE, MN** (L6) **56347**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/18/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **70** (L18)
13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Kathleen Lucas, Unit Supervisor — 10/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Certification Specialist — 10/06/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/11/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245244

October 6, 2017

Mr. Daniel Swenson, Administrator
Centracare Health System - Long Prairie
20 Ninth Street Southeast
Long Prairie, MN 56347

Dear Mr. Swenson:

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 September 12, 2017 the above facility is recommended for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 6, 2017

Mr. Daniel Swenson, Administrator
Centracare Health System - Long Prairie
20 Ninth Street Southeast
Long Prairie, MN 56347

RE: Project Number S5244026

Dear Mr. Swenson:

On August 16, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 2, 2017. 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 September 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 22, 2017 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 August 2, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 12, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 2, 2017, effective September 12, 2017 and therefore remedies outlined in our letter to you dated August 16, 2017, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8G2N

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00778

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245244**

2.STATE VENDOR OR MEDICAID NO.
(L2) **278525100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH SYSTEM - LONG PRAIRIE**
(L4) **20 NINTH STREET SOUTHEAST**
(L5) **LONG PRAIRIE, MN** (L6) **56347**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/02/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **70** (L18)

13.Total Certified Beds **70** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Carlene Lang, HFE-NE II 09/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 10/04/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/11/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 16, 2017

Mr. Daniel Swenson, Administrator
Centracare Health System - Long Prairie
20 Ninth Street Southeast
Long Prairie, MN 56347

RE: Project Number S5244026

Dear Mr. Swenson:

On August 2, 2017, 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 electronically delivered CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

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 September 11, 2017, 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 September 11, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 2, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on

the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 2, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

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

St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245244	A. BUILDING _____ B. WING _____	C 08/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347**

(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 7/31/2017-08/02/2017, a standard 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, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=B	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written	F 156		8/18/17

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

Electronically Signed | 08/24/2017

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
	245244	A. BUILDING _____ B. WING _____	C 08/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347**

(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 156	Continued From page 1 description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245244	A. BUILDING _____ B. WING _____	C 08/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347**

(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 156	Continued From page 2 Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245244	A. BUILDING _____ B. WING _____	C 08/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347**

(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 156	Continued From page 3 (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 4 (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services	F 156		

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F 156	Continued From page 5 available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the appropriate liability	F 156	F156 Facility failed to provide the appropriate liability notices to 5 of 6	

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F 156	Continued From page 6 notices to 5 of 6 residents (R28, R6, R12, R73, R76,) and timely notice of medicare non-coverage for 1 of 6 residents (R76) whose Medicare Part A benefits ended while residing in the facility. Findings include: R28's admission record identified she was admitted on 12/15. A Notice of Medicare Non-Coverage CMS form 10123 indicated R28's Medicare Part A benefits were ending on 2/9/17; the notice was given timely and signed 2/6/17. R28 continued to reside in the facility but did not receive the appropriate liability forms, or Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) CMS form 10055. R6's admission record identified she was admitted on 2/17. A Notice of Medicare Non-Coverage CMS form 10123 indicated R6's Medicare Part A benefits were ending on 2/24/17; the notice was given timely and signed 2/21/17. R6 continued to reside in the facility but did not receive the appropriate liability forms, or SNFABN CMS form 10055. R12's admission record identified he was admitted on 5/17. A Notice of Medicare Non-Coverage CMS form 10123 indicated R12's Medicare Part A benefits were ending on 7/31/17; the notice was given timely and signed 7/26/17. R12 continued to reside in the facility but did not receive the appropriate liability forms, or SNFABN CMS form 10055. R73's admission record identified she was admitted on 4/17. A Notice of Medicare Non-Coverage CMS form 10123 indicated R73's	F 156	residents (R28, R6, R12, R73, R76) and timely notice of Medicare non-coverage for 1 of 6 residents (R76) whose Medicare Part A benefits ended while residing in the facility. Social Services staff were reeducated on 8-4-17 on the requirement for appropriate liability notices and the importance of timely notice of Medicare non-coverage whose Medicare Part A benefits ended while residing in the facility according to Medicare Denial guidelines. Social Services will follow Medicare Denial guidelines to ensure that appropriate liability notices and timely notices of Medicare non-coverage are completed as appropriate. Director of Nursing or Social Services designee will keep a log on all skilled residents for these forms to ensure appropriate forms are completed as needed. Logged results will be brought to QAPI meetings for review to ensure continued compliance.	

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CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347**

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F 156	Continued From page 7	F 156		

Medicare Part A benefits were ending on 6/8/17; the notice was given timely and signed 6/5/17. R73 continued to reside in the facility but did not receive the appropriate liability forms, or SNFABN CMS form 10055.

R76's admission record identified he was admitted on 6/17. A Notice of Medicare Non-Coverage CMS form 10123 indicated R76's Medicare Part A benefits were ending on 7/18/17; however, the notice was signed the same day on 7/18/17, and was not given 48 hours in advance. In addition, R76 continued to reside in the facility but did not receive the appropriate liability forms, or SNFABN CMS form 10055.

During interview on 8/2/17, at 11:48 a.m. resident account administrative (RAA) was unaware as to why R76's notice was signed on the same day coverage ended. RAA stated social services gave the denial notices; however, she kept the originals of the denial notices. RAA was not aware of any other liability forms used when residents stayed in the facility.

During interview on 8/2/17, at 1:00 p.m. social services (SS)-A stated she tried to go give the denial notices two day in advance. SS-A stated she only gave out the denial notices, and while she discussed the financial liability and insurance coverage with residents and families at the time of the denial notice, she was not aware of the liability notices and had not been giving them out. SS-A stated R76 was unable to sign his denial notice, and family was updated prior to the end of services. However, SS-A had no documentation proving family had been notified services ending, and stated going forward needing to make better notes.

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F 156	Continued From page 8 A facility policy was requested but not received.	F 156		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to post notice of availability of the last three years of State agency survey results. This had the potential to affect all	F 167	F167 Facility failed to post notice of availability of the last three years of State agency survey results.	8/4/17

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F 167	Continued From page 9 64 current residents, visitors, and staff who wished to review this information. Findings include: During initial tour of the facility on 7/31/16, at 1:20 p.m. a blue folder with clear front, labeled, Minnesota Department of Health Survey Results from June 2016 were in a black plastic bin mounted to the wall by the front desk area. The survey results were dated 6/30/16, however, there were no additional surveys identified in the binder. There was no signage notifying residents, family and staff that three years of results were available upon request. During an interview on 8/1/17, at 3:15 p.m. with staff scheduler stated the DON puts the state survey results in the bin on the wall. During an interview on 8/2/17, at 8:24 a.m. the director of nursing (DON) stated the last year's survey results were put in the bin by the DON. The DON stated the last three years survey results are available to the residents, visitors, and staff and that they just have to ask for them. The DON stated there was no direction posted for residents, visitors, or staff to find the previous two years of survey results. A facility policy was requested but none was provided.	F 167	All three past years survey results were placed into black bin that is mounted on the wall by front desk area on August 1, 2017. Area is posted with "Survey Results" so residents, visitors, staff and families can see they are there available. DON or designee will continue to keep posted most recent three years of survey results in slot and updated when new ones are available. Policy on Posting of State/Federal Survey Results was reviewed and updated and staff are being educated on policy. Residents will be notified at next Council meeting that the past three years results are available for their viewing. Posting of three years of survey results will be brought up at QAPI meetings and reviewed to ensure continued compliance.	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals	F 225		8/25/17

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F 225	Continued From page 10 who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 225		

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F 225	Continued From page 11 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to report potential neglect of care for 1 of 3 residents (R28) reviewed for abuse and neglect related to an injury sustained from a fall from a lift. Findings include: R28 's quarterly Minimum Data Set (MDS) dated 3/21/17, indicated R28 was cognitively intact, had diagnoses of osteoarthritis, hemiplegia, hemiparesis, and artificial left knee placement and required extensive staff assistance with activities of daily living (ADL). R28's progress note, dated 3/12/17, at 8:20 a.m. indicated "client was being transferred from w/c [wheelchair] to recliner with Blue pal [PAL] lift".	F 225	F225 Facility failed to report potential neglect of care for 1 of 3 residents (R28) reviewed for abuse and neglect related to an injury sustained from a fall from a lift. Report was filed on incident for resident (R28) on 8-24-17. All staff are being reeducated on the Vulnerable Adult-Abuse and/or Neglect Reporting and Protection Plan/Policy and that "Neglect: is a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness" and that any physical harm to a resident that could have been avoided should be reported to OHFC. DON or designee will do audits of all incidents five days a week for four weeks then weekly to ensure continued	

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F 225	Continued From page 12 Client was hooked to pal [PAL], clients legs strapped in pal [PAL] and legs of machine open. When pulled away from wheel chair pal [PAL] lift tipped over onto client (tipped towards client not onto side). Client denied hitting her head. Part of pal [PAL] lift where strap hooks is what was on clients chest. " The note also indicated the registered nurse was called and the resident taken to the emergency room for evaluation. The note indicated "client stated she does have increase in back pain than normal." R28 progress note dated 3/12/17, at 10:25 a.m. indicated R28 "was seen in ER [emergency room], X-ray showed no new fractures in chest or spine, apply ice or heat to area every 2-3 hours, client is starting to bruise where clavicle and sternum come together." R28 progress note dated 3/12/17, 3:15 p.m. indicated "bruise on chest seems to be getting bigger around, darker in color, measured 7 x 12.5 cm in size, area marked in ink so could be monitored." R28 progress note dated 3/12/17, 6:30 p.m. indicated resident stated "chest area where bruise is hurt a little but not very much." R28 progress noted dated 3/13/17, 3:12 a.m. indicated "bruise line has exceeded the line marks on the chest, bruising is really dark purple and has a hard lump, complained that it did hurt more than earlier." R28 progress noted dated 3/13/17, 11:18 p.m. indicated "resident complained of sternal pain this shift."	F 225	compliance. Audit results will be brought to QAPI meetings for review to ensure continued compliance.	

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Facility document titled #2100 Fall, which the director of nursing (DON) stated was the facility incident report, dated 3/12/17, 8:48 a.m. indicated R28 had a fall while being transferred with PAL, injury type indicated bruise injury to chest.

Untitled and undated document (the DON had indicated was the summary of the investigation of the incident with the PAL for R28) indicated, "resident has bruise to chest but no fractures or serous injuries." The document also indicated the facility had begun an investigation of the incident on 3/12/17, "...Lift was immediately removed from use". In addition, the document indicated the "Clinical engineer was here on 3/16/17 at 0915 and looked at machine."

Facility document titled, Work Order # 92154 (FAILURE), dated 3/30/17, indicated "Request: nursing staff states lift tipped over while lifting a 100 lb person and lift has been quarantined. " Action, performed functional and visual inspection of all casters, straps, fittings, welds, appear to be in satisfactory condition. Tried to physically tip lift with heavy person hanging on lift with legs spread apart and together and couldn't get it to tip. In my opinion there isn't anything wrong with this lift and is ok to use. "
During an interview on 8/1/17, at 9:36 a.m. R28, stated she had a fall from the standing lift machine about ten weeks ago. R28 stated the machine tipped over, she fell on her buttocks. R28 stated she had bruising on her upper body. Stated she had gone to the emergency room and had no broken bones.

During an interview on 8/1/17, at 1:20 p.m. the DON stated the accident was not reported to Office of Health Facility Complaints (OHFC) since

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F 225	Continued From page 14 the resident had no fractures, she only had bruising, that she had been called right away, had the machine pulled out of service immediately and that they investigated and found no error in use of the equipment, however, based on the summary of investigation; the investigation to determine cause, continued well beyond the 24 hours reporting requirement. In addition the DON stated she had the Centra Care Clinical Engineer evaluate the machine and that they had tried to re-enact the PAL tipping over but had not been able to tip it over. The DON stated the clinical engineer had evaluated the PAL and hadn't found anything wrong with it. Facility policy titled, Vulnerable Adults-Abuse and /or Neglect Reporting and Protection Plan, dated 6/15, indicated " It is the responsibility of Centra Care Health-Long Term Care facilities to report abuse or neglect of vulnerable adults as mandated by law." The policy also indicated, "In accordance with federal requirements, the following definitions delineate what is to be reported to MDH [Minnesota Department of Health] with 24 hours of the incidents discovery: . . .Neglect: A failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of	F 226		8/25/17

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	245244	A. BUILDING _____ B. WING _____	C 08/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347**

(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 226	Continued From page 15 resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to operationalize their Vulnerable Adult-Abuse and/or neglect policy for 1 of 3 residents (R28) reviewed for abuse and neglect related to an injury sustained from a fall from a lift. Findings include: Facility policy titled, Vulnerable Adults-Abuse and /or Neglect Reporting and Protection Plan, dated 6/15, indicated " It is the responsibility of Centra	F 226	F226 Facility failed to operationalize their Vulnerable Adult-Abuse and/or Neglect policy for 1 of 3 residents (R28) reviewed for abuse and neglect related to an injury sustained from a fall from a lift. Vulnerable Adult-Abuse and/or Neglect Policy was operationalized and report was filed on incident for resident (R28) on 8-24-17. All staff are being reeducated on the Vulnerable Adult-Abuse and/or Neglect Reporting and Protection	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347**

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F 226	Continued From page 16 Care Health-Long Term Care facilities to report abuse or neglect of vulnerable adults as mandated by law." The policy also indicated, "In accordance with federal requirements, the following definitions delineate what is to be reported to MDH [Minnesota Department of Health] with 24 hours of the incidents discovery: . . .Neglect: A failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." R28 's quarterly Minimum Data Set (MDS) dated 3/21/17, indicated R28 was cognitively intact, had diagnoses of osteoarthritis, hemiplegia, hemiparesis, and artificial left knee placement and required extensive staff assistance with activities of daily living (ADL). R28's progress note, dated 3/12/17, at 8:20 a.m. indicated "client was being transferred from w/c [wheelchair] to recliner with Blue pal [PAL] lift". Client was hooked to pal [PAL], clients legs strapped in pal [PAL] and legs of machine open. When pulled away from wheel chair pal [PAL] lift tipped over onto client (tipped towards client not onto side). Client denied hitting her head. Part of pal [PAL] lift where strap hooks is what was on clients chest. " The note also indicated the registered nurse was called and the resident taken to the emergency room for evaluation. The note indicated "client stated she does have increase in back pain than normal." R28 progress note dated 3/12/17, at 10:25 a.m. indicated R28 "was seen in ER [emergency room], X-ray showed no new fractures in chest or spine, apply ice or heat to area every 2-3 hours, client is starting to bruise where clavicle and sternum come together."	F 226	Plan/Policy and that "Neglect: is a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness" and that any physical harm to a resident that could have been avoided should be reported to OHFC. DON or designee will do audits of all incidents five days a week for four weeks then weekly to ensure continued compliance. Audit results will be brought to QAPI meetings for review to ensure continued compliance.	

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CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347**

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F 226	Continued From page 17 R28 progress noted dated 3/13/17, 11:18 p.m. indicated "resident complained of sternal pain this shift." Facility document titled #2100 Fall, which the director of nursing (DON) stated was the facility incident report, dated 3/12/17, 8:48 a.m. indicated R28 had a fall while being transferred with PAL, injury type indicated bruise injury to chest. Untitled and undated document (the DON had indicated was the summary of the investigation of the incident with the PAL for R28) indicated, "resident has bruise to chest but no fractures or serous injuries." The document also indicated the facility had begun an investigation of the incident on 3/12/17, "...Lift was immediately removed from use". In addition, the document indicated the "Clinical engineer was here on 3/16/17 at 0915 and looked at machine." Facility document titled, Work Order # 92154 (FAILURE), dated 3/30/17, indicated "Request: nursing staff states lift tipped over while lifting a 100 lb person and lift has been quarantined. " Action, performed functional and visual inspection of all casters, straps, fittings, welds, appear to be in satisfactory condition. Tried to physically tip lift with heavy person hanging on lift with legs spread apart and together and couldn't get it to tip. In my opinion there isn't anything wrong with this lift and is ok to use. " During an interview on 8/1/17, at 9:36 a.m. R28, stated she had a fall from the standing lift machine about ten weeks ago. R28 stated the machine tipped over, she fell on her buttocks. R28 stated she had bruising on her upper body. Stated she had gone to the emergency room and	F 226		

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CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347**

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F 226	Continued From page 18 had no broken bones. During an interview on 8/1/17, at 1:20 p.m. the DON stated the accident was not reported to Office of Health Facility Complaints (OHFC) since the resident had no fractures, she only had bruising, that she had been called right away, had the machine pulled out of service immediately and that they investigated and found no error in use of the equipment, however, based on the summary of investigation; the investigation to determine cause, continued well beyond the 24 hours reporting requirement. In addition the DON stated she had the Centra Care Clinical Engineer evaluate the machine and that they had tried to re-enact the PAL tipping over but had not been able to tip it over. The DON stated the clinical engineer had evaluated the PAL and hadn't found anything wrong with it.	F 226		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed	F 431		8/23/17

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F 431	Continued From page 19 pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired medications were labeled and not administered	F 431	F431 Facility failed to ensure expired medications were labeled and not administered for 2 of 6 residents (R1, R2)	

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F 431	Continued From page 20 for 2 of 6 residents (R1, R2), who received expired Xalatan eye drops. Findings include: R1's Admission Record, dated 8/2/17, identified a diagnosis included unspecified glaucoma. R1's 6/1/17 care plan identified R1 had glaucoma, with an intervention to administer medications as ordered. R1's physician orders identified an order dated 2/22/17, for Xalatan (Latanoprost) solution, with directions to instill 1 drop in the right eye at bedtime for open angle glaucoma. R1's July 2017, electronic medication administration record (EMAR) was reviewed. Staff documented administration of 1 drop of Xalatan Solution to R1's right eye at 8:00 p.m. for all 31 days in July as ordered. R2's Admission Record, dated 8/2/17, identified R2 admitted to the facility on 8/30/16. Diagnoses included unspecified glaucoma. R2's 6/1/17, care plan identified R2 had glaucoma, with an intervention to administer medications as ordered. R2's physician orders revealed a 6/27/16, order for Xalatan (Latanoprost) solution 0.005%, with directions to instill 1 drop in both eyes at bedtime for glaucoma. R2's July 2017, electronic medication administration record was reviewed. Staff documented administration of 1 drop of Xalatan solution 0.005% to both eyes all 31 days in July as ordered.	F 431	who received expired Xalantan eye drops. Medications that were outdated and not labeled for residents R1 and R2 were destroyed and new eye drops were ordered on 8-1-17. All medication carts were inspected on 8-9-17 for any further issues. All nursing staff are being reeducated on the policy for Medication Storage and Medication Expiration Dating/undated. Medication carts are being checked weekly by staff to ensure all medications are being removed if outdated and that meds are marked appropriately. Medication carts will be audited monthly by DON or designee for three months and until compliance is met. Audit results will be brought to the QAPI meetings for review and to ensure continued compliance.	

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F 431	Continued From page 21 Observations of the west medication cart with licensed practical nurse (LPN)-A on 8/1/17, at 8:28 a.m. revealed a bottle of Latanoprost 0.005% eye drops labeled with R1's name. The bottle had a hand written date opened of 6/10/17, with written date of expiration of 7/22/17, (8 days earlier). Another bottle of Latanoprost 0.005% eye drops was labeled with R2's name. The bottle was labeled with a delivery date of 5/1/17. The bottle was not labeled with an open date. The only expiration date was the pharmacy expiration date of 5/1/18. When asked about expiration dates for Xalatan, LPN-A referred to a form titled Medication Expiration Dating. LPN-A stated once opened, Xalatan is good for 42 days then should be discarded. LPN stated when a bottle of Xalatan is opened the nurse is to write the date the bottle was opened and the date of expiration on the bottle. LPN-A stated both R1's and R2's Xalatan drops were open and no other Xalatan drops bottles were in the cart labeled with R1's or R2's names. LPN-A stated R1's drops had expired on 7/22/17 and removed the bottle for destruction. LPN-A stated R2's bottle was not labeled with an expiration date after opening and removed the bottle for destruction. During an interview on 08/02/17, at 11:16 a.m. the DON stated staff were expected to date the Xalatan eye drop bottle when opened as well as write an expiration date on the bottle. She also stated staff are expected to discard the eye drops when expired and not use past the 42 days. The facility's policy Medication Expiration Dating , undated, indicated Xalatan eye drops expire 42 days (6 weeks) after opened. "If the manufacturer's expiration date occurs before an	F 431		

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F 431	Continued From page 22 expiration date based on date of opening, the earliest expiration date should be used." A policy related to labeling Xalatan eye drops was requested and not provided.	F 431		
F 465 SS=B	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure furniture located in the common areas of the Rose Lane unit (200 unit-memory care), Room 202, and the common area of the Lilac Lane unit (300 unit), were clean and in good repair. This had the potential to affect all 38 residents residing on those units. Findings include: On 7/31/17, at 4:03 p.m. two brown leather-like recliners located in the common area of the 200 unit were observed, each occupied with a resident, with the footrests elevated. Both recliners were observed to be torn and peeling on	F 465	F465 Facility failed to ensure furniture located in the common areas on Rose Lane unit, Room 202 and the common area of the Lilac Lane unit were clean and in good repair. Policy on Maintenance Requests were reviewed. All staff are being reeducated on the policy on Maintenance Requests regarding needed repairs of facility furniture. Recliners on Rose Lane unit, room 202, and Lilac Lane unit will be removed when replacements arrive. Replacements are being ordered. DON or designee will do audits of	8/25/17

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F 465	Continued From page 23 the head rest, both armrests, footrest, seat, and along the sides of each chair, exposing the gray fabric underneath the brown material. One chair had a blanket draped on the headrest to partially cover the peeling under the resident's head. A large amount of small brown leather-like pieces were observed on the floor, surrounding each chair. At 7:15 p.m. a resident was observed in Room 202, sleeping in a brown leather-like recliner. The recliner was observed to be torn and peeling on the footrest, exposing the fabric under the brown material, and small pieces of the brown leather-like material were observed on the floor, surrounding the chair. On 8/2/17, at 8:45 a.m. an unoccupied brown leather-like recliner located in the common area of the 300 unit was observed to be peeling on the right armrest and back of the recliner, with several small pieces of the brown leather-like material on the floor, surrounding the chair. During an environmental tour on 8/2/17, at 9:28 a.m. the maintenance manager stated the director of nursing (DON) handled concerns regarding the furniture in the facility. During a tour on 8/2/17, at 9:40 a.m. of the 200 and 300 units, the DON indicated she was in charge of concerns with furniture in the facility, and verified the recliners on the 200 and 300 units were in poor condition and had uncleanable surfaces. DON stated she looked at the furniture in the facility every couple of months and replaced the items when there was a problem, but did not indicate if she was aware of the condition of the recliners. DON stated, "The residents must pick at the arms [on the recliners] or they rub them. I will have to replace these."	F 465	common areas and residents rooms twice monthly to ensure furniture is clean and in good repair. Audit results will be brought to QAPI meetings for review to ensure continued compliance.	

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F 465	Continued From page 24 When interviewed on 8/2/17, at 11:43 a.m. environmental services assistant (ESA) indicated the two recliners in the common area of the 200 unit and the facility owned recliner in Room 202, had been peeling "for months," and indicated she had reported the condition of the recliners to her supervisor and to the DON. ESA indicated it was difficult to clean the surface of the recliners due to the peeling material, and stated, "I wipe them down as much as I can. Sanitary wise, it's not possible." ESA added, "When residents and family sit on them, the peelings stick to their clothes. It gets all over. It looks bad." Review of the facility's policy, Maintenance Reporting Repairs, reviewed 8/16, included, "It is the policy of the Nursing Department to have all staff report anything that may need replacement or repair due to damage or high utilization as soon as a problem is noted." The policy further directed staff to place an online request with the exact details of the problem and where the problem was located.	F 465		

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	245244	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/01/2017**

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CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST** **LONG PRAIRIE, MN 56347**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey CentraCare Health System Long Prairie NH was 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/24/2017

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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K 000	Continued From page 1 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 CentraCare Health System Long Prairie C & NC was built in 1963 with additions in 1966 and 1976. The 1963 building is 1- story, without a basement and was determined to be Type II (111) construction. In 1966 an addition to the south of the original building was built, is 1-story without a basement and was determined to be of a Type II (111) construction. The 1976 addition to the east of the 1966 addition is 1-story with a partial basement and was determined to be of Type V (000) construction. The building is divided into 6 smoke zones by 1/2 hour fire barriers. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building is completely protected with an automatic fire sprinkler system that is installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has	K 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST** **LONG PRAIRIE, MN 56347**

(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 a fire alarm system that includes some corridor smoke detection, with additional detection in all common areas and a doors that are held open. The fire alarm system has been installed in accordance with NFPA 72 "The National Fire Alarm Code". Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code. The fire alarm has automatic fire department notification. The facility has a capacity of 70 beds and had a census of 65 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K 353		9/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245244	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/01/2017**

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K 353	Continued From page 3 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to test and maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 70 patients and an undetermined amount of staff and visitors. Findings include: During record review between 8 am and 12:00 pm on 08/01/17 records revealed the sprinkler system has not had a visual obstruction inspection in over 5 years and has other deficiencies noted on sprinkler report noted that there is no documentation available stating that it has been fixed. This deficient condition was verified by the Maintenance Engineer.	K 353	Perform the 5 year obstruction inspection on scheduled date. POC was submitted via mail or email as requested on 2567	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and	K 712		8/9/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245244	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/01/2017**

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K 712	Continued From page 4 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all residents and an undetermined amount of staff and visitors. Findings include: On 08/01/2017 at 8 AM, documentation reviewed revealed fire drills were not performed correctly during these times: 1) 1st quarter 1st & 3rd shift of 2017 2) 2nd quarter 1st and 2nd shift of 2017 3) 3rd quarter 1st shift of 2016 4) 4th quarter 1st and 3rd shift of 2016 This deficient condition was verified by the Maintenance Engineer.	K 712	Started conducting separate fire drills on 8/9/17 POC was submitted via mail or email as requested on 2567	