



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 6, 2025

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

RE: CCN: 245371
Cycle Start Date: April 15, 2025

Dear Administrator:

On April 16, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor

Marshall District Office

Health Regulation Division

Minnesota Department of Health

1400 East Lyon Street, Suite 102

Marshall, Minnesota 56258-2504

Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 16, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 16, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

Prairie View Senior Living

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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

PRINTED: 05/19/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245371	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/16/2025
NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 On 4/14/25 to 4/16/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 4/14/25 through 4/16/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53712592C (MN110103) and H53712591C MN105194). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/15/2025

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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F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623			5/27/25

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F 623	Continued From page 2 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623			

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F 623	Continued From page 3 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the Office of the Ombudsman of transfers and discharge for 2 of 5 residents (R29 and R39) reviewed for hospitalizations and/or discharges. Findings include: R29's 3/16/25, discharge return anticipated Minimum Data Set (MDS) assessment identified an unplanned discharge to general hospital. 3/19/25 an entry tracking record was completed. R39's 2/3/25, discharge return not anticipated MDS identified he returned to home/community. Review of the February and March 2025 Monthly Notice to Office of Ombudsman for Long-Term Care of Emergency Acute Care Transfer and Discharges form identified that neither R29 nor R39 were on the list of resident who had been	F 623	1. In Continuing Compliance with F623, Notice of transfer and Discharge, Prairie View Senior Living corrected the deficiency by Executive Director educating the Social Services Designee on 4/17/2025 of the requirements to notify the Local Ombudsman of all discharges from the facility monthly and State Ombudsman quarterly and of the Accura Notice of Transfer or Discharge Process. 2. To ensure the deficiency does not reoccur all licensed Nursing staff will be educated by 5/27/2025 of the Accura Notice of Transfer or Discharge Process and the requirement to complete a Emergency Notice of Transfer/Discharge and Notice of Bed Hold Policy and Return form on all residents who are discharged from the facility and or sent to the emergency department. The Executive		

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F 623	Continued From page 4 discharged. Interview on 4/16/25 at 9:20 a.m., with social service designee (SSD) identified she notified the ombudsman monthly of any hospital discharges. She did not notify the ombudsman of any other types of discharges. She reported that the nurse took care of ombudsman notification if a resident discharged to home or anther facility. She confirmed that R29's hospital discharge did not get reported to the ombudsman. She identified that there had been a agency staff working that shift and did not fill out the Emergency Notice of Transfer/Discharge, Notice of Bed Hold Policy and Return form so she was unaware of the hospital discharge and the need to notify the Ombudsman. Interview on 4/16/25 at 11:43 a.m., with assistant director of nursing (ADON) identified that as far as she was aware the SSD notified the ombudsman of all discharges. Interview on 4/16/25 at 2:30 p.m., with director of nursing (DON) identified that the prior Minimum Data Set (MDS) nurse who was no longer employed at the facility, had been completing some discharge notices to the Ombudsman while the SSD notified the ombudsman of hospital discharges. She confirmed since the MDS nurse left, some discharge notices had not been made. The MDS nurse that left completed a lot of tasks and the facility was still figuring out what she had been taking care of and what needed to be re-assigned. The SSD worked on discharge planning and already completed the hospital discharge notices to the Ombudsman and could probably take over ensuring the Ombudsman was notified of all discharges.	F 623	Director or designee will audit the Monthly transfer and Discharge logs for the Ombudsman monthly for 4 months to ensure compliance. 3. As part of Prairie View Senior Living's commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		

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F 623	Continued From page 5	F 623			
F 641 SS=D	Review of the 10/22/21, Notice of Transfer or Discharge Process policy identified the Office of the State Long-Term Care Ombudsman would be notified of discharges monthly. Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 2 of 12 sampled residents (R13 and R14). Findings include: R13 was admitted February 2025. R13's undated, current diagnosis list identified R13 received a diagnosis of bipolar disorder 11/05/24. R13's 3/03/25, Level II PASARR had indicated R13 had meet criteria for severe mental illness. R13's 3/28/25, Significant change Minimum Data Set (MDS) identified R13 was moderately, cognitively impaired and had a diagnoses of anxiety, bipolar disease and dementia. R13 had little interest or pleasure in doing things, never to 1 day and felt down, depressed or hopeless 2 to 6 days. R13 was dependent with ADLS and required substantial maximal assist with	F 641	1. In continuing compliance with F641, Accuracy of Assessments, Prairie View Senior Living corrected the deficiency by correcting the MDS for R13, R148 and all like residents. 2. To correct the deficiency and to ensure the problem does not recur Accura's Director of Clinical Reimbursement was educated on 05/12/2025 on Accura's Conducting an Accurate Resident Assessment Guideline by the Chief Clinical Officer. The DNS and/or designee will audit 2 MDS's for accurate coding of Level II PASRR and Hospice weekly for 4 weeks, monthly for two months and then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process.		5/27/25

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F 641	Continued From page 6 transfers. R13 had taken antipsychotics, antianxiety and antidepressant on a routine basis. Section A 1500 PASARR: resident been evaluated by Levell II PASARR and determined to have a serious mental illness and/or mental retardation, or a related condition was marked "no". Interview on 4/15/25 at 12:56 p.m., with Registered nurse (RN)-A identified the Level II (PASARR) was missed and would have to modify the entry error and update the correct data on R13's MDS. Interview on 4/16/25 at 8:49 a.m., with the director of nursing and assistant director of nursing voiced in agreement they would expect the MDS entry to be coded accurately. Interview on 4/16/25 at 9:12 a.m., with the administrator would expect residents MDS submission to be accurate. He identified the facility did not have a policy for MDS but used the RAI manual for guidance. Review of the Resident Assessment Instrument (RAI) manual identify residents MDS submissions must be accurate during the look back period, in accordance with standards of clinical practice and documentation. R14's 3/31/25, significant change Minimum Data Set (MDS) assessment identified R14 had severe cognitive impairments, and he was dependent on staff for cares. The assessment identified he did not have a prognosis that may result in a life expectancy of less than 6 months, and he was not on hospice. R14's prior significant change MDS dated 12/11/24 and his quarterly MDS dated	F 641			

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F 641	Continued From page 7 3/6/25 both identified he was on hospice. R14's medical record identified an order on 11/29/24 for hospice services. Medical record further identified R14 had been admitted to Avera at Home Hospice on 12/3/24. R14's 12/4/24, care plan identified terminal prognosis requiring hospice services. R14's comfort would be maintained. Staff were to adjust provisions of cares to compensate changing abilities. Assess coping strategies and respect wishes. Staff were to contact Avera Hospice with concerns or question. Encourage support systems of friends and family. There were multiple other interventions identified for comfort and coordination of care with hospice. On 4/16/25 at 12:51 p.m., an attempt was made to contact the regional clinical reimbursement specialist that was identified as the staff completing R14's MDS assessments. A voice mail was left to return call with no response. Interview on 4/16/25 at 2:30 p.m., with director of nursing (DON) identified she would expect that the MDS assessment accurately reflected the resident status. She confirmed that R14's significant change MDS lacked identification of hospice.	F 641			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed	F 755			5/27/25

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F 755	Continued From page 8 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 1 resident (R15) rapid acting insulin injection was administered according to the manufactures instructions. Finding include: R15's 1/21/25, Significant Change Minimum Data Set (MDS) assessment identified R15 cognition was intact, he had no pain, no behaviors, was on a therapeutic diet, received insulin, anticoagulant,	F 755	1. In Continuing Compliance with F755, Pharmacy Services, Prairie View Senior Living corrected the deficiency by Executive Director educating LPN-A on 1/27/2025 on requirement not to provide insulin prior to meals or outside the manufacturer recommendations. LPN-A also received education and competency on 1/27/2025 regarding insulin administration. On 4/17/2025 LPN-A received an education on the facility on		

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F 755	Continued From page 9 diuretic, hypoglycemic medication daily and was on isolation. R15's diagnosis list identified he had diabetes mellitus type 2, long term use of insulin, heart failure, chronic kidney disease, edema, atrial fibrillation, and hypertension. R15's January 2025, Medication Administration Record identified R15 received insulin Glargine Solution 48 units every morning and evening and Fiasp insulin aspart injection solution 32 units three times a day at 8:00 a.m., noon, and 5:00 p.m.. R15's medication administration audit report identified documentation on 1/26/25 at: 1) 9:17 a.m., Fiasp insulin 32 units had been administered. 2) 9:18 a.m. insulin Glargine 48 units had been administered. 3) 12:17 p.m. Fiasp insulin 32 units had been administered. R15's 1/26/25 at 1:46 p.m., progress note identified LPN-A documented R15 was given his dinner medication and insulin around 11:45 a.m. Staff brought R15 his dinner at 12:30 p.m. (forty-five minutes later) and found R15 to be sweating and drooling from his mouth. R15 was unable to answer appropriately, blood pressure was 135/86 millimeters/mercury (mm/hg) (normal 120/80 mm/hg), temperature 97.5 Fahrenheit (F) (within normal limits), pulse 80 beats per minute (bpm) (normal), respirations 20 per minute (normal), and oxygen saturation 95% (normal) on room air. The ambulance was called at 1:20 p.m., and R15 left the facility at 1:30 p.m. The progress note lacked identification of what R15's BS was at	F 755	diabetic protocols and the requirement to follow those protocols. 2. To ensure the deficiency does not recur, licensed nursing staff will be educated by the Director of Nursing Services by 5/27/2025 of the facility diabetic protocols, received insulin injection competency education and education on the requirements of providing insulin per manufacturer recommendations as well as following physician guidance regarding insulin. The Director of Nursing and/or designee will audit insulin administration to ensure that it is provided per manufacturer guidelines 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks, and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit resident blood sugars to ensure facility diabetic protocol is followed 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks and then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process.		

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F 755	Continued From page 10 12:30 when staff identified his level of conscious changes, or what, if any, interventions had been implemented at the facility. R15's vital signs documentation identified on 1/26/25 at 9:18 a.m., R15's BS was 103 milligrams/deciliter (mm/dL). At 12:22 p.m., R15's BS was 99 mg/dL, and at 1:44 p.m. (after R15 had left the facility), staff recorded R15's BS was 68 mg/dL. It is unknown if this was a late entry. Interview on 4/15/25 at 7:55 a.m., with registered nurse (RN)-B identified she would check the resident blood sugar, if it was low at all she would wait to see what the resident ate before giving fast acting insulin. She was unsure if there was any protocol on what to do or what other nurses did for insulin. Interview on 4/15/25 at 8:31 a.m., with LPN-A identified on 1/26/25, from what she could recall, R15 never usually had a low blood sugar, but it was low that day. R15 ate his meal, but occasionally he would get "bucky" and not want to come out for his meal right away. She thought perhaps staff likely went to get him, but he would not come out, so they brought him his meal and that was when they found him unable to answer appropriately. Staff then came and got her to go and assess him. R15's blood sugar level and blood pressure had gone down so she sent him to the ED for evaluation. Further interview on 4/16/25 at 7:33 a.m., with LPN-A identified on 1/26/25, the day she sent R15 to the emergency department (ED) she had assessed him, attempted to give him orange juice with sugar in it. She reported she did not use the glucagon gel because she was unsure if he would	F 755			

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F 755	Continued From page 11 have been able to swallow that as it was thicker. From what she could recall, she wasn't aware if the facility had glucagon injectable medication and did not report what she had not used that if she had concerns about R15's ability to swallow medication. Review of the June 2023, Fiasp insulin aspart injection 100 units/ml manufacturer instructions identified Fiasp was a rapid-acting human insulin analog indication to improve glycemic control for patients with diabetes mellitus (1). Fiasp insulin was to be given at the start of a meal or within 20 minutes after starting a meal. R15's 1/26/25, emergency department record identified R15 with a history of diabetes, the facility reported that R15 had a BS of 68 and was given 4 packets of sugar while at nursing home. Upon arrival R15 had a BS of 33. R15 had tested positive for influenza on 1/20/25 and had not been eating or drinking well however, and the facility had continued to give him his usual insulin doses. He had been receiving Lantus 48 units twice a day along with NovoLOG 32 units three times a day with meals. R15's 1/30/25, hospital discharge summary identified R15 had been admitted on 1/26/25 for hypoglycemia, influenza A, and acute renal disease and hypotension secondary to dehydration. Review of the current, undated, American Diabetes Association (ADA) , Severe Hypoglycemia (Severe Low Blood Glucose) article, located at https://diabetes.org/living-with-diabetes/hypoglycemia-low-blood-glucose/severe, identified severe hypoglycemia, which may also be referred to as an insulin reaction or insulin shock, is when your			F 755			

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F 755	Continued From page 12 blood glucose (blood sugar) drops dangerously low. If you have severe hypoglycemia, you may become confused, pass out (lose consciousness), or treatments for a low blood glucose aren ' t working. People on blood glucose-reducing medications (insulin) were at risk. Signs and symptoms of severe hypoglycemia were listed as: 1) An altered mental state 2) Fainting or losing consciousness 3) Incredibly weak and unable to help yourself 4) Seizure 5) Coma If left untreated for too long, severe hypoglycemia can lead to brain or organ damage or even death. Glucagon, preferably ready-to-use, should be used to treat severe hypoglycemia. It quickly raises blood glucose levels by causing the liver to release the glucose it stores into your bloodstream. Review of the 12/10/2016, ADA and EASD Joint Statement on Hypoglycemia (low BS) article, located at https://www.diabetesincontrol.com/ada-easd-joint-statement-on-hypoglycemia/, identified 3 stages of low blood sugar: 1) Level 1: A glucose alert value of 70mg/dL. 2) Level 2: A glucose level of 54 mg/dL is sufficiently low to indicate serious, clinically important hypoglycemia. 3) Level 3: Severe hypoglycemia, as defined by the ADA, denotes severe cognitive impairment requiring external assistance for recovery. R15's 5/7/24, signed Prairie View Senior Living Physician Standing Orders identified diabetics: administer glucose gel 15 gram by mouth if resident with hypoglycemia is alert enough to			F 755			

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F 755	Continued From page 13 swallow get. Administer the glucagon injection, 1 milligram via intramuscular or subcutaneously for hypoglycemia if resident was unresponsive and has a low blood glucose (BS) level. Call the physician to update and implement further orders as soon as possible. Interview on 4/15/25 at 2:10 p.m., with consulting pharmacist identified no one should be taking insulin more than 30 minutes prior to eating in general. Diabetics even if sick still need to take their insulin however, if the resident was not eating the facility should have reached out to the provider to make sure the insulin dose did not need to be adjusted. Fiasp insulin was a rapid acting insulin and should be given just before eating and staff should follow the manufacturer's instruction for any insulin they are administering. The dispensing pharmacy confirmed that the facility emergency kit (E-kit) contained both glucagon gel and glucagon injections 2 doses of each at the time of the incident. Once the facility used an item out of the E-kit the facility would send a fax and they would replace the item the next delivery day. Interview on 4/15/25 at 2:43 p.m., with director of nursing (DON) identified that fast acting insulin should never be given more than 15 minutes prior to eating. On 1/26/25, LPN-A had attempted to give R15 sugar packets with orange juice prior to breaking into the emergency kit (E-kit). She agreed that R15 should have been given his insulin with his meal and the nurse should have made sure he started to eat. She revealed that insulin was an issue with R15 because if he did not like his insulin order he would seek out another provider and make an appointment and set up a ride independently to have his insulin	F 755			

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F 755	Continued From page 14 order changed. Further interview on 4/16/25 at 2:30 p.m., director of nursing (DON) revealed that R15's progress note on 1/26/25, indicated that R15 had been given his insulin 45 minutes prior to being served his meal, resulting in a low blood sugar. R15 took Fiasp insulin which was a rapid acting insulin and should have been given with food confirming that LPN-A did not follow the manufacture instruction and gave R15 the insulin before he ate his meal. She further confirmed that LPN-A did not follow the facility standing order protocol for low blood sugar to administer either glucagon gel or glucagon injection according to standing orders. She reported at the time of the incident, LPN-A stated she had given juice or sugar to R15 related to his low blood sugar instead of the correct procedure outlined in the standing orders. She had re-educated LPN-A at that time and had planned to re-educate all the licensed nurses on using the facility standing order protocol for low blood sugars. She had performed a new competency for LPN-A on 1/27/25, however she could not recall if all nursing staff had received competencies yearly. Review of LPN-A's employee file identified education on insulin administration occurred on 3/10/23, 3/13/23, and 3/20/23. On 4/1/23, LPN-A met the requirements for competency of medication pass. There were no competencies listed for 2024 related to insulin administration or identifying potential complications. On 1/27/25, LPN-A had re-education and met the requirements for competency of insulin administration including checking times insulin should be administered.			F 755			

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F 755	Continued From page 15 Interview on 4/16/25 at 3:52 p.m., with the emergency department provider who had who treated R15 on 1/26/25 and treated him previously in the past also identified R15 had received his mealtime insulin before he was given his meal. R15 had not been eating well and when she spoke to the facility nurse, she reported that she re-educated the nurse for R15 who had previous concerns with low blood sugars, that the facility should have used critical thinking and brought him out to dining area to ensure he ate his meal after administering his insulin. She confirmed R15 should not be administered his rapid acting Fiasp insulin without eating his meal, his order was insulin at mealtime which means he gets it with a meal and the facility needs to watch that better. She reported the facility was "doing the best they can, but they needed to work on critical thinking skills" as some nurses just follow orders and "do not question anything". If R15 had not been feeling well and had been eating poorly, the nurse should R15 ate within the required timeframe. Review of the 2/17/25, Blood Glucose Monitoring policy identified the policy notes after checking a resident's blood sugar level, staff were to report critical results and test results outside parameters timely. There was no mention on what staff should look for with diabetic complications, if they should follow insulin manufacturer's guidelines, or what to do if those complications should arise. Review of 8/1/24, Facility Assessment identified 9 licensed nurses were employed at the facility. The facility was to ensure nursing staff were to maintain competencies required to meet the residents needs including pharmacological. Staff were to be trained on procedures and policies			F 755			

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F 755	Continued From page 16 consistent with their roles. There was no mention staff should be deemed competent at least yearly, or more often as necessary, according to the roles and duties they provide in order to ensure those competencies were maintained. There was no policy related to following manufacture instruction provided by end of survey.	F 755			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(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 and interview the facility	F 761	1. In Continuing Compliance with	5/27/25	

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F 761	Continued From page 17 failed to ensure only authorized personnel entered 1 of 1 medication storage room. Findings include: Observation and interview on 4/16/25 at 8:24 a.m. of licensed practical nurse (LPN)-A wheeled R8 into the medication storage room adjacent to the dining room. LPN-A donned gloves and primed Humulin Kwik pen with 2 units. LPN-A identified R8's blood sugar was 171 and then dialed up 20 units of insulin for administration. LPN-A administered the insulin in R8's left abdomen and discarded the insulin needle in the sharp's container and removed her gloves. LPN-A then wheeled R8 back out to the dining room table. LPN-A reported that typically she did not give insulin in the medication room however R8 had gotten out the dining room before she caught her to give her insulin. She also revealed that there were typically 2 licensed nurses on duty during the daytime hours and today she was the only licensed nurse on duty with a trained medication aide (TMA) so she had to give all the insulins in the facility so that was why she gave the insulin in the medication room. Interview on 4/16/25 at 8:30 a.m., with the assistant director of nursing (ADON)/infection control nurse identified that if a resident needed insulin that she had taken them into the medication room to provide privacy before. Interview on 4/16/25 at 2:30 p.m., with the director of nursing (DON) identified that she was unaware nurses had been taking residents into the medication room to administer insulin. She agreed that would be an infection control concern and a medication storage concern if the nurse	F 761	F761, Label/Store Drugs & Biologicals, Prairie View Senior Living corrected the deficiency by Executive Director educating LPN-A and ADON on 5/9/2025 on facility requirements that no resident or unauthorized personnel is to enter the medication room for any reason as this is a secure and clean area. 2. To ensure the deficiency does not recur, all licensed nursing staff and trained medication aides will be educated by the Director of Nursing Services by 5/27/2025 on the requirement that no resident or unauthorized personnel is to enter the medication room for any reason as this is a secure and clean area. The Director of Nursing Services and/or designee will audit the medication room to ensure no unauthorized personnel enter 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks and then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process.		

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F 761	Continued From page 18 had to run out for some reason like an emergency, the resident could potentially get left unattended. The DON was surprised to hear more than one nurse had brought a resident into the medication room to administer insulin.	F 761			
F 812 SS=D	Review of the undated, Medication Storage in the Facility policy identified the medication supply was only accessible to licensed nursing personnel, staff members lawfully authorized to administer medications, or the pharmacy personnel. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure 1 of 1 nursing assistant (NA-A)	F 812			5/27/25
			1. In Continuing Compliance with F812, Food Procurement, Store/Prepare,		

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F 812	Continued From page 19 entering the food preparation area in the kitchen wore a hair net. Findings include: Observation and interview on 4/14/25 at 12:25 p.m., of NA-A standing in the kitchen food preparation area where the cook was dishing up the meal onto plates. NA-A was standing within 2 feet of the cook dishing up the food onto the plate with no hair net on. NA-A obtained a meal tray and exited the kitchen. When asked about hair nets when in the kitchen NA-A stated, "I do not think the nurse aides have to wear one". She denied that she typically goes into the kitchen to retrieve a meal, then reported, the resident was out in the dining room, but then changed their mind and wanted to eat in their room. Interview on 4/14/25 at 12:32 p.m., with dietary manager identified staff were able to enter the kitchen as far as the hand washing sink which was just inside the kitchen door. Any distance after that they need to have the hair net on. She confirmed there should be no staff without hair nets in the kitchen serving area. Interview on 4/16/25 at 2:30 p.m., with director of nursing (DON) identified she would expect that any staff entering the kitchen would be donning a hair net prior to entering the kitchen for any reason. She reported the rule has always been you either put on a hair net or you wait at the door. The facility had no policy related to wearing hair nets in the kitchen however, they provided The Safe Food Handler protocol they followed that identified that hair restraints or hats were required	F 812	Serv Sanitary, Prairie View Senior Living corrected the deficiency by Executive Director educating NA-A on 4/15/2025 of the requirement to wear a hair net past the hand wash sink and in any food prep or serving area. 2. To ensure the deficiency does not recur, on 4/17/2025 signs and identifying line on floor were placed in the kitchen notifying that hair nets are required past that area. A hair net dispenser was also placed on the wall outside the kitchen for staff use on 4/17/2025. All staff were educated by the Dietary Manager on 5/13/2025 on the requirements to wear hair nets in any food prep or serving area. The Dietary Manager and/or designee will audit staff for hair net compliance 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks and then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's commitment to quality assurance, the Dietary Manager and/or designee will report identified concerns through the community's QA Process.		

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F 812	Continued From page 20			F 812			
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population;			F 838			5/27/25

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F 838	Continued From page 21 (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a) (1). § 483.71(b) In conducting the facility assessment, the facility must ensure:	F 838			

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F 838	Continued From page 22 § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the			F 838			

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F 838	Continued From page 23 facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement thier facility assessment to ensure 1 of 1 licensed practical nurse (LPN)-A and potentially 8 other licensed nurses (registered nurses (RN's) and LPN's) who administered insulin had yearly competencies for safe administration of insulin, and identifcation of complications of low or high blood sugar levels and any actions needed. This had the potential to affect all residents who were diabetic. Finding include: R15's 1/21/25, Significant Change Minimum Data Set (MDS) assessment identified R15 cognition was intact, he had no pain, no behaviors, was on a therapeutic diet, received insulin, anticoagulant, diuretic, hypoglycemic medication daily and was on isolation. R15's diagnosis list identified he had diabetes mellitus type 2, long term use of insulin, heart failure, chronic kidney disease, edema, atrial fibrillation, and hypertension. R15's January 2025, Medication Administration Record identified R15 received insulin Glargine Solution 48 units every morning and evening and Fiasp insulin aspart injection solution 32 units three times a day at 8:00 a.m., noon, and 5:00 p.m..	F 838	1. In Continuing Compliance with F838, Facility Assessment, F838, Prairie View Senior Living corrected the deficiency by Executive Director educating LPN-A on 1/27/2025 on requirement not to provide insulin prior to meals or outside the manufacturer recommendations. LPN-A also received education and competency on 1/27/2025 regarding insulin administration. On 4/17/2025 LPN-A received an education by the Executive Director on the facility diabetic protocols and the requirement to follow those protocols. 2. To ensure the deficiency does not recur, all licensed nursing staff were educated by the Director of Nursing Services on 5/13/2025 the facility diabetic protocols, received insulin injection competency education and education on the requirements of providing insulin per manufacturer recommendations as well as following physician guidance regarding insulin. The Director of Nursing and/or designee will audit insulin administration to ensure that it is provided per manufacturer guidelines 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks, and then randomly to ensure continued compliance. The Director of Nursing		

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F 838	Continued From page 24 R15's medication administration audit report identified documentation on 1/26/25 at: 1) 9:17 a.m., Fiasp insulin 32 units had been administered. 2) 9:18 a.m. insulin Glargine 48 units had been administered. 3) 12:17 p.m. Fiasp insulin 32 units had been administered. R15's 1/26/25 at 1:46 p.m., progress note identified LPN-A documented R15 was given his dinner medication and insulin around 11:45 a.m. Staff brought R15 his dinner at 12:30 p.m. (forty-five minutes later) and found R15 to be sweating and drooling from his mouth. R15 was unable to answer appropriately, blood pressure was 135/86 millimeters/mercury (mm/hg) (normal 120/80 mm/hg), temperature 97.5 Fahrenheit (F) (within normal limits), pulse 80 beats per minute (bpm) (normal), respirations 20 per minute (normal), and oxygen saturation 95% (normal) on room air. The ambulance was called at 1:20 p.m., and R15 left the facility at 1:30 p.m. The progress note lacked identification of what R15's BS was at 12:30 when staff identified his level of conscious changes, or what, if any, interventions had been implemented at the facility. R15's vital signs documentation identified on 1/26/25 at 9:18 a.m., R15's BS was 103 milligrams/deciliter (mm/dL). At 12:22 p.m., R15's BS was 99 mg/dL, and at 1:44 p.m. (after R15 had left the facility), staff recorded R15's BS was 68 mg/dL. It is unknown if this was a late entry. Interview on 4/15/25 at 7:55 a.m., with registered nurse (RN)-B identified she would check the resident blood sugar, if it was low at all she would wait to see what the resident ate before giving	F 838	and/or designee will audit resident blood sugars to ensure facility diabetic protocol is followed 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks and then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process.		

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F 838	Continued From page 25 fast acting insulin. She was unsure if there was any protocol on what to do or what other nurses did for insulin. Interview on 4/15/25 at 8:31 a.m., with LPN-A identified on 1/26/25, from what she could recall, R15 never usually had a low blood sugar, but it was low that day. R15 ate his meal, but occasionally he would get "bucky" and not want to come out for his meal right away. She thought perhaps staff likely went to get him, but he would not come out, so they brought him his meal and that was when they found him unable to answer appropriately. Staff then came and got her to go and assess him. R15's blood sugar level and blood pressure had gone down so she sent him to the ED for evaluation. Further interview on 4/16/25 at 7:33 a.m., with LPN-A identified on 1/26/25, the day she sent R15 to the emergency department (ED) she had assessed him, attempted to give him orange juice with sugar in it. She reported she did not use the glucagon gel because she was unsure if he would have been able to swallow that as it was thicker. From what she could recall, she wasn't aware if the facility had glucagon injectable medication and did not report what she had not used that if she had concerns about R15's ability to swallow medication. Review of the June 2023, Fiasp insulin aspart injection 100 units/ml manufacturer instructions identified Fiasp was a rapid-acting human insulin analog indication to improve glycemic control for patients with diabetes mellitus (1). Fiasp insulin was to be given at the start of a meal or within 20 minutes after starting a meal.	F 838			

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F 838	Continued From page 26 R15's 1/26/25, emergency department record identified R15 with a history of diabetes, the facility reported that R15 had a BS of 68 and was given 4 packets of sugar while at nursing home. Upon arrival R15 had a BS of 33. R15 had tested positive for influenza on 1/20/25 and had not been eating or drinking well however, and the facility had continued to give him his usual insulin doses. He had been receiving Lantus 48 units twice a day along with NovoLOG 32 units three times a day with meals. R15's 1/30/25, hospital discharge summary identified R15 had been admitted on 1/26/25 for hypoglycemia, influenza A, and acute renal disease and hypotension secondary to dehydration. Review of the current, undated, American Diabetes Association (ADA) , Severe Hypoglycemia (Severe Low Blood Glucose) article, located at https://diabetes.org/living-with-diabetes/hypoglycemia-low-blood-glucose/severe, identified severe hypoglycemia, which may also be referred to as an insulin reaction or insulin shock, is when your blood glucose (blood sugar) drops dangerously low. If you have severe hypoglycemia, you may become confused, pass out (lose consciousness), or treatments for a low blood glucose aren ' t working. People on blood glucose-reducing medications (insulin) were at risk. Signs and symptoms of severe hypoglycemia were listed as: 1) An altered mental state 2) Fainting or losing consciousness 3) Incredibly weak and unable to help yourself 4) Seizure 5) Coma If left untreated for too long, severe hypoglycemia can lead to brain or organ damage or even death.	F 838			

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F 838	Continued From page 27 Glucagon, preferably ready-to-use, should be used to treat severe hypoglycemia. It quickly raises blood glucose levels by causing the liver to release the glucose it stores into your bloodstream. Review of the 12/10/2016, ADA and EASD Joint Statement on Hypoglycemia (low BS) article, located at https://www.diabetesincontrol.com/ada-easd-joint-statement-on-hypoglycemia/, identified 3 stages of low blood sugar: 1) Level 1: A glucose alert value of 70mg/dL. 2) Level 2: A glucose level of 54 mg/dL is sufficiently low to indicate serious, clinically important hypoglycemia. 3) Level 3: Severe hypoglycemia, as defined by the ADA, denotes severe cognitive impairment requiring external assistance for recovery. R15's 5/7/24, signed Prairie View Senior Living Physician Standing Orders identified diabetics: administer glucose gel 15 gram by mouth if resident with hypoglycemia is alert enough to swallow gel. Administer the glucagon injection, 1 milligram via intramuscular or subcutaneously for hypoglycemia if resident was unresponsive and has a low blood glucose (BS) level. Call the physician to update and implement further orders as soon as possible. Interview on 4/15/25 at 2:10 p.m., with consulting pharmacist identified no one should be taking insulin more than 30 minutes prior to eating in general. Diabetics even if sick still need to take their insulin however, if the resident was not eating the facility should have reached out to the provider to make sure the insulin dose did not need to be adjusted. Fiasp insulin was a rapid	F 838			

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F 838	Continued From page 28 acting insulin and should be given just before eating and staff should follow the manufacturer's instruction for any insulin they are administering. The dispensing pharmacy confirmed that the facility emergency kit (E-kit) contained both glucagon gel and glucagon injections 2 doses of each at the time of the incident. Once the facility used an item out of the E-kit the facility would send a fax and they would replace the item the next delivery day. Interview on 4/15/25 at 2:43 p.m., with director of nursing (DON) identified that fast acting insulin should never be given more than 15 minutes prior to eating. On 1/26/25, LPN-A had attempted to give R15 sugar packets with orange juice prior to breaking into the emergency kit (E-kit). She agreed that R15 should have been given his insulin with his meal and the nurse should have made sure he started to eat. She revealed that insulin was an issue with R15 because if he did not like his insulin order he would seek out another provider and make an appointment and set up a ride independently to have his insulin order changed. Further interview on 4/16/25 at 2:30 p.m., director of nursing (DON) revealed that R15's progress note on 1/26/25, indicated that R15 had been given his insulin 45 minutes prior to being served his meal, resulting in a low blood sugar. R15 took Fiasp insulin which was a rapid acting insulin and should have been given with food confirming that LPN-A did not follow the manufacture instruction and gave R15 the insulin before he ate his meal. She further confirmed that LPN-A did not follow the facility standing order protocol for low blood sugar to administer either glucagon gel or glucagon injection according to standing orders.			F 838			

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F 838	Continued From page 29 She reported at the time of the incident, LPN-A stated she had given juice or sugar to R15 related to his low blood sugar instead of the correct procedure outlined in the standing orders. She had re-educated LPN-A at that time and had planned to re-educate all the licensed nurses on using the facility standing order protocol for low blood sugars. She had performed a new competency for LPN-A on 1/27/25, however she could not recall if all nursing staff had received competencies yearly. Review of LPN-A's employee file identified education on insulin administration occurred on 3/10/23, 3/13/23, and 3/20/23. On 4/1/23, LPN-A met the requirements for competency of medication pass. There were no competencies listed for 2024 related to insulin administration or identifying potential complications. On 1/27/25, LPN-A had re-education and met the requirements for competency of insulin administration including checking times insulin should be administered. Interview on 4/16/25 at 3:52 p.m., with the emergency department provider who had who treated R15 on 1/26/25 and treated him previously in the past also identified R15 had received his mealtime insulin before he was given his meal. R15 had not been eating well and when she spoke to the facility nurse, she reported that she re-educated the nurse for R15 who had previous concerns with low blood sugars, that the facility should have used critical thinking and brought him out to dining area to ensure he ate his meal after administering his insulin. She confirmed R15 should not be administered his rapid acting Fiasp insulin without eating his meal, his order was insulin at mealtime which means he	F 838			

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F 838	Continued From page 30 gets it with a meal and the facility needs to watch that better. She reported the facility was "doing the best they can, but they needed to work on critical thinking skills" as some nurses just follow orders and "do not question anything". If R15 had not been feeling well and had been eating poorly, the nurse should R15 ate within the required timeframe. Review of the 2/17/25, Blood Glucose Monitoring policy identified the policy notes after checking a resident's blood sugar level, staff were to report critical results and test results outside parameters timely. There was no mention on what staff should look for with diabetic complications, if they should follow insulin manufacturer's guidelines, or what to do if those complications should arise. Review of 8/1/24, Facility Assessment identified 9 licensed nurses were employed at the facility. The facility was to ensure nursing staff were to maintain competencies required to meet the residents needs including pharmacological. Staff were to be trained on procedures and policies consistent with their roles. There was no mention staff should be deemed competent at least yearly, or more often as necessary, according to the roles and duties they provide in order to ensure those competencies were maintained.	F 838			
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and	F 867			5/27/25

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NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 250 FIFTH STREET EAST TRACY, MN 56175			
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F 867	Continued From page 31 procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success,			F 867			

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F 867	Continued From page 32 and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope	F 867			

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F 867	Continued From page 33 and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have evidence of a Performance Improvement Project (PIP) which focused on high risk or problem-prone areas identified thorough and appropriate data collection and analysis and evaluation of the identified concern(s) during QAPI. This had the potential to affect all 43 residents. Review of the facilities QAPI minutes from June of 2024 through March of 2025 identified the following:	F 867	1. In Continuing Compliance with F867, QAPI/QAA Improvement Activities, Prairie View Senior Living corrected the deficiency by Executive Director, Director of Nursing Services and Assistant Director of Nursing Services attending PIP's in PCC training with Accura's Vice President of Clinical Services on 4/30/2025. 2. To ensure the deficiency does not recur all Performance Improvement Projects will be placed into Point Click Care Insights		

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F 867	Continued From page 34 1. June 2024 minutes identified the facility chose a PIP of pain. The minutes did not include any data collection, analysis, evaluation of the identified concern, or an action plan. 2. July, August, September, October, November, December of 2024 and January, February, March of 2025 QAPI minutes identified the facility chose a PIP of pain but lacked any data collection, analysis or evaluation of the identified concern or an action plan. Interview on 4/15/25 at 4:30 p.m., with the administrator identified the QAPI committee had chosen pain from the facilities CMS Quality measures as their PIP project back in June. He reported they had not developed an action plan. He would expect the committee to follow the PIP process to bring the data to QAPI, discuss the problem, set a measurable goal, developed an action plan, and revisit and adjust the plan as needed until completion. Review of the facility provided October 2024, QAPI Plan identified at least annually, a project that focuses on high risk or problem-prone areas will be addressed through the QAPI program including PIP development. A minimum of one PIP and a maximum of four PIP's will occur simultaneously. A PIP worksheet which establishes the goals, scope, timing, milestones, and team's roles and responsibilities will be developed for each PIP. The PIP team will be assembled by the QAPI committee. The team will be interdisciplinary with employees representing each job role affected by the project and may include resident and/or family representation, when appropriate. A project lead will be selected and will be responsible for coordinating, organizing and directing the activities of that	F 867	for PIP documentation. Current PIP of Pain was placed into PCC insights on 5/2/2025 and conducted the first meeting on 5/9/2025. The PIP team will meet weekly and bring recommendations to the Interdisciplinary team each week. The facilitator will bring and present the data at least quarterly to QAPI to report. The Executive Director and/or designee will audit for Performance Improvement Projects (PIP's) compliance weekly for 12 weeks and then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		

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F 867	Continued From page 35	F 867			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880			5/27/25

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F 880	Continued From page 36 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 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			F 880			

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F 880	Continued From page 37 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 ensure 1 of 1 medication room was not used for resident insulin administration and/or blood glucose checks, in order to prevent potential cross-contamination. Observation and interview on 4/16/25 at 8:24 a.m. of licensed practical nurse (LPN)-A wheeled R8 into the medication storage room adjacent to the dining room. LPN-A donned gloves and primed Humulin Kwik pen with 2 units. LPN-A identified R8's blood sugar was 171 and then dialed up 20 units of insulin for administration. LPN-A administered the insulin in R8's left abdomen and discarded the insulin needle in the sharp's container and removed her gloves. LPN-A then wheeled R8 back out to the dining room table. LPN-A reported that typically she did not give insulin in the medication room however R8 had gotten out the dining room before she caught her to give her insulin. She also revealed that there were typically 2 licensed nurses on duty during the daytime hours and today she was the only licensed nurse on duty with a trained medication aide (TMA) so she had to give all the insulins in the facility so that was why she gave the insulin in the medication room. Interview on 4/16/25 at 8:30 a.m., with the assistant director of nursing (ADON)/infection control nurse identified that if a resident needed insulin that she had taken them into the medication room to provide privacy before. Interview on 4/16/25 at 2:30 p.m., with the director of nursing (DON) identified that she was	F 880	1. In Continuing Compliance with F880, Infection Control and Prevention, Prairie View Senior Living corrected the deficiency by Executive Director educating LPN-A and ADON on 5/9/2025 on facility requirements that no resident or unauthorized personnel is to enter the medication room for any reason as this is a secure and clean area. 2. To ensure the deficiency does not recur, licensed nursing staff and trained medication aides will be educated by the Director of Nursing Services by 5/27/2025 on the requirement that no resident or unauthorized personnel is to enter the medication room for any reason as this is a secure and clean area. The Director of Nursing Services and/or designee will audit the medication room to ensure no unauthorized personnel enter 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks and then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's commitment to quality assurance, the DNS and/or designee will report identified concerns through the community's QA Process.		

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F 880	Continued From page 38 unaware nurses had been taking residents into the medication room to administer insulin. She agreed that would be an infection control concern and posed a likelihood of cross-contamination. The DON was surprised to hear more than one nurse had brought a resident into the medication room to administer insulin. Review of 6/21/21, General guild lines for infection control identified facility would maintain a sanitary environment by adhering to infection control practices. The infection preventionist and/or the director of nurses would be responsible for the facility infection control procedures. The charge nurse would be responsible to carry out functions of infection control. Infection control practices are necessary to prevent or control the spread of infections. Review of 2/1/25, Medication Storage in the Facility policy identified the medication storage areas are to be kept clean and only authorized personnel should be in the medication storage area.	F 880			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/15/2025. At the time of this survey, Prairie View Senior Living 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/15/2025

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Prairie View Senior Living The facility has a capacity of 45 beds and had a census of 42 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:			K 000			

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K 712 K 712 SS=F	Continued From page 2 Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/15/2025 between 9:00 AM and 11:00 AM, it was revealed by a review of available documentation that the facility was not varying times for fire drills. An interview with the Maintenance Supervisor and Executive Director verified this deficient finding at the time of discovery.	K 712 K 712			5/1/25

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K 712	Continued From page 3	K 712	concerns through the community's QA Process.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 3, 2025

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

RE: CCN: 245371
Cycle Start Date: April 16, 2025

Dear Administrator:

On June 3, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112