Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 14, 2023

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

RE: CCN: 245371
Cycle Start Date: February 9, 2023

Dear Administrator:

On March 1, 2023, we notified you a remedy was imposed. On March 27, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 14, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 16, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 1, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 9, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
March 1, 2023

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

RE: CCN: 245371
Cycle Start Date: February 9, 2023

Dear Administrator:

On February 9, 2023, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 9, 2023, the situation of immediate jeopardy to potential health and safety cited at F684 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 16, 2023.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 16, 2023, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 16, 2023, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 9, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Prairie View Senior Living is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 9, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 August 9, 2023 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services,

Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services

Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing

Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245371	A. BUILDING _____ B. WING _____	C 02/09/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 2/6/23 through 2/9/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS Revised due to IDR. On 2/6/23 through 2/9/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be 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: H53718096C (MN89151) and H53718095C (MN88646, MN88648, and MN88650). The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F684 began on 1/14/23, when the facility failed to appropriately identify and intervene when an emergent COC occurred for R36 whose health had dramatically declined. The facility administrator and director of nursing (DON) were	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/10/2023

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 000	Continued From page 1 notified of the IJ on 2/8/23 at 2:26 p.m.. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 2/8/23. 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 in accordance with your verification.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R188) was assessed to safely self-administer medication. Findings include: Observation and interview on 2/6/23 at 11:11 a.m., with R188 in their room identified a vial of medication was left on bedside table. R188 stated	F 554	1. In continuing compliance with F 554, Resident Self-Admin Meds-Clinically Approp, Prairie View Senior Living corrected the deficiency by completing Self-Administration of Medication Assessment on R188 on 2/7/2023. All like residents were assessed for self-administration of nebulization on 3/3/2023. 2. To correct the deficiency and to ensure	3/10/23

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F 554	Continued From page 2 that was medication for their nebulizer from previous night. LPN-A identified the medication that was left out was budesonide (inhaled medication) that had been left unattended in the room from last the last night. MAR indicates the physicians order of budesonide to be given every evening. Interview on 2/7/23 at 3:06 p.m., DON relays this was not acceptable standard practice. Nurses were to secure medication in the cart, or kept with the nurse at all times. Interview on 2/7/23 at 3/:56 p.m., with the consultant pharmacist (RPh) indicated medications were to be stored securely and not left unattended if a resident was not assessed to self administer medication. There was no policy related to self-administration of medication provided by the end of survey.	F 554	the problem does not recur all licensed staff and TMA s were educated by the Director of Nursing Services on the self-administration of nebulization process on 3/7/2023. The Director of Nursing Services and/or Designee will audit for Self-Administration of Nebulization 3x/week for 4 weeks, 2x/week for 4 weeks, 1x/week for 4 weeks and then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living s ongoing commitment to quality assurance, the Director of Nursing Services and/or designee will report identified concerns through the community s QA Process.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		2/9/23

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F 580	Continued From page 3 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician of a change of condition (COC) for 1 of 1 resident (R36) who had a serious decline in health and 1 of 1 resident	F 580	1. In continuing compliance with F 580, Notify of Changes. Prairie View Senior Living corrected the deficiency by notifying R37 physician of the AMA	

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F 580	Continued From page 4 (R37) who discharged from the facility against medical advice (AMA). Findings include: R36 was admitted to the facility on 1/12/23, from a regional hospital after having had a fall with fracture with diagnoses of congestive heart failure with a recent history of acute respiratory failure (life threatening emergency requiring medication and potential breathing treatment), and recent pelvic fracture. R36's admission note dated 1/12/23, identified R36's vital signs were all within normal limits upon admission. They were as follows: blood pressure (BP) 123/80 millimeters of mercury (mm/hg) pulse (P) 71 beats per minute (bpm), temperature (T) 97.7 degrees Fahrenheit and her respiratory rate (RR) was 20 breaths per min (bpm). R36's progress notes and accompanying vital signs identified from 1/12/22 to 1/13/22, R36 had no signs of declining health until a progress note was made on 1/14/23 at 2:08 a.m., when licensed practical nurse (LPN)-B identified R36 was noted to have been uncomfortable all night. This writer noted mottling [web-like pattern on the skin appearing red, bluish, or purple, signaling poor circulation] and nail beds bluish [also a sign of low oxygen. R36 had been on the bed pan once, was continent of urine, but staff noted she had "scant" amounts. Staff noted they had checked her RR at 1:15 a.m. and noticed the beginning of a decline. R36 had a RR of 36 with audible wheezing. Staff then administered an Albuterol inhaler. LPN-B then noted R36's respirations had "increased over the last two hours". Her RR was 44 and her	F 580	discharge on 2/24/2023 by Social Service Designee. R36 was discharged from the facility on 1/14/2023. Policy for Change in Resident Health Status created by Accura Healthcare on 2/8/2023. 2. To correct the deficiency and to ensure the problem does not recur a reference guide was purchased for licensed staff to reference change of condition on 2/9/2023. Education was provided to all nurses on Change in Resident Health Status policy, emergent situations, reference guide, and ensuring that physicians are notified when a resident leaves AMA by Director of Nursing Services on 2/9/2023. The Director of Nursing Services and/or designee will audit 24-hour report for physician notification related to resident change in condition 5x/week for 30 days, 3x/week for 30 days, weekly for 30 days, and then randomly to ensure continued compliance. The Director of Nursing Services and/or Designee will audit all AMA discharges for physician notification weekly for 12 weeks and then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's ongoing commitment to quality assurance, the Director of Nursing Services and/or designee will report identified concerns through the community's QA Process.	

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F 580	Continued From page 5 SpO2 had dropped to 77% (dangerously low oxygen saturation (SpO2) normal is 95 to 100%)on room air. LPN-B administered oxygen at 2 liters (L) per minute. "Will continue to monitor...". LPN-B lacked noting at 1/14/22 at 2:08 a.m. progress note that R36 also had a slight fever of 99.3 °F, and her blood pressure had decreased from her normal to 112 /56 mmHg. There was no indication LPN-B identified the emergent decline in R36's overall health status or called emergency medical services (EMS or 911) or called the hospital's on-call physician who was located across the street in the local hospital emergency room (ER). R36's progress note dated 1/14/23, identified staff had reportedly re-checked R36's SpO2 at 3:15 a.m., while she was on 2 L of oxygen. R36's SpO2 was 97% at that time. There is no documentation to support this was an accurate reading as it was not included in the vital sign charting, or if a physical assessment had been performed by the nurse to check for RR, skin changes to show continued lack of oxygen, or if her RR had decreased from 44. Review of R36 progress notes lacked any other updated information until 8:04 a.m., 5 hours later when LPN-B noted "Resident very hypoxic this morning. O2 81% at 4 liters. Nail beds dark blue...ambulance called to send her to [regional hospital] per [R36's] request". Staff noted the ambulance arrived at 7:00 a.m., and it was discovered by EMS, R36's BP had dropped to 80's over 40's (seriously low BP. Normal is 120's over 80's). At that time, the determination was made to take R36 to the local ER across the street for emergency treatment. The last note made on 1/14/23 at 1:15 p.m. identified the local	F 580		

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F 580	Continued From page 6 hospital called the facility to inform them R36 had been admitted with a diagnosis of sepsis (serious and often life threatening whole body infection). Interview on 2/08/23 at 1:48 p.m. with the director of nursing (DON) and the regional nurse consultant (RNC) identified both were unaware of the COC that occurred with R36 prior to her emergency transfer and subsequent hospitalization. The RNC stated would do random audits on medical records to identify problems or concerns with care if she had been made aware. The DON was unaware of the situation as she had been on vacation at the time the incident occurred. Both noted the facility had no policy or procedure or had professional references for nursing to follow with regards to identifying a COC or an emergent situation. Both agreed the incident was an emergency and at minimum, LPN-B should have called the on-call MD across the street at the local hospital if she was unsure how to proceed, but because R36 showed such a drastic decline in her health, EMS should have been called right away at 2:08 a.m.. Both agreed LPN-B failed to perform appropriate assessments, identify and emergent situation, and timely intervene on R36's behalf. Interview on 2/08/23 at 4:46 p.m., with physician's assistant (PA)-B identified he was the on-call provider on 1/14/23 when R36 was brought to the ER at the local hospital. When R36 arrived, he had very limited information on her condition as the facility failed to call the ER and give any status update. R36 had low oxygen levels, was hypotensive (low blood pressure) and she "looked like she was crumping" (slang for a major decline). The ER did a complete examination , oxygenated her and identified R36 had sepsis	F 580		

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F 580	Continued From page 7 due to a previously unidentified urinary tract infection . R36 was a do not resuscitate (DNR) so they tried giving her fluids to increase her BP. R36's family member came and it was decided to approach palliative care. R36 was given a broadband antibiotic. R36 did recover slightly, however, her condition continued to worsen and R36 passed away later that day. PA-B expected LPN-B or any other nursing staff at the facility should have called the ER on-call service at minimum to ask questions on a non-emergent basis. However, had he received a call, he would have instructed them to immediately call 911. R37's progress notes identified on: 1) 12/15/22, R37 was admitted to the facility from a regional hospital with diagnoses of recurrent gastrointestinal bleeding (GI), atrial fibrillation (abnormal heart beat), high blood pressure, bladder cancer, and Stage 4 chronic kidney disease (CKD). R37 used a wheelchair but was able to ambulate with a walker. R37 was receiving physical and occupational therapy and required assist of 1 staff with cares and was admitted for strengthening. 2) 12/22/22, R37 was now independent with toileting in her room and was continent of bowel and bladder, but was reminded to still call staff for assistance for safety. 3) 12/31/22 at 11:34 a.m.,, staff noted R37 was discharged against medical advice (AMA) from the facility with her family member (FM)-A. AMA papers were signed, a medication list given, and belongings sent with R37. There was no indication staff had attempted to call R37's physician, nor was there evidence R37's needs were able to be met in the community and no outreach services were needed to be acquired to ensure a safe transition back to the community.	F 580		

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F 580	Continued From page 8 R37's 12/31/22, AMA form identified she signed the form stating she was being discharged from the facility AMA and acknowledged she accepted responsibility for any and all ill effects which the discharge might have had on herself or her family. The document was signed as witnessed by R37's FM-A and registered nurse (RN)-A. Interview on 2/08/23 at 4:27 p.m., with the social services designee (SSD) identified she was aware of R37's AMA. The SSD was unable to find any documentation in the paper chart or electronic record, R37's physician was ever notified. There was no policy related to notification to the physician	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(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 §483.10(g)(17)(i)(A) and (B) of this section.	F 582		2/13/23

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F 582	Continued From page 9 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services 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 required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) CMS-10055 for 1 of 3 residents (R34).	F 582	1. In continuing compliance with F 582, Medicaid/Medicare Coverage Liability Notice, Prairie View Senior Living corrected the deficiency iyby educating	

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F 582	Continued From page 10 Finding include: R34's medical record identified R34 received a Notice of Medicare Non-Coverage 11/23/22, related to her Medicare Part A benefits ending 11/25/22. Interview on 2/06/23 at 5:30 p.m. with the business office manager (BOM) identified at the time of the notice, a new staff member, the Minimum Data Set (MDS) Coordinator, hired in January 2022, was assisting in the process beginning in October 2022. The BOM stated no SNFABN was provided to R34 on 11/23/22, which would have identified if she had elected to receive benefits not covered under Medicare Part A, she may have had to pay out of pocket for services received. Review of the April 2018, Beneficiary Notice Guidelines identified an SNFABN should have been provided.	F 582	the Business office manager and MDS Coordinator on 2/13/2023 by Executive Director on the process and procedure for providing Notice of non-coverage (NOMNC) and Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SFNABN) within 48-hours of coverage ending. Tracking tool was implemented to ensure 48-hour compliance, and signed NOMNC is received back to the facility. 2. To correct the deficiency and to ensure the problem does not recur the Executive Director and/or designee will audit all resident (NOMNC) and (SFNABN) ending Medicare coverage weekly for 3 months and as needed to ensure continued compliance. 3. As part of Prairie View Senior Living's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations	F 644		3/7/23

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F 644	Continued From page 11 from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the county (designated state mental health authority) when 3 of 5 residents (R3, R4, and R10). had new on-set of mental illness or when the preadmission screen had not identified a current mental health diagnosis upon admission. Finding include: R10's 2/8/23, diagnosis list, identified diagnoses of post traumatic stress disorder (PTSD), anxiety disorder, major depressive disorder, and schizophrenia. R10's 11/10/22, Significant Change Minimum Data Set (MDS) assessment identified R10 had a diagnosis of anxiety, depression, and post traumatic stress disorder. R10's 2/3/23, significant change assessment MDS identified R10 had a diagnosis of anxiety, depression, post traumatic stress disorder, and schizophrenia. R10's 6/9/22, initial Pre-Admission Screening (PAS), identified that R10 had required a PASARR level II be completed prior to admission.	F 644	1. In continuing compliance with F 644, Coordination of PASRR and Assessments, Prairie View Senior Living corrected the deficiency by completing R10's level II PASRR screen on 2/7/2023. R3 and R4 had level II PASRR screen completed on 2/17/2023 with request for Level II PASRR screening sent on 2/9/2023. All resident charts were reviewed to ensure that PASRRs are accurate on 2/9/2023. 2. To correct the deficiency and to ensure the problem does not recur education was provided to the Executive Director, Director of Nursing Services, Assistant Director of Nursing, Social Service Designee, and Minimum Data Set Coordinator to ensure all resident diagnosis/medications are reviewed and PASRR level II screenings are completed for those that trigger on 2/9/2023 by Clinical Quality Specialist with Accura Healthcare. Social Service Designee and/or designee will audit all PASRR's for accuracy weekly for 12 weeks and then randomly to ensure continued	

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F 644	Continued From page 12 R4's face sheet indicated R4 had admitted to the facility on 1/5/22, with a primary diagnosis of heart failure. R4's face sheet further identified a diagnosis of bipolar disorder and major depressive disorder. R4's 1/4/23, PAS did not identify a diagnosis of bipolar disorder and did not indicate the need for a level II PASARR to be completed. Interview on 2/7/23 at 10:30 a.m., with social service designee (SSD)-A indicated that when she receives a PAS she forwards it to RN-B for review. Interview on 2/7/23 at 11:00 a.m., with the Minimum Data Set (MDS) coordinator MDS-D revealed that she does not review the resident's PAS for completion or accuracy at any time. Interview on 2/7/23 at 11:30 a.m., with the director of nursing (DON), and nurse consultant (NC) indicated the facility ensures they have received a preadmission screen prior to coming but that they do not review them for accuracy, they only upload them to the residents chart. Policy was requested, none was provided. R3's 10/4/22, quarterly MDS identified R3 had a new diagnosis of schizophrenia, major depressive, depression, and anxiety disorder. R3's 6/28/21, PASARR identified recurrent depressive disorder, and anxiety. The PASARR had no mention of schizoaffective disorder.	F 644	compliance. 3. As part of Prairie View Senior Living's ongoing commitment to quality assurance, the Social Service Designee and/or designee will report identified concerns through the community's QA Process.	

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F 644	Continued From page 13 Interview on 2/7/23 at 12:15 p.m., MDS coordinator (RN-B) identified, she was aware that R3 had a history of anxiety, depression, and auditory hallucinations, but was unaware of a new diagnosis of schizoaffective disorder. RN-B recalls R3 had hallucinations, and recalled R3 sat on the edge of the bed and hallucinated that there was a fire. RN-B clarified it was her responsibility to review medical records and contact county when a new diagnosis which would require mental health services for a level 2 PASARR with a new diagnosis of mental health services, she further revealed she had not contacted the county to make them aware of R3's new diagnosis. R3's progress notes 4/14/22 through 7/7/22 has no mention of contacting the county regarding mental health status change.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		3/7/23

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F 656	Continued From page 14 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop a comprehensive care plan for 1 of 1 resident (R14) reviewed for communication. Finding include: R14's Significant Change Minimum Data Set (MDS) assessment identified R14 had a Brief Interview for Mental Status (BIMS) score of 9	F 656	1. In continuing compliance with F 656, Develop/Implement Comprehensive Care Plan, Prairie View Senior Living corrected the deficiency by updating R14 and all like resident care plans to reflect communication techniques used to ensure effective communication on 3/7/2023.	

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F 656	Continued From page 15 indicating moderately impaired cognition, R14 required extensive assistance of one staff for all cares. R14 had diagnoses that included: diabetes, other symptoms and signs involving cognitive functions and awareness, hypertension, and osteoarthritis. R14's 9/16/22, revised care plan identified area's of concern that included risk for alteration in psychosocial well being related to restrictions on visitation due to COVID-19, self care deficit requiring 1 staff assistance, code status, little or no interest in activities, elimination deficit, oral deficit, physical behaviors, elopement and wandering risk, potential for altered nutrition, and potential for impaired skin integrity related to incontinence and diabetes. There was no mention of potential communication barrier related R14 speaking Spanish more frequently verses English or intervention to ensure R14 and staff understood each other. Interview on 2/6/23 at 4:51 p.m., nursing assistant (NA)-A identified R14 talked in Spanish when he was confused and staff just needed to ask him to speak in English and he usually would do that in short answers. She revealed that R14 was speaking in Spanish more frequently. She was not aware of any special instruction for when R14 was speaking Spanish other than staff just asking him to speak English. Interview on 2/7/23 on 9:30 a.m., with registered nurse (RN)-A identified R14 had lived in the United States for 30 years. She reported that R14 normally spoke English but with R14's dementia he was reverting back and speaking more and more Spanish now. She reported that if staff	F 656	2. To correct the deficiency and to ensure the problem does not recur all nurses will be educated on communication care planning on 3/7/2023 by Director of Nursing Services. MDS coordinator was educated on 3/7/2023 by Director of Nursing Services on ensuring communication has been addressed for each resident as appropriate. The Director of Nursing and/or Designee will audit care plans for communication 2x/week for 4 weeks, 1x/week for 4 weeks then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's ongoing commitment to quality assurance, the Director of Nursing Services and/or designee will report identified concerns through the community's QA Process.	

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F 656	Continued From page 16 waited a few minutes and then asked R14 to speak English he would usually do that. If staff were unable to understand him when he was speaking Spanish they could ask another staff to approach him to see if he would speak English to them. She was unaware of any special interventions on R14's care plan that staff were to do if he was speaking Spanish and they could not understand him. Interview on 2/7/23 at 11:35 a.m., with the community life director identified they were unaware who was responsible for the communication needs and addressing those needs on the residents care plan but felt it would be between activities and social services. She revealed that there were Spanish speaking staff and if staff did not speak Spanish they could watch for body language cues. The community life director further identified if R14 was speaking Spanish to staff they were to remind him to speak English. She identified if he continued to speak more Spanish the facility would need to install a translator to their Ipad. Interview on 2/7/23 at 11:44 a.m., with social service designee (SSD) identified upon admission she got as much information about the resident as she could. She reported when R14 first was admitted he spoke English and but confirmed R14 had been speaking more Spanish lately. She reported the facility had signs or pictures in his room for staff to use if they needed. SSD revealed that the family spoke Spanish and could translate and there were also a few staff that spoke Spanish that could translate, but confirmed those individuals were not always available. She confirmed there were no interventions on R14 care plan to direct staff what to do if they could	F 656		

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F 656	Continued From page 17 not understand him when he spoke Spanish. Observation and Interview on 2/7/23 at 12:28 p.m., with the SSD who was looking around R14's room for a paper with some basic pictures on it that was a communication tool for when R14 spoke Spanish so staff could understand what he wanted. SSD was unable to find any type of communication tool and reported R14 must have thrown his papers away. She reported she spoke to the administrator would be re-activating the translator app that the facility had on their Ipad. SSD reported I guess we had this app before at one point and it just needed to be re-activated. She reported she would re-print pictures and get them laminated. She agreed the care plan lacked any information on what to do if R14 spoke Spanish and/or what types of devices were available to assist in identifying any needs in the event he was only speaking his native language of Spanish. Observation and interview on 2/7/23 at 2:52 p.m., of the SSD showing R14 some laminated pictures, a type of communication tool with basic pictures of toilet, food, pain etc... SSD revealed since she could not find the picture tool in his room earlier she had to print a new set out. SSD also showed a small device that she stated was a translator that had been kept at the nurses station. She was unable to confirm if staff were aware of the translator or how to use the device. Interview on 2/7/23 at 5:07 p.m., with NA-B reported she knew a little Spanish and was able to ask simple question. She also would ask him to speak English if he was speaking Spanish to her. She then reported the facility had a translator box thing that staff could use.	F 656		

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F 656	Continued From page 18 Interview on 2/8/23 at 7:32 a.m., with NA-C who identified R14 does speak Spanish and English. She had never seen any type of translator device to use in case he was speaking Spanish and staff were unable to understand him. She reported she had not had any trouble being able to figure out what he needed. Review of the October 2017, Person Centered Care Plan policy identified that the care plan was an on-going process and addressed goals to support the residents choices and the residents care needs. The care plan should be directed to prevent declines, manage risk factors, build on the resident strength's, and respect choices. The policy identified several area's that should be included on the resident care plan which included communication. For the communication area how the resident understands or is understood along with potential functional communication systems or special instructions could be include for communication. There was no indication the policy had been reviewed annually per regulation.	F 656		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		2/9/23

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F 684	Continued From page 19 Based on interview and document review, the facility failed to identify and act upon an emergent change of condition (COC) for 1 of 1 resident (R36) who had significant changes in her health. The facilities failure to get immediate emergent medical evaluation resulted in delayed treatment for severe sepsis (life threatening infection) resulting in serious harm. R36 died that afternoon in the hospital as a result of her infection. The IJ began on 1/14/23, when the facility failed to appropriately identify and intervene when an emergent COC occurred for R36 whose health had dramatically declined. The facility administrator and director of nursing (DON) were notified of the IJ on 2/8/23 at 2:26 p.m.. The IJ was removed on 2/9/23 at 11:29 a.m., but non-compliance remained at the lower scope and severity of D: ISOLATED, the potential for more than minimal harm that is not immediate jeopardy. Findings include: R36 was admitted to the facility on 1/12/23, from a regional hospital after having had a fall with fracture with diagnoses of congestive heart failure with a recent history of acute respiratory failure (life threatening emergency requiring medication and potential breathing treatment), and recent pelvic fracture. R36's admission note dated 1/12/23, identified R36's vital signs were all within normal limits upon admission. They were as follows: blood pressure (BP) 123/80 millimeters of mercury (mm/hg) pulse (P) 71 beats per minute (bpm), temperature (T) 97.7 degrees Fahrenheit and her respiratory rate (RR) was 20 breaths per min	F 684	1. In continuing compliance with F 684, Quality of Care, Prairie View Senior Living corrected the deficiency by creating a policy for Change in Resident Health Status by Accura Healthcare on 2/8/2023. 2. To correct the deficiency and to ensure the problem does not recur a reference guide was purchased for licensed staff to reference change of condition on 2/9/2023. Education was provided to all nurses on Change in Resident Health Status policy, emergent situations, and reference guide by Director of Nursing Services on 2/9/2023. All residents were reviewed on 2/9/2023 to ensure Physician was notified if change of condition was identified and no other residents were effected. The Director of Nursing Services and/or designee will audit 24-hour report for physician notification related to resident change in condition 5x/week for 30 days, 3x/week for 30 days, weekly for 30 days, then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's ongoing commitment to quality assurance, the Director of Nursing Services and/or designee will report identified concerns through the community's QA Process.	

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F 684	Continued From page 20 (bpm). R36's progress notes and accompanying vital signs identified from 1/12/22 to 1/13/22, R36 had no signs of declining health until a progress note was made on 1/14/23 at 2:08 a.m., when licensed practical nurse (LPN)-B identified R36 was noted to have been uncomfortable all night. This writer noted mottling [web-like pattern on the skin appearing red, bluish, or purple, signaling poor circulation] and nail beds bluish [also a sign of low oxygen. R36 had been on the bed pan once, was continent of urine, but staff noted she had "scant" amounts. Staff noted they had checked her RR at 1:15 a.m. and noticed the beginning of a decline. R36 had a RR of 36 with audible wheezing. Staff then administered an Albuterol inhaler. LPN-B then noted R36's respirations had "increased over the last two hours". Her RR was 44 and her SpO2 had dropped to 77% (dangerously low oxygen saturation (SpO2) normal is 95 to 100%)on room air. LPN-B administered oxygen at 2 liters (L) per minute. "Will continue to monitor...". LPN-B lacked noting at 1/14/22 at 2:08 a.m. progress note that R36 also had a slight fever of 99.3 °F, and her blood pressure had decreased from her normal to 112 /56 mmHg. There was no indication LPN-B identified the emergent decline in R36's overall health status or called emergency medical services (EMS or 911) or called the hospital's on-call physician who was located across the street in the local hospital emergency room (ER). R36's progress note dated 1/14/23, identified staff had reportedly re-checked R36's SpO2 at 3:15 a.m., while she was on 2 L of oxygen. R36's SpO2 was 97% at that time. There is no documentation to support this was an accurate	F 684		

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F 684	Continued From page 21 reading as it was not included in the vital sign charting, or if a physical assessment had been performed by the nurse to check for RR, skin changes to show continued lack of oxygen, or if her RR had decreased from 44. Review of R36 progress notes lacked any other updated information until 8:04 a.m., 5 hours later when LPN-B noted "Resident very hypoxic this morning. O2 81% at 4 liters. Nail beds dark blue...ambulance called to send her to [regional hospital] per [R36's] request". Staff noted the ambulance arrived at 7:00 a.m., and it was discovered by EMS, R36's BP had dropped to 80's over 40's (seriously low BP. Normal is 120's over 80's). At that time, the determination was made to take R36 to the local ER across the street for emergency treatment. The last note made on 1/14/23 at 1:15 p.m. identified the local hospital called the facility to inform them R36 had been admitted with a diagnosis of sepsis (serious and often life threatening whole body infection). Interview on 2/08/23 at 1:48 p.m. with the director of nursing (DON) and the regional nurse consultant (RNC) identified both were unaware of the COC that occurred with R36 prior to her emergency transfer and subsequent hospitalization. The RNC stated would do random audits on medical records to identify problems or concerns with care if she had been made aware. The DON was unaware of the situation as she had been on vacation at the time the incident occurred. Both noted the facility had no policy or procedure or had professional references for nursing to follow with regards to identifying a COC or an emergent situation. Both agreed the incident was an emergency and at minimum, LPN-B should have called the on-call MD across	F 684		

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F 684	Continued From page 22 the street at the local hospital if she was unsure how to proceed, but because R36 showed such a drastic decline in her health, EMS should have been called right away at 2:08 a.m.. Both agreed LPN-B failed to perform appropriate assessments, identify and emergent situation, and timely intervene on R36's behalf. Interview on 2/08/23 at 4:46 p.m., with physician's assistant (PA)-B identified he was the on-call provider on 1/14/23 when R36 was brought to the ER at the local hospital. When R36 arrived, he had very limited information on her condition as the facility failed to call the ER and give any status update. R36 had low oxygen levels, was hypotensive (low blood pressure) and she "looked like she was crumping" (slang for a major decline). The ER did a complete examination , oxygenated her and identified R36 had sepsis due to a previously unidentified urinary tract infection . R36 was a do not resuscitate (DNR) so they tried giving her fluids to increase her BP. R36's family member came and it was decided to approach palliative care. R36 was given a broadband antibiotic. R36 did recover slightly, however, her condition continued to worsen and R36 passed away later that day. PA-B expected LPN-B or any other nursing staff at the facility should have called the ER on-call service at minimum to ask questions on a non-emergent basis. However, had he received a call, he would have instructed them to immediately call 911. The IJ was removed on 2/9/23 at 11:29 a.m., when it could be verified through staff interviews and document review, the facility had created a policy and procedure specific to a resident' COC, had purchased nursing reference book, and had educated all nurses, including LPN-B prior to their	F 684		

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F 684	Continued From page 23 next shift, and had a process for all staff to be re-educated for those not currently working.	F 684		
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(g). The facility may permit unlicensed 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:	F 755		2/10/23

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F 755	Continued From page 24 Based on observation and interview, the facility failed to ensure 1 of 1 resident (R21) was free from a medication error. Findings include: R21's significant Minimum Data Set (MDS) assessment identified Brief Interview for Mental Status (BIMS) score of 6 severe cognitive impairment. R21 required extensive assist of 1 to 2 staff for cares. R21 took a daily anticoagulant and had a daily insulin injection. R21 had the following diagnoses: hypertension, diabetes mellitus, high cholesterol, dementia, history of stroke. R21's February 2023, Treatment Administration Record identified order for NovoLog Solution (Insulin Aspart) injection as per sliding scale: 0-69=treat per hypoglycemia protocol; 70-179=none, 180-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, 401-450=10 units, over 451 call provider, subcutaneously three times a day for diabetes. Observation and interview on 2/7/23 at 11:21 a.m., with registered nurse (RN)- A who completed a blood sugar check on R21 with blood sugar registering at 239. RN-A revealed that R21 would need 2 units of NovoLog sliding scale. RN-A was observed to obtain the Novolog FlexPen, RN-A removed the device cap, wiped the rubber stopper with an alcohol wipe, attached the disposable needle, pulled off the inner needle cap and dialed up 2 units. RN-A administered the injection into R21's abdomen. RN-A did not prime the Novolog FlexPen with 2 units prior to dialing up ordered dose of insulin. RN-A revealed she had never primed an insulin pen before, she	F 755	1. In continuing compliance with F 755, Pharmacy Srvcs/Procedures/Pharmacist/Records, Prairie View Senior Living corrected the deficiency by immediately educating RN-A on ensuring R21 and all like resident insulin pens are primed prior to administration and competency completion for insulin pen administration on 2/7/2023 by Director of Nursing Services. R10's PRN pain medication parameters were clarified by the physician on 2/9/2023. All resident medications have been reviewed to ensure all PRN medications have parameters on 2/9/2023. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses were educated on priming insulin pens prior to administration and competencies on insulin pen administration on 2/7/2023 and 2/8/2023 by Director of Nursing Services. All licensed nurses were educated on ensuring all PRN medications have parameters on 2/10/2023 by Director of Nursing Services. Director of Nursing Services and/or Designee will audit insulin pen administration 3x/week for 4 weeks, 1x/week for 8 weeks then randomly to ensure continued compliance. Director of Nursing Services and/or Designee will audit 3 resident order sets for PRN parameters 3x/week for 4 weeks, 2x/week for 4 weeks, 1x/week for 4 weeks then randomly to ensure continued compliance.	

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F 755	Continued From page 25 stated she was unaware that the insulin pen needed to be primed. Interview on 2/7/23 at 11:31 a.m., with director of nursing (DON) confirmed staff should be priming insulin pens with 2 units prior to dialing up ordered dose of insulin. Interview on 2/7/23 at 3:56 p.m., with consultant pharmacist identified she would recommend staff follow the manufactures instruction and insulin pens should be primed. Review of the March 2021, revised NovoLog FlexPen manufacture instructions identified to avoid injecting air and ensure proper dosing, the NovoLog FlexPen should be held with the needle pointing up and tap the syringe with your finger so any air bubbles collect in the top of the reservoir. Then prime the pen by dialing up 2 units and press the button as far as it will go in order to ensure insulin appears at the needle tip. Check that the dose selector is set at 0, then dial up the number of units you need to inject. Based on interview and document review the facility failed to ensure as-needed (PRN) narcotic pain medication had parameters for the 2 different doses ordered, and when to use which dose 1 of 5 resident (R10). Findings include: R10's 2/3/23, Significant Change Minimum Data Set (MDS) Assessment identified that R10 had received opioid medication three of seven days. R10's 11/10/22 Significant Change MDS identified that R10 received opioid medication seven of seven days.	F 755	3. As part of Prairie View Senior Living's ongoing commitment to quality assurance, the Director of Nursing Services and/or designee will report identified concerns through the community's QA Process.	

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F 755	Continued From page 26	F 755		

R10's 10/28/22, electronically signed admission orders indicated an order to administer hydromorphone 2 mg tablet, 2 to 4 mg oral every 4 hours as needed for pain, max of 6 per day.

R10's Medication Administration Record identified an as-needed (PRN) order for hydromorphone HCl tablet 2 milligrams (mg) by mouth every four hours as needed for pain, give 1 to 2 tabs, max of 6 tabs. The MAR indicated the hydromorphone order started on 1/5/23, and had lacked any indication of how to determine which dose should have been administered.

Interview on 2/1/22 at 2:57 p.m., with LPN-C indicated that when assessing for the need of a prn pain mediation she would ask resident to rate pain on a scale from 0-10, she further revealed that if the MAR did not have parameters she would only give the higher dose of 2 tabs if R10 is wincing or grimacing. LPN-C agreed the MAR lacked an area to document what dose was given.

Interview on 2/7/23 at 3:13 p.m., with LPN-D indicated if a resident had a medication order without parameters she would contact the physician for clarification, if someone needs PRN pain medication prior to receiving clarification she would administer the lowest dose indicated. LPN-D revealed she does not always have time to call physician for clarification and indicated this is likely the reason R10's order had not yet been clarified with the physician.

Interview on 2/7/23 at 4:02 p.m., with director of nursing (DON) indicated her expectation is that the facility staff would call physician for clarification upon receipt of the order.

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F 755	Continued From page 27 Interview on 2/7/23 at 4:17 p.m., with medical director indicated it was his expectation that facility nursing staff would request clarification from the prescribing physician or the physician on call when a medication order is received that does not have parameters.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		2/10/23

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F 758	Continued From page 28 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure as-needed (PRN) antipsychotic medication (Seroquel) had been re-evaluated every 14 days to ensure the appropriateness of continued use for 1 of 5 residents (R4) reviewed for unnecessary medications. Findings include: R4's face sheet identified diagnoses of dementia without behavioral disturbance, bipolar disorder, major depressive disorder without psychotic features, anxiety, and Parkinson's disease. R4's Medication Administration Record (MAR) identified an order to administer Seroquel tablet 12.5 milligrams (mg) by mouth in the evening for anxiety, and may increase Seroquel to 25 m.g. "if	F 758	1. In continuing compliance with F 758, Free from Unnecessary Psychotropic Meds/PRN Use, Prairie View Senior Living corrected the deficiency by discontinuing Resident 4's PRN psychotropic on 2/8/2023. All resident medications have been reviewed to ensure PRN psychotropic medications have specific parameters and are reviewed by physicians face-to-face every 14 days on 2/9/2023. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses were educated on ensuring all PRN psychotropic medications have specific parameters with a face-to-face physician visit scheduled every 14 days on 2/10/2023 by the Director of Nursing	

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(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 758	Continued From page 29 needed" (PRN). The administration order identified a start date of 1/5/23, but did not indicate a stop date or identify the order as a PRN medication. The MAR lacked parameters for when to use the additional PRN dose of Seroquel. R4's 1/9/23, 1/18/23, and 2/1/23, physician visits lacked any mention of rationale for continued use of a PRN antipsychotic. Interview on 2/8/23 at 9:45 a.m., with licensed practical nurse (LPN)-A agreed there was no place in the administration record to record the use of the PRN Seroquel, and that it "would be difficult" to identify when R4 had received an increased dose of the medication. Interview on 2/8/23 at 9:53 a.m., with director of nursing (DON) indicated the order was incorrectly transcribed as a regularly scheduled medication. She further indicated it was her expectation an order indicating a PRN dose would be entered as a separate PRN medication order. Residents receiving a PRN antipsychotic medication were to have a face to face doctor visit every 14 days to address continued use. Review of 1/7/22, PRN Psychotropic Medication Process identified all PRN orders for psychotropic medications should be limited to 14 days unless the physician identified the required clinical rational and documented in the resident's medical record to extend the medication beyond 14 days. The nurse taking the order for any psychotropic medication was to request from the prescriber a specific duration for the order for all PRN psychotropic medication orders. The document further identified all PRN anti-psychotic medications were to be limited to 14 days.	F 758	Services. Director of Nursing and/or designee will audit 3 resident charts for PRN psychotropic parameters and face-to-face physician visit every 14 days 3x/week for 4 weeks, 2x/week for 4 weeks, 1x/week for 4 weeks then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's ongoing commitment to quality assurance, the Director of Nursing Services and/or designee will report identified concerns through the community's QA Process.	

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	245371	A. BUILDING _____ B. WING _____	C 02/09/2023

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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, interview, and record review, the facility failed to ensure 2 of 2 insulin pens belonging to R2 and R34 were securely stored and inaccessible from resident access. Findings include: Observation on 2/6/23 at 9:45 a.m.,of the medication carts identified one Novolog Flexpen and one Novolog Flexpen were unattended and	F 761	1. In continuing compliance with F 761, Label/Store Drugs and Biologicals, Prairie View Senior Living corrected the deficiency by immediately educating RN on ensuring all medications are secured in medication cart when unattended for R2, R34, and all like residents on 2/10/2023 by Director of Nursing Services. 2. To correct the deficiency and to ensure	3/9/23

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F 761	Continued From page 31 not within reach of a licensed nurse and belonged to R2 and R34. R2's current, undated, medication administration record (MAR) identified a Novolog flex pen was ordered. R34's current, undated MAR identified a Novolog flex pen was ordered. Interview on 2/7/2023 at 3:06 p.m., with the director of nursing, (DON) identified leaving medication unattended had the potential for residents passing by to access medication and potentially cause harm. Nurses were to secure all medication away from unauthorized use. Interview on 2/7/2023 at 3:56 p.m., with the consultant pharmacist (RPh)-A identified it was their expectation medication was to be secured in the medication cart or with the nurse at all times. Review of the 1/1/22, LTC Facility's Pharmacy Services and Procedures Manual policy identified staff were not leave medications unattended. There was no policy provided regarding self administration.	F 761	the problem does not recur all licensed nurses and TMA staff were educated on ensuring all medications are secured in medication cart while unattended on 2/10/2023 by Director of Nursing Services. Director of Nursing and/or Designee will audit medication carts for unsecure medications 3x/week for 4 weeks, 1x/week for 8 weeks then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's ongoing commitment to quality assurance, the Director of Nursing Services and/or designee will report identified concerns through the community's QA Process	

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	245371	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/07/2023**

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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 02/07/2023. 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		03/01/2023

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 is a 1 story building with partial basement. The building was constructed in 1965 and was determined to be of Type II (111) construction. The building is divided into three separate smoke compartments. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 45 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 712 SS=C	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 per NFPA 101 (2012 edition), Life Safety Code, section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/07/2023 at 10:30 AM, it was revealed by a review of available documentation that a fire drill was not conducted on the 3rd shift during the 3rd quarter of 2022. An interview with the Admininstrator and Maintenance Director verified this deficient finding	K 712	K712 1. Observed that drill was not conducted on the 3rd shift during the 3rd Quarter. The Fire pull station was pulled during the evening on 9/20/2023.This was intended to be used as the audible notice of the drill and a fire drill then conducted during the NOC shift later that evening. 2. On February 14, 2023, all fire drills and required shifts were verified on the Direct Supply TELS monthly maintenance program to ensure drills are conducted. 3. Maintenance supervisor was educated on 2/14/2023 on the requirement of conducting a fire drill for each month in each quarter. The	2/14/23

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K 712	Continued From page 3 at the time of discovery.	K 712	Executive Director will audit each fire drill each month for 12 months to ensure the drill for the proper shift was completed. 4. The executive Director will monitor for compliance and the data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.	