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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: JKSG
Facility ID: 00650

1. MEDICARE/MEDICAID PROVIDER NO.(L 1) **245482**

2. STATE VENDOR OR MEDICAID NO. (L 2) **122343700**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRAIRIE MANOR CARE CENTER**
(L4) **220 THIRD STREET NORTHWEST**
(L5) **BLOOMING PRAIRIE, MN** (L6) **55917**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **5/19/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

x A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on 5/19/2016. Refer to CMS form 2567B.

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 6/6/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 6/6/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245482

June 6, 2016

Mr. Richard Feeney, Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, MN 55917

Dear Mr. Feeney:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 13, 2016 the above facility is certified for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.
Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112

An equal opportunity employer

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 2, 2016

Mr. Richard Feeney, Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, MN 55917

RE: Project Number S5482026

Dear Mr. Feeney:

On May 5, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 10, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on March 11, 2016, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on April 28, 2016. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 19, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on April 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 13, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed onMay 19, 2016 , as of May 13, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 13, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of May 5, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 11, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective June 10, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective June 10, 2016, is

to be rescinded.

In our letter of May 5, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 10, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 13, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
245482 (Y1)	(Y2)	5/19/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0247 Reg. # 483.15(e)(2) LSC	Correction Completed 05/13/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	6/2/2016	31221	5/19/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/11/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

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PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: JKSG
Facility ID: 00650

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245482**

2. STATE VENDOR OR MEDICAID NO. (L2) **122343700**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRAIRIE MANOR CARE CENTER**
(L4) **220 THIRD STREET NORTHWEST**
(L5) **BLOOMING PRAIRIE, MN** (L6) **55917**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/28/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Based on the PCR, it has been determined that the facility has not achieved substantial compliance pursuant to the March11, 2016 standard survey.
Refer to the CMS 2567 (For health), CMS 2567b for both health and life safety code.

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 05/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 5/12/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **05/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

May 5, 2016

Mr. Richard Feeney, Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, MN 55917

RE: Project Number S5482026

Dear Mr. Feeney:

On March 30, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 11, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 28, 2016, the Minnesota Department of Health and on April 13, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 11, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 19, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on March 11, 2016. The deficiency not corrected is as follows:

F0247 -- S/S: D -- 483.15(e)(2) -- Right To Notice Before Room/roommate Change

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective May 10, 2016. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new

admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 11, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 11, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 11, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, Prairie Manor Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 11, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

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

APPEAL RIGHTS

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:

Jan.Suzuki@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 Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 September 11, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING ______ B. WING ______	R 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	**220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on April 27 & 28, 2016. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected at the time of onsite PCR which are located on the CMS2567. 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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 247} SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure notification was given prior to a roommate change for 1 of 1 resident (R9) reviewed for admission, transfer and discharge. Findings Include: R9 had a new roommate move in to her room on 4/26/16. R9 and family were informed of the new roommate on 4/27/16, a day after the new	{F 247}	The staff at Prairie Manor Care Center respect the residents' rights to receive notice before the resident's room or roommate is changed. The staff is sensitive to the trauma that a move or change of roommate can cause a resident and attempt to be as accommodating as possible. The resident	5/13/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 5/12/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING ______ B. WING ______	R 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

(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 247}	Continued From page 1 roommate moved according to medical record review and social service interview. R9 ' s social service progress noted dated 4/27/16, included, " Should be noted that SS [social services] was out of the building on 4-26-16. [R9] did get a new roommate on 4-26-16. SS did inform [R9] and her family on 4-27-16 that she did [have a] new roommate and that the roommate would be moving [in] on 4-27-16 from her [previous] room. " On 4/27/16, at 12:36 p.m. social services (SS)-A stated R9 received a new roommate on 4/26/16. SS-A stated social services was out of the building and the facility did not inform R9 she was getting a new roommate until 4/27/16, when SS-A talked to her the day after the new roommate moved in. SS-A stated family was also notified on 4/27/16. SS-A stated the social service department will be implementing a system to ensure room change and new roommate notification are completed when social services is out of the building. The facility's policy Policy for Room Assignments dated 4/6/16 included: "1. Social Services will inform the resident and/or, if known, the resident's family member or legal representative when there is a change in room or roommate assignment. This notification will be documented."	{F 247}	is asked about his/her preferences which are then taken into account when discussing changes of rooms or roommates and the timing of such changes. When a resident is moved at the facility's request, an explanation of the reason for the move is provided. The resident is given the opportunity to see the new location, ask questions about the move, and meet the new roommate when possible. When a resident receives a new roommate, the resident is given as much notice and information about the new person as possible, while maintaining confidentiality regarding medical information. The facility provides support to a resident whose roommate has died, and whenever possible provides time for adjustment before moving another person into the room. The policy for notifying the resident, family/legal representative of changes in room/roommate and was reviewed and revised to include assignment of notification responsibilities when the social service staff is unavailable. A social services admission reference sheet has been developed and includes the task of notifying the resident of room changes and new roommates in a timely manner. A more detailed reference sheet listing the tasks for admitting a resident to the facility when the social service staff is not available to direct the admission process has also been developed. The task list includes notifying the resident and family/legal representative of room/roommate changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING ______ B. WING ______	R 04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

(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 247}	Continued From page 2	{F 247}	The Administrator counseled with the social service staff regarding the regulations and facility polices for timely notification of residents and families/legal representatives of room and roommate changes. The social workers participated to the policy and procedure developments/revisions and are aware of the requirements for timely notification of room and roommate changes. Resident number nine was satisfied with her new roommate. The roommate moved to another room the next day according to her preference. Resident number nine as well as all other residents will be informed in a timely manner of any subsequent changes in room or roommates. The nurse manager/designee will audit the records of residents changing rooms and getting new roommates for four weeks to verify that the residents received adequate notice prior to room/roommate changes initiated by the facility. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the quarterly Quality Assurance and Assessment Committee meeting. Completion date: May 13, 2016	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245482	A. Building B. Wing	4/28/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	Correction Completed 04/19/2016	ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	Correction Completed 04/19/2016	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 04/08/2016
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 04/19/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 04/19/2016	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 04/19/2016
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 04/19/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 04/19/2016	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 04/19/2016
ID Prefix F0334 Reg. # 483.25(n) LSC	Correction Completed 04/19/2016	ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 04/19/2016	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 04/19/2016
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 04/19/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	05/05/2016	31221	4/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/11/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245482	A. Building 02 - CHAPEL B. Wing	4/13/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0154	Correction Completed 04/05/2016	ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 04/05/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	05/05/2016	37008	4/13/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/10/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

May 5, 2016

Mr. Richard Feeney, Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, MN 55917

Re: Reinspection Results - Project Number S5482026

Dear Mr. Feeney:

On April 28, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 28, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
00650 (Y1)	(Y2)	4/28/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix 20302 Reg. # MN State Statute 144.6503 LSC	Correction Completed 04/19/2016	ID Prefix 20560 Reg. # MN Rule 4658.0405 Subp. 2 LSC	Correction Completed 04/19/2016	ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 04/19/2016
ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. 4 LSC	Correction Completed 04/19/2016	ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 04/19/2016	ID Prefix 20910 Reg. # MN Rule 4658.0525 Subp. 5 A.B LSC	Correction Completed 04/19/2016
ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. 1 LSC	Correction Completed 04/19/2016	ID Prefix 21426 Reg. # MN St. Statute 144A.04 Subd. 3 LSC	Correction Completed 04/19/2016	ID Prefix 21530 Reg. # MN Rule 4658.1310 A.B.C LSC	Correction Completed 04/19/2016
ID Prefix 21535 Reg. # MN Rule4658.1315 Subp.1 ABCD LSC	Correction Completed 04/19/2016	ID Prefix 21665 Reg. # MN Rule 4658.1400 LSC	Correction Completed 04/19/2016	ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 14 LSC	Correction Completed 04/19/2016
ID Prefix 21855 Reg. # MN St. Statute 144.651 Subd. 15 LSC	Correction Completed 04/19/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 5/5/2016	SIGNATURE OF SURVEYOR 31221	DATE 4/28/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/11/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: JKSG
Facility ID: 00650

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245482**

2. STATE VENDOR OR MEDICAID NO. (L2) **122343700**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRAIRIE MANOR CARE CENTER**
(L4) **220 THIRD STREET NORTHWEST**
(L5) **BLOOMING PRAIRIE, MN** (L6) **55917**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/11/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

__ 2. Technical Personnel	__ 6. Scope of Services Limit
__ 3. 24 Hour RN	__ 7. Medical Director
__ 4. 7-Day RN (Rural SNF)	__ 8. Patient Room Size
__ 5. Life Safety Code	__ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE
Justin Main, HFE NE II
Date : 04/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL
Kamala Fiske-Downing, Health Program Representative
Date: 04/25/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 30, 2016

Mr. Richard Feeney, Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, MN 55917

RE: Project Number S5482026

Dear Mr. Feeney:

On March 11, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 20, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 20, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 11, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 11, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING ______ B. WING ______	03/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	**220 THIRD STREET NORTHWEST** **BLOOMING PRAIRIE, MN 55917**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		4/19/16

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

Electronically Signed — 04/09/2016

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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	245482	A. BUILDING ______ B. WING ______	03/11/2016

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F 164 — Continued From page 1

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide privacy during a transfer from a resident's room to the shower room for 1 of 1 resident (R79).

Findings include:

R79 was observed in the left hall on 3/9/16 at 9:17 a.m. transported in a shower chair from her room to the shower room. R79 was wearing a long sleeved top and a bath blanket was draped over the shower chair. R79 was exposed on her bottom half from the waist down on both sides. A male resident was in the hallway and a female resident in the room across the hall was within full view of R79.

On 3/9/16 at 12:20 p.m. R79 was surprised to learn she was exposed in the hallway stating, "Oh really? Usually there is nobody in the hallway anyway. It's up to the nurse that brings you there [shower room] how covered up you are. As long as the most important parts are covered I guess that is what is important."

On 3/10/16 at 8:30 a.m. nursing assistant (NA)-F was interviewed via telephone and stated, "We have bath blankets and we do have to make sure they are covered up as much as possible. That

F 164 — Provider's Plan of Correction:

483.10(e) 483.75(l) (4) Tag F164

Prairie Manor Care Center staff respects the resident's right to personal privacy including accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings with family and resident groups.

The facility has policies and procedures appropriately addressing the residents' right to privacy and confidentiality. During the April 14 and 15, 2015 mandatory meeting, all staff were reminded of the state and federal regulations and facility policies addressing residents' privacy rights. The nurses and nursing assistants were counseled regarding being sensitive to care delivery practices that could compromise resident dignity. The supervisory nursing staff have been instructed to be observant of resident privacy during cares/transport and to counsel with the direct care staff if privacy rights are compromised.

Procedures to assure respect for the residents' privacy during personal cares

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F 164	Continued From page 2 [transporting R79] was a little more difficult, we are trying to order a new shower chair. I can't get it [bath blanket] tucked into the sides and I try to get as much covered up as I can. I guess I could try wrapping it around her top half around her shoulders." On 3/10/16 at 10:38 a.m. the director of nursing (DON) stated, "You want them [residents] to be covered up. I wouldn't expect areas to be showing." The DON verified R79's exposed sides from the waist down should have been covered up. The facility policy; Bath, Shower dated 6/4/09, included: "1. Place resident in shower chair and cover with appropriate drape."	F 164	were reinforced (e.g., closing doors, pulling divider curtains, covering residents when in view from common areas, knocking before entering, providing personal cares/treatments out of view of others). The residents' right to privacy, confidentiality, and dignified treatment is included in the orientation training for new employees and is addressed during the annual mandatory in-service training. Compliance will be monitored by the Director of Nurses or her designee. Weekly tours of the nursing care unit will be made for six weeks, if privacy/confidentiality problems are noted, additional monitoring and staff counseling will be done. Compliance will be further monitored by the social service staff through direct observation and resident interview. If noncompliance is noted, additional staff counseling will be done. Compliance will be reviewed during the April quarterly Quality Assurance and Assessment meeting.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F 225		4/19/16

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F 225	Continued From page 3 other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct an investigation of an allegation of abuse for 1 of 17 residents (R18) reviewed for abuse. Findings include: During a stage I interview with R39 on 3/8/16 at 10:22 a.m., R39 was asked whether he'd ever seen any other resident abused by staff. R39	F 225	Regulation 483.13(c) Tag F225 Staff Treatment of Residents Prairie Manor Care Center does not knowingly employ individuals who have been found guilty of abusing, neglecting, or mistreating residents. Any knowledge of actions against an employee which would indicate unfitness for service in a resident care position is investigated and	

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F 225	Continued From page 4 stated, "There is one guy that stayed here and he had this one girl, I think he got her pregnant." R39 stated the "guy" resided at the facility [R18]. R39 then stated the girl worked at the facility, "He was an outsider. He was here for a short time. He is still residing here. He got an employee pregnant here. She still works here. I told a nurse's aide about it. Well, she moved him down the hallway somewhere else. Well, that didn't help any and she still goes down to him." A social services (SS) progress note dated 1/7/16 addressed concerns reported by R39; "[R39] told the group [at a care conference meeting] about an incident that happen [sic] out in the day room. He said that [R18] was out there and there was 2 girls. One of the girls walked over and sat on his lap [sic] He said they were having a great time. He said the other girl just watched. He said the girl ran off and that was the last he saw of her. He chuckled when he talked about the incident. He said he was sure his eyes were not playing tricks on him because he was right there and saw it all. [R39] had brought this up to SS before. As far as Can [sic] tell this incident did not happen. [R39] has before accuse [sic] staff or other resident of having sex. [R39] had no other concerns for CC [care conference]. SS will continue to inform and invite [R39] and his family to CC with the goal they will attend and or express concerns. SS-A was interviewed on 3/8/16 at 3:25 p.m., SS-A stated she had not spoken with the R18 about the allegation that a girl had sat on his lap. SS-A stated, "I didn't because I didn't feel it was something that I needed to bring up with [R18]." SS-A also stated she had no other documentation regarding the episode that had been reported on 1/7/16 except for the progress note she'd	F 225	reported to the State nurse aid registry or licensing authorities. The facility's policies and procedures for investigation/reporting of incidents were reviewed and found appropriate. Prairie Manor Care Center policy requires that all alleged violations involving resident mistreatment, neglect, abuse, injuries of unknown source and misappropriation of property be 1) reported immediately to the administrator and appropriate state agencies and 2) thoroughly investigated in a timely manner with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action will be taken. The facility intervenes to prevent further potential abuse while the investigation is in process. On April 12 and 14, 2016 all Prairie Manor Care Center staff will be instructed on the following: 1) the definition of a vulnerable adult 2) who is a mandated reporter of actual or suspected resident abuse/neglect/misappropriation of property 3) the types of incidents that must be reported to the common entry point and/or the Minnesota Department of Health 4) the requirements of immediate reporting of alleged abuse/neglect and misappropriation of funds to the supervisory/administrative staff and appropriate governmental agencies and 5) forms and procedures for appropriate and timely reporting. The staff is educated on vulnerable adult issues at least every	

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F 225	Continued From page 5 documented in the medical record. When asked whether she had reported the allegation to the administrator, Office of Health Facility Complaints (OHFC), or whether she'd initiated an investigation, SS-A verified she hadn't. The director of nursing (DON) was interviewed on 3/8/16 at 4:06 p.m., and questioned about whether or not the allegation reported 1/7/16 by R39 (regarding R18) had been reported in accordance with facility policy. The DON stated they hadn't determined R39's report from 1/7/16 to be a reportable event, but stated they would report now. When interviewed on 3/8/16 at 5:08 p.m., social services (SS)-A stated that she had no idea who the alleged girls R39 said he saw sitting on R18's lap were. She stated that R39 had said he'd never seen them before. When interviewed on 3/8/16 at 6:13 p.m. the administrator, DON, SS-A were present when the administrator stated that R18 could make his own decisions and stated, "Who knows who those girls were, they could have been anyone...it could have been his granddaughters, how do we know?" When interviewed on 3/9/16 at 9:18 a.m., the administrator stated the allegation of potential sexual abuse for R18 should have been more thoroughly investigated. However, he reiterated there was nothing in the SS progress note 1/7/16 regarding R39's allegation that indicated any inappropriate behavior had taken place. The administrator stated since there was nothing about lewd behavior, they hadn't thought the incident was reportable.	F 225	twelve months; vulnerable adult investigation and reporting are addressed during new employee orientation. At the time Resident Number 39 alleged that there were girls sitting on the lap of Resident Number 18 in the day room (a common area frequently occupied by other residents and visitors), the social worker assessed the situation and determined there was no abuse to Resident Number 18. Resident Number 39 had previously accused the staff and other residents of sexual behaviors, and since there was no additional evidence that this incident had occurred as reported, it was felt to be a false allegation and a report was not submitted to the Office of Health Facility Complaints (OHFC). After discussion with the state surveyors, a report was made to the OHFC March 8, 2016 regarding possible abuse. The federal auditor did not support the state surveyor's request to file a vulnerable adult report and instructed the lead state surveyor to "take this back to your team for another review." The March 9, 2016 OHFC response indicated that no further action was needed by their office. During the Social Worker's March 9, 2016 interview with Resident Number 18 regarding possible sexual mistreatment, he denied being mistreated by the staff or others. He stated that he "has been treated find here and is very satisfied here. The care plan for Resident Number 39 was updated to address the resident's regular habit of making unsubstantiated allegations about other residents being	

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F 225	Continued From page 6 An investigative report, dated 3/9/16, indicated that the facility did follow up with R18 regarding the abuse allegation which had allegedly occurred on 1/7/16. The 3/9/16 report indicated R18 had denied any sexual abuse. The Facility Abuse Prevention Plan Policy/Procedure (11/12/15), included: "All reports of suspected abuse are reported immediately according to current regulation. The Administrator is immediately notified of all reports. All reports of suspected abuse are investigated promptly under the direction of the Administrator. Social Services and the Director of Nursing will work closely together on these investigations. All interviews will be appropriately documented and maintained with investigated reports...the investigating team or Designee shall thoroughly investigate the complaint, determining whether it is true or false or not possible to substantiate or disprove through interviews and examination with involved parties...Any person with the knowledge or suspicion of suspected violations shall report immediately..."	F 225	abused by the staff. Allegations by Resident Number 39 will continue to be investigated to ensure that no resident is being mistreated. Compliance with the facility's vulnerable adult policies and procedures and related regulatory requirements will be monitored by both social workers for the next three months. The social workers will collaborate in the investigation of all alleged incidents that have a possible risk of sexually-related resident abuse. All incidents of alleged sexually inappropriateness will also be discussed with the Administrator and/or Director of Nurses and an interdisciplinary decision will be made whether the incident is reportable to the Office of Health Facility Complaints. Compliance will be reviewed during the April Quality Assurance and Assessment Committee quarterly meeting and ongoing.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 226	Regulation 483.13(c) Tag F226	4/8/16

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facility failed to implement their policies for reporting and investigation related to an allegation of abuse for 1 of 17 residents (R18) reviewed for abuse.

Findings include:

The Facility Abuse Prevention Plan Policy/Procedure (11/12/15), included: "All reports of suspected abuse are reported immediately according to current regulation. The Administrator is immediately notified of all reports. All reports of suspected abuse are investigated promptly under the direction of the Administrator. Social Services and the Director of Nursing will work closely together on these investigations. All interviews will be appropriately documented and maintained with investigated reports...the investigating team or Designee shall thoroughly investigate the complaint, determining whether it is true or false or not possible to substantiate or disprove through interviews and examination with involved parties...Any person with the knowledge or suspicion of suspected violations shall report immediately..."

During a stage I interview with R39 on 3/8/16 at 10:22 a.m., R39 was asked whether he'd ever seen any other resident abused by staff. R39 stated, "There is one guy that stayed here and he had this one girl, I think he got her pregnant." R39 stated the "guy" resided at the facility [R18]. R39 then stated the girl worked at the facility, "He was an outsider. He was here for a short time. He is still residing here. He got an employee pregnant here. She still works here. I told a nurse's aide about it. Well, she moved him down the hallway somewhere else. Well, that didn't help any and she still goes down to him."

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Staff Treatment of Residents

Prairie Manor Care Center has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures address the seven following components: screening, training, prevention, identification, investigation, protection and reporting/response.

Prairie Manor Care Center staff recognize and respect each resident’s right to be free from mistreatment and misappropriation of property and does all that is within their control to prevent such occurrences. The staff 1) identifies residents who are at risk for abuse, neglect and/or misappropriation of property as well as those at risk of abusing others 2) develops intervention strategies to prevent occurrences and 3) continually reassesses the effectiveness of the interventions.

The policies, procedures, and forms for identifying, reporting and internally investigating incidents were reviewed and found appropriate. During the mandatory staff meetings April 12 and 14, 2016 the Vulnerable Adult Awareness and Prevention Plan will be reviewed and the staff will be instructed on: 1) the definition of a vulnerable adult 2) who is a mandated reporter of actual or suspected resident abuse/neglect/ misappropriation of property 3) the types of incidents that

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F 226 Continued From page 8

A social services (SS) progress note dated 1/7/16 addressed concerns reported by R39; "[R39] told the group [at a care conference meeting] about an incident that happen [sic] out in the day room. He said that [R18] was out there and there was 2 girls. One of the girls walked over and sat on his lap [sic] He said they were having a great time. He said the other girl just watched. He said the girl ran off and that was the last he saw of her. He chuckled when he talked about the incident. He said he was sure his eyes were not playing tricks on him because he was right there and saw it all. [R39] had brought this up to SS before. As far as Can [sic] tell this incident did not happen. [R39] has before accuse [sic] staff or other resident of having sex. [R39] had no other concerns for CC [care conference]. SS will continue to inform and invite [R39] and his family to CC with the goal they will attend and or express concerns.

SS-A was interviewed on 3/8/16 at 3:25 p.m., SS-A stated she had not spoken with the R18 about the allegation that a girl had sat on his lap. SS-A stated, "I didn't because I didn't feel it was something that I needed to bring up with [R18]." SS-A also stated she had no other documentation regarding the episode that had been reported on 1/7/16 except for the progress note she'd documented in the medical record. When asked whether she had reported the allegation to the administrator, Office of Health Facility Complaints (OHFC), or whether she'd initiated an investigation, SS-A verified she hadn't.

The director of nursing (DON) was interviewed on 3/8/16 at 4:06 p.m., and questioned about whether or not the allegation reported 1/7/16 by R39 (regarding R18) had been reported in

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must be reported to the common entry point and/or the Minnesota Department of Health 4) timely reporting of incidents 5) the policies and procedures for communicating/documenting resident concerns/incidents and 6) internal reporting of vulnerable adult issues. The staff are educated on vulnerable adult issues at least every twelve months and vulnerable adult reporting and investigation are addressed during new employee orientation.

At the time Resident Number 39 alleged that there were girls sitting on the lap of Resident Number 18 in the day room (a common area frequently occupied by other residents and visitors), the social worker assessed the situation and determined there was no abuse to Resident Number 18. Resident Number 39 had previously accused the staff and other residents of sexual behaviors, and since there was no additional evidence that this incident had occurred as reported, it was felt to be a false allegation and a report was not submitted to the Office of Health Facility Complaints (OHFC). After discussion with the state surveyors, a report was made to the OHFC March 8, 2016 regarding possible abuse. The federal auditor did not support the state surveyor's request to file a vulnerable adult report and instructed the lead state surveyors to "take this back to your team for another review." The March 9, 2016 OHFC response indicated that no further action was needed by their office.

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F 226	Continued From page 9 accordance with facility policy. The DON stated they hadn't determined R39's report from 1/7/16 to be a reportable event, but stated they would report now. When interviewed on 3/8/16 at 5:08 p.m., social services (SS)-A stated that she had no idea who the alleged girls R39 said he saw sitting on R18's lap were. She stated that R39 had said he'd never seen them before. When interviewed on 3/8/16 at 6:13 p.m. the administrator, DON, SS-A were present when the administrator stated that R18 could make his own decisions and stated, "Who knows who those girls were, they could have been anyone...it could have been his granddaughters, how do we know?" When interviewed on 3/9/16 at 9:18 a.m., the administrator stated the allegation of potential sexual abuse for R18 should have been more thoroughly investigated. However, he reiterated there was nothing in the SS progress note 1/7/16 regarding R39's allegation that indicated any inappropriate behavior had taken place. The administrator stated since there was nothing about lewd behavior, they hadn't thought the incident was reportable. An investigative report, dated 3/9/16, indicated that the facility did follow up with R18 regarding the abuse allegation which had allegedly occurred on 1/7/16. The 3/9/16 report indicated R18 had denied any sexual abuse.	F 226	Compliance with the facility's vulnerable adult policies and procedures and related regulatory requirements will be monitored by both social workers for the next three months. The social workers will collaborate in the investigation of all alleged incidents that have a possible risk of sexually-related resident abuse. All incidents of alleged sexually inappropriateness will also be discussed with the Administrator and/or Director of Nurses and an interdisciplinary decision will be made whether the incident is reportable to the Office of Health Facility Complaints. Compliance will be reviewed during the April Quality Assurance and Assessment Committee quarterly meeting and ongoing.	
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE	F 247		4/19/16

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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 247	Continued From page 10 A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure notification was given prior to a roommate change for 1 of 2 residents (R39) reviewed for admission, transfer and discharge. Findings include: On 3/8/16 at 10:35 a.m. R39 stated he was not given notice of a change in roommate. On 3/11/16 at 8:53 a.m. R39 added, "I didn't know anything about my last roommate he just showed up. I wasn't told by anyone that he was coming." R39's significant change Minimum Data Set dated 12/25/15 identified R39 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated R39 had intact cognition. On 3/10/15 at 2:00 p.m. social services (SS)-A stated, "We don't document it [informing of roommate change] every time that we tell them [residents]. We usually just stop in and tell them that morning they are getting a new roommate. I can't guarantee that we document that it is done every time." The facility's policy Policy for Room Assignments dated 10/19/11 included: "1. Social Services will inform the resident and/or, if known, the resident's family member or legal representative when there is a change in room or roommate assignment."	F 247	Regulation 483.15(e)(2) Tag F247 Notice Before Room/Roommate Change The staff at Prairie Manor Care Center respect the residents' right to receive notice before the resident's room or roommate is changed. The staff is sensitive to the trauma that a move or change of roommate can cause a resident and attempt to be as accommodating as possible. The resident is asked about his/her preferences which are then taken into account when discussing changes of rooms or roommates and the timing of such changes. When a resident is moved at the facility's request, an explanation of the reason for the move is provided. The resident is given the opportunity to see the new location, ask questions about the move, and meet the new roommate when possible. When a resident receives a new roommate, the resident is given as much notice and information about the new person as possible, while maintaining confidentiality regarding medical information. The facility provides support to a resident whose roommate has died, and whenever possible provides time for adjustment before moving another person into the room.	

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F 247	Continued From page 11	F 247	The policy for room change notification and documentation was reviewed and revised to include the documentation of the notification of changes in room and roommate. The social workers participated to the policy revision and are aware of the need to document when residents are notified of room changes and new roommates. Resident number 39 was interviewed by the social worker and was satisfied with his roommate; they are conversant with each other. The resident will be informed in a timely manner of any subsequent change in room or roommates. The nurse manager/designee will audit the records of residents changing rooms and getting new roommates for four weeks to verify that the residents received adequate notice prior to room/roommate changes initiated by the facility. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the quarterly Quality Assurance and Assessment Committee meeting.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279		4/19/16

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plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to care plan missing teeth for 1 of 3 residents (R75) reviewed for dental status.

Findings include:

R75 was observed on 3/7/16 at 6:26 p.m., to have missing teeth on the lower gum line.

On 3/10/16, at 7:50 a.m. licensed practical nurse (LPN)-A observed R75's teeth and verified R75 had missing teeth towards the front and on the left side of lower gum line.

The Nursing Admission Assessment for R75, dated 1/19/16, identified oral/dental: missing teeth, top partial and noted: has own teeth on bottom and partial uppers.

F 279

Tag F279 – Comprehensive Care Plans

Prairie Manor Care Center uses the results of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident's needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents' right to refuse cares/services.

The care plan related policies/procedures and the staff responsibilities for development and revision of the

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F 279	Continued From page 13 R75's care plan printed 3/11/16, identified a problem area related to dental status. "requires assistance with providing dental care." Interventions included for staff to make sure "dentures are in mouth and cleaned prior to meals. Remove, clean, and soak dentures every bedtime. Last dental appointment 2015. Provide oral hygiene with a.m. (morning) cares, p.m. (evening) cares, and as needed. Resident has upper dentures and own lower teeth. Will continue to offer/encourage a dental appointment per facility policy." The care plan did not indicate R75 had missing teeth. On 3/10/16 at 12:31 p.m., registered nurse (RN)-A verified R75's care plan failed to include missing teeth. On 3/10/16 at 1:00 p.m., the director of nursing stated she would expect missing teeth to be identified on R75's care plan. The facility's policy, Care Plan Policy dated 8/13/13, indicated a care plan would be developed for each resident identifying the needs of the individual resident. Each resident care plan will address every specific area of care for each resident.	F 279	comprehensive plans of care were reviewed and updated. At the time of admission, a temporary care plan is implemented that addresses the residents' need for assistance with activities of daily living; the interdisciplinary care plan is developed within seven days after completion of the comprehensive assessment. As part of the quarterly care conference process, the interdisciplinary team reviews the care plans for completeness, accuracy, and relevancy. During the mandatory meetings April 14 and 15, 2016, the nursing staff will be reminded 1) of the facility policies for care plan reviews and updates 2) that the residents' care plans must be current at all times and 3) that care plans must continue to address the residents' dental condition and any dental care needs. A registered nurse assessed the oral cavity and dentition of resident number 75. The care plan was updated to reflect that the resident has missing teeth. Compliance will be monitored by the MDS Coordinator. For the next three months, if dental problems identified during the routine oral assessments or triggered on the minimum data set screening tool, the care plan will be reviewed to ensure that the resident's dental status/condition is appropriately addressed. If noncompliance is noted, additional staff training and auditing will be done. Compliance will be reviewed at the April	

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F 279	Continued From page 14	F 279	quarterly Quality Assurance and Assessment Committee meeting.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise the care plan to include skin interventions to promote healing and prevent breakdown of skin for 1 of 1 resident (R27) reviewed for pressure ulcers; failed to revise the care plan to include risk for bruising for 1 of 3 residents (R27) reviewed for skin conditions; failed to revise a care plan for 1 of 1 resident (R38) reviewed for contractures; and	F 280	Regulation 483.20 (d)(3) 483.10(k)(2) Tag F280 Comprehensive Care Plans Prairie Manor Care Center staff develop comprehensive care plans within seven days after the completion of the comprehensive assessment. Care plans are prepared by an interdisciplinary team,	4/19/16

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F 280	Continued From page 15 failed to revise the plan of care for 1 of 1 resident (R39) who demonstrated delusional behaviors and who made frequent inaccurate allegations about other residents being abused. Findings include: LACK OF INTERVENTION/S FOR "SPONGY HEELS:" R27's care plan printed 3/11/16, identified the following: Resident is at risk for skin breakdown related to history of intragluteal ulcer right inner buttock and spongy heels. Interventions included: Apply vanicream to dry skin areas with cares AM (morning) and PM (evening), report any red or very dry skin areas to nurse, barrier cream to peri-area after all incontinent episodes, bilateral heel cups on while in bed, dressing change to coccyx as ordered PRN (as needed), and use of a medication to alleviate itching. Monitor for effectiveness and side effects, pressure relieving device: Advantage contour mattress on bed and panacea in wheelchair, skin assessment, Braden scale quarterly and PRN (as needed), skin tolerance testing annually, with readmission and PRN, turn and reposition every 2 hours while in bed, turn side to side as much as possible, and reposition when in chair every 2 hours. A progress note dated 2/5/16, indicated R27 had the following: wound note, assessed residents heels. Heels are spongy and soft to the touch. Left is spongier than the right. Shoes are removed during the day while in recliner. However, this intervention was not added to the current comprehensive care plan. On 3/9/16, at 12:41 p.m., nursing assistant (NA)-B and nursing assistant (NA)-C were	F 280	which includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance the residents' functional abilities and quality of life. The residents and their families/legal representative are encouraged to participate in the care planning process and the quarterly care conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each quarterly assessment and more often as necessary. The care plan policies and procedures were reviewed and updated. During the April 14 and 15, 2016, mandatory meetings, the nursing staff will be 1) informed of the regulatory requirement that the residents' care plans be current at all times 2) reinstructed on the facility policies for care plan reviews and updates and 3) reminded of the importance of addressing the following in the plan of care: resident behaviors including false allegations about other residents/staff, risk of bruising, contractures, and skin related interventions to promote healing/prevent breakdown. Resident number 27 – A registered nurse reassessed the resident's skin-related plan of care. The intervention to remove the resident's shoes while the resident is in the recliner to prevent skin breakdown on the resident's heels was added to the	

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observed to transfer R27 to his recliner using an EZ stand mechanical lift. NA-C elevated R27's feet in the recliner, placed R27's call light within reach and walked out of R27's room without removing R27's shoes.

On 3/9/16, at 12:45 p.m. NA-C confirmed R27's shoes had been left on while R27 sat in the recliner. NA-C and NA-B stated they were not aware R27's shoes were to be removed when R27 was sitting in the recliner. NA-C stated they had care sheets they followed for resident care. NA-C and NA-B reviewed R27's care sheet and verified the care sheet failed to indicate R27's shoes were to be removed during the day while he sat in the recliner.

On 3/10/16, at 9:47 a.m. registered nurse (RN)-C stated removing R27's shoes when in the recliner had been implemented some time ago. RN-C stated the nursing assistants should have been aware R27's shoes were to be removed when he sat in the recliner however, when RN-C reviewed R27's care plan she verified the care plan had not been revised to include the removal of R27's shoes during the day while in the recliner. RN-C stated she did not know why the intervention had not been added to the care plan and stated, "I should have caught that."

On 3/10/16 at 12:51 p.m., the director of nursing (DON) stated she would have expected R27's care plan to be revised to include removal of his shoes during the day when in the recliner, and would have expected the nursing assistant kardex to be updated.

LACK OF IDENTIFYING RISK OF BRUISING AND INTERVENTIONS IF OBSERVED:

F 280

plan of care and the nursing assistant care instruction Kardex. The care plan has been updated to address the resident's risk of bruising, interventions to prevent bruising, and interventions to implement if bruising is identified. Skin monitoring by the direct care staff and charge nurses is part of the weekly bathing process.

Resident number 38 – A registered nurse reviewed the resident's care plan. A focus statement was added addressing the resident's right-hand contractures and refusal of related interventions.

Resident number 39 – A registered nurse and social worker reviewed the resident's plan of care. The care plan was revised to include a focus statement addressing the resident's regular habit of making unsubstantiated allegations about other residents being abused by the staff, related resident goals, and interdisciplinary interventions to address the behaviors/allegations. Allegations will continue to be investigated to ensure that no resident is being abused. Significant escalations in behavior will be reported to the resident's attending physician.
To monitor compliance the MDS Coordinator will audit the care plans for completeness and accuracy for residents who have open skin areas, contractures, and are receiving medications such as aspirin, Coumadin or prednisone, or have other risk factors that increase the risk of bruising. The social worker will audit the care plans of residents who are receiving

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F 280	Continued From page 17 R27 was observed on 3/7/16, at 6:42 p.m. to have a purple bruise on top of his left hand. On 3/8/16, at 2:54 p.m., R27 was observed to be sitting in a recliner in his room. The purple bruised area was observed on R27's left hand, and another purple colored bruise was noted above R27's left elbow. R27's quarterly Minimum Data Set dated 12/17/15 identified diagnoses of dementia, polymyalgia rheumatic and atrial fibrillation. R27's physician orders dated 1/19/16, identified an order for prednisone 5 mg (milligrams) one time a day (corticosteroids, side effect; thinning of the skin) and aspirin 81 mg one time a day. R27's medication administration record, dated 3/16 identified R27 received the medications daily as ordered. R27's incident reports identified the following: 1/2/16, multiple bruises on both upper arms, many areas identified as blue in color. 1/6/16, new bruises on right elbow and two on bicep. 2/12/16 resident has a bruise on his right hand. 2/20/16 resident has a bruise on his left side upper lip. 3/3/16, bruises reported on top of left hand and left elbow. Resident known to be combative and resistive with cares at times and is prone to bruising. Does use EZ stand mechanical lift for transfers. Resident unable to verbalize how bruising may have occurred. R27's care plan was reviewed and did not include a problem area related to R27's risk for bruising,	F 280	psychotropic medications to ensure that related behaviors are addressed. If care plan omissions or inaccuracies are identified, additional care plan audits and staff training will be done. During the interdisciplinary care conferences (conducted at least quarterly and with significant change in the resident's condition), the care plans will continue to be reviewed to assure the plans accurately reflect the resident's condition and the care and services needed/provided. Compliance will be reviewed during the April Quality Assessment and Assurance Committee quarterly meeting.	

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interventions to prevent bruising, nor interventions to implement if bruising was identified.

On 3/10/16 at 12:41 p.m., registered nurse (RN)-A verified the risk of bruising had not been included on R27's care plan. RN-A stated they try to find the source that caused the bruising, but verified they had not implemented interventions to prevent bruising.

On 3/11/16, the director of nursing (DON) acknowledged the risk for bruising should have been added to R27's care plan.
LACK OF CURRENT STATUS FOR RIGHT HAND CONTRACTURE INTERVENTIONS:

R38's care plan dated 1/30/16, included diagnosis of primary generalized osteoarthritis. Interventions related to the osteoarthritis diagnosis included, "Staff will place rolled up wash cloth in resident's right hand r/t [related to] contractures, to aid with decreasing pain as resident allows."

A restorative nursing Progress Note dated 7/8/15 indicated the resident had been non-compliant with trailing of hand splint/palm roll to the right hand. The note indicated the resident's non compliance had to do with R38 routinely holding her hand in a closed fist position.

On 3/9/16 at 11:58 a.m., licensed practical nurse (LPN)-B stated, "She [R38] can't open her right hand, it's contracted. We tried doing exercises, applying a brace and using a rolled washcloth but she did not tolerate it. We tried doing the exercises but she can get easily combative."

On 3/11/16 at 8:57 a.m. the director of nursing

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F 280	Continued From page 19 (DON) stated, "I don't see the issue identified anywhere in the care plan except for her experiencing pain with the use of a rolled washcloth." The DON verified the care plan had not been updated to reflect R38's current contracture status with her right hand and refusal of interventions. LACK OF CARE PLANNED BEHAVIORAL INTERVENTIONS: R39's admission record dated 5/12/15, indicated the resident had diagnoses including anxiety disorder and unspecified dementia without behavioral disturbance. R39's Minimum Data Set (MDS) dated 12/30/15, indicated R39 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. In addition, the MDS noted R39 had experienced no behaviors. R39's PHQ-9 (a patient health questionnaire used as a tool to monitor the severity of depression) identified a score of 11, which indicated the resident had mild depression. According to the documentation, R39 had stated on the PHQ-9 that he felt down, depressed or hopeless; and that he felt bad about himself. R39's care plan (no date), indicated he had suffered a chronic/progressive decline in intellectual functioning characterized by memory deficit, judgment, decision making and thought processes related to short term memory loss and dementia. The care plan indicated that if R39's confusion increased suddenly, staff were to assess and evaluate whether there were any signs or symptoms of infection, or any other medical problems. R39's care plan identified the resident at being a low to medium risk of being	F 280		

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abused. Interventions indicated R39 was encouraged to report any concerns related to abuse/neglect to social services, nursing and/or appropriate outside agency. However, the care plan did not address the resident's regular habit of making accusations about other residents being abused by staff which occurred over the past six months, which had been unsubstantiated.

During a stage I interview with R39 on 3/8/16 at 10:22 a.m., R39 was asked whether he'd ever seen any other resident abused by staff. R39 stated, "There is one guy that stayed here and he had this one girl, I think he got her pregnant." R39 stated the "guy" resided at the facility [R18]. R39 then stated the girl worked at the facility, "He was an outsider. He was here for a short time. He is still residing here. He got an employee pregnant here. She still works here. I told a nurse's aide about it. Well, she moved him down the hallway somewhere else. Well, that didn't help any and she still goes down to him."

When interviewed on 3/8/16 at 11:00 a.m., the director of nursing (DON) stated R39 had thought the employee whom he had referred to during interview was his own girlfriend. The DON explained that R39 thought the employee was having an affair with another staff member. She stated the last time R39 had acted this way he'd been diagnosed with a urinary tract infection (UTI) and that once it had been treated, the behaviors had stopped. The DON stated this had happened twice in the past. The DON also stated the employee in question was an evening shift nursing assistant that R39 had picked as his girlfriend. The DON explained that there was also a male nursing assistant working at the facility,

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and that when R39 saw those two nursing assistants talking, R39 would get upset. The DON stated social service staff had spoken with R39 and the female nursing assistant, and the DON had spoken with the male nursing assistant, and they'd been unable to substantiate any of R39's allegations.

When interviewed on 3/9/16 at 12:11 p.m., R39 stated that one day he was in the dayroom watching television in the carpeted area. He described the lighting as dark with no lights on. He stated "these girls" came in the area "from the outside" and one of the girls sat on R18's lap and started "loving him up." R39 stated he did not think it was a family member. R39 stated then the girls ran off after that. He described the girls as "grown up."

When interviewed on 3/8/16 at 3:25 p.m., Social services (SS)-A stated R39's behaviors began back in October (2015). She stated the behaviors appeared to correlate with the advent of a urinary tract infection and that nursing was notified when behaviors appeared, and they tracked for any infections.

When interviewed on 3/8/16 at 3:59 p.m., licensed practical nurse (LPN)-C confirmed R39 had a urinary tract infection in January 2016 and at that time thought he was in a relationship with a staff member. LPN-C stated she'd thought R39's behaviors had ended. In addition, LPN-C stated the nursing staff thought perhaps R39 had been experiencing delusions. LPN-C stated R39 did get a lot of urinary tract infections.

When interviewed on 3/9/16 at 9:18 a.m., the administrator stated that R39's behaviors should

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F 280	Continued From page 22 have been care planned. He stated that there were instances of R39's behaviors which should have been investigated more. When interviewed on 3/9/16 at 11:00 a.m., SS-A stated a problem related to R39's behaviors of making allegations about other residents being sexually abused should have been care planned. She stated that she would initiate training for the staff which included reporting abuse allegations. When interviewed on 3/9/16 at 2:34 p.m., registered nurse (RN)-A stated that social services had been aware of R39's behaviors. She also stated R39 would usually wait for a care conference meeting to bring up any issues, that the nursing assistants would normally report when R39 was experiencing behaviors. RN-A stated she was aware of one episode the DON had investigated that had been reported by R39. The facility's policy, Care Plan Policy dated 8/13/13, included: "...A care plan will be developed for each resident identifying the needs of each individual resident. Each resident care plan will address every specific area of care for each resident. The care plan will be reviewed and updated from the nurse manager quarterly, annually, and with a significant change. The care plan will be updated from a registered nurse with any changes in resident care as needed..."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		4/19/16

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F 282	Continued From page 23	F 282		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to implement care plan interventions for repositioning for 1 of 1 resident (R27) reviewed for pressure ulcers; and failed to monitor and report skin changes for 1 of 3 residents (R77) reviewed with non-pressure related skin concerns (bruising).

Findings include:

LACK OF REPOSITIONING ACCORDING TO THE COMPREHENSIVE CARE PLAN:

R27's care plan, print date 3/11/16, identified the following: Resident is at risk for skin breakdown related to history of intragluteal ulcer right inner buttock and spongy heels. Intervention of reposition when in chair every two hours.

R27 was observed continuously on 3/9/16, from 9:55 a.m. until 12:27 p.m., (a total of 2 hours and 32 minutes), in which R27 had not been repositioned. At 9:55 a.m., nursing assistant (NA)-B and NA-C were observed to transfer R27 from the toilet back into his wheelchair using an EZ stand mechanical lift. R27 was observed to have a red, shiny, open area noted on his left buttock. NA-C confirmed R27 had an open area on his left buttock and applied barrier cream to R27's buttock. At 10:03 a.m., R27 remained sitting in his wheelchair in his room. WAS CREAM APPLIED after he transfered back to his w/c???
10:12 a.m., R27 remained sitting in his wheelchair in his room. At 10:25 a.m., NA-C

Tag F282 Services by Qualified Personnel per Care Plan

Prairie Manor Care Center provides services that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each resident's written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes modifications as necessary.

The facility has policies and procedures for developing individualized plans of care and communicates the plan to the direct care givers by use of the nursing assistant care instruction Kardex. The care plan policies and procedures were reviewed and revised.

During the April 14 and 15, 2016, mandatory meetings, the nursing staff will be reminded/instructed 1) that the residents' plans of care must be followed 2) that repositioning residents according to their plan of care is essential to preserve skin integrity and prevent/treat

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F 282	Continued From page 24 entered R27 room, shut off R27 television and asked R27 if he would like to go to brunch. NA-C then assisted R27, who remained sitting in his wheelchair, to the dining room. 10:40 a.m., R27 remained sitting in his wheelchair in the dining room. At 10:50 a.m., R27 remained sitting in his wheelchair in the dining room. At 11:05 a.m., R27 remained sitting in his wheelchair in the dining room. NA-B was observed to sit next to R27 at the dining room table and assisted R27 with eating. At 11:36 a.m., R27 remained sitting in his wheelchair in the dining room. NA-B continued to assist R27 with eating. At 11:50 a.m., NA-B was observed to assist R27 from the dining room back to R27's room. R27 remained sitting in his wheelchair. NA-B placed R27's call light within reach, turned on R27's television and stated to R27 I will be right back, in just a few minutes. At 12:05 p.m., R27 remained sitting in his wheelchair in his room. Registered nurse (RN)-C entered R27's room to look at R27's right arm, which had a dressing in place. R27 remained sitting in his wheelchair. At 12:09 p.m., R27 remained sitting in his wheelchair in his room, 12:18 p.m., R27 remained sitting in his wheelchair in his room. 12:25 p.m., R27 remained sitting in his wheelchair in his room, 12:27 p.m., NA-B and NA-C entered R27's room with an EZ stand mechanical lift and transferred R27 from his wheelchair to the toilet. R27's left side buttock area was purple in color, blanchable and the open area looked dry. On 3/9/16, at 12:45 p.m., NA-C stated R27 was to be repositioned every two to three hours. NA-C stated they had care sheets they follow for resident cares. NA-C reviewed R27's care sheet and verified the care sheet read reposition when	F 282	pressure ulcers and 3) that job performance expectations include being aware of and following the resident's plan of care including timely repositioning. The orientation for new employees will continue to address the importance of following the resident's plan of care for activities of daily living including assistance with repositioning. Resident number 27 – A registered nurse reviewed the resident's skin condition and skin-related plan of care; every two-hour repositioning remains appropriate. The nursing assistants have been reminded of the residents of the need for every two-hour repositioning and the policy for referring to the care Kardex for the resident's repositioning plan of care. Resident number 77 – The lesions on the top of the resident's right hand were assessed by a nurse on March 9, 11, and 13. The plan of care included applying antibiotic ointment to the affected area. The resident was discharged March 18, 2016 to another long term care facility to be closer to her family. Compliance with timely repositioning for residents with mobility dependencies will be monitored by the charge nurses through observation of the direct care staff. Resident care observations will be assigned by the Director of Nurses/designee for two weeks. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the	

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F 282	Continued From page 25 in chair every two hours (not three hours as previously stated). NA-B stated she was aware R27 was to be repositioned every two hours. On 3/10/16, at 12:41 p.m., registered nurse (RN)-A stated she would expect the care plan to be followed for repositioning every two hours, because R27's skin is so fragile. We will continue to reposition R27 every two hours even though R27 is healed in reference to an open area on left buttock at this time. On 3/10/16, at 12:51 p.m., the director of nursing (DON) stated she would expect R27 to be repositioned every two hours if that was care planned for R27, or somewhere in the close vicinity of two hours. NON-PRESSURE RELATED SKIN CONDITION: R77 was observed on 3/7/16, at 3:10 p.m., revealed a lesion on the back of R77's right hand, approximately one centimeter in size. The lesion was covered in a dark brown crust, with no red skin surrounding the area. Observations on 3/8/16, at 8:30 a.m., and 3/9/16, at 11:20 a.m., revealed the lesion remained same on back of right hand. R77 was admitted to the facility on 2/15/16 with diagnosis that included hemiplegia, hemiparesis, and dysphagia following cerebral infarction, according to facility admission record. The facility identified R77 on the body audit dated 2/15/16, with rash in groin and on left arm, bruise on left shin, and open area on right knee. There was no indication of lesion on back of right hand. Facility care plan print date of 3/9/16, directed staff a focus of required assistance with bathing. Interventions included skin integrity will be	F 282	April quarterly Quality Assurance and Assessment Committee meeting.	

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F 282	Continued From page 26 monitored weekly on bath day and as needed, report any changes, problems or redness to nursing. Document review of nursing assistant kardex, printed 3/9/16, directed staff skin integrity will be monitored weekly on bath day and as needed, report any changes, problems, redness to nursing. Although nursing assistant documentation identified the lesion on 3/5/16, there was no further evidence of monitoring and reporting the lesion to nursing. Document review of facility progress notes dated 2/26/16 to 3/8/16, revealed the following: 2/26/16-quarterly skin risk assessment-at high risk for skin breakdown, required extensive to total assist with cares, transferred by mechanical lift, did not ambulate, foley catheter in place, had pink folds at times, reposition every one to two hours sitting and lying. Monitor skin daily with cares, weekly with bath, and as needed. 2/29/16-shower this morning with no new bruising or skin tears. 3/7/16-had shower and weekly skin check this shift. No new skin issues at this time. Document review of facility incident report log dated 3/1/16 to 3/6/16, revealed no identification of R77's skin lesion. During interview on 3/9/16, at 12:15 p.m., nursing assistant (NA)-G stated she had became aware of R77's hand lesion on 3/7/16. NA-G	F 282		

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F 282	Continued From page 27 stated she did not know how the lesion occurred. During interview at that time, NA-D stated was aware of the lesion today, 3/9/16. NA-D stated would document on the lesion and notify the nurse. During interview on 3/9/16, at 12:17 p.m., licensed practical nurse (LPN)-B stated was not aware of the lesion. During interview at that time, NA-D stated when staff discover a non-pressure related area, staff are to document in the memo book and give the white page of the carbon copy to the nurse. Document review of the memo book at that time with NA-D, revealed the lesion was identified on 3/5/16, as "sore on top of right hand." Document review revealed progress note dated 3/9/16, at 4:22 p.m., "Staff reported sore to resident's right hand." Two areas were identified as dry patches on back of right hand, one area measured 0.7 centimeter by 0.9 centimeter, the other measured 0.2 centimeter by 0.3 centimeter. The areas were noted to have no drainage and no signs of infection. Triple antibiotic ointment was initiated two times a day and leave open to air. During interview on 3/10/16, at 7:38 a.m., registered nurse (RN)-A verified facility was not aware of R77's right hand lesion until 3/9/16, and the wound nurse assessed the area at that time. RN-A stated she expected staff to report skin concerns to the wing nurse, wing nurse to complete an incident report, and send emails to notify director of nursing, nurse manager, wound nurse, social services and administrator. RN-A stated she expected the wing nurse to document skin concerns in progress notes. RN-A stated	F 282		

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F 282	Continued From page 28 skin concerns were monitored by the wound nurse completing an assessment weekly and by the wing nurse who looked at the area daily. RN-A verified R77's treatment of triple antibiotic ointment started on evening of 3/9/16, as documented in facility medication administration record. RN-A verified the nursing assistant memo book-white part of carbon copy was to be given to the wing nurse and yellow part of the carbon copy stayed in the memo book. During interview on 3/10/16, at 9:50 a.m., director of nursing stated she expected nursing assistants to report skin concerns to the wing nurse and to document the concern in the nursing assistant memo book. Director of nursing stated she expected the wing nurse to assess the concern, complete an incident report, and report to charge nurse, director of nursing, administrator and social services. The facility Care Plan Policy, dated 8/13/13, indicated purpose, to develop a plan of care for every resident to ensure care is given per resident preference. Procedure, each resident care plan will address every specific area of care for each individual resident.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		4/19/16

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F 309	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to monitor bruising for 1 of 3 residents (R27) reviewed for non pressure related skin conditions. In addition, the facility failed to identify and investigate a non-pressure related skin area and provide interventions to promote healing for 1 of 3 residents (R77) reviewed with non-pressure related skin concerns. Findings include: R27 was observed on 3/7/16, at 6:42 p.m. to have a purple bruise on top of his left hand. On 3/8/16, at 2:54 p.m., R27 was observed to be sitting in a recliner in his room. The purple bruised area was observed on R27's left hand, and another purple colored bruise was noted above R27's left elbow. R27's quarterly Minimum Data Set dated 12/17/15, identified diagnoses of dementia, polymyalgia rheumatic and atrial fibrillation. R27's physician orders dated 1/19/16, identified an order for prednisone 5 mg (milligrams) one time a day (corticosteroids, side effect; thinning of the skin) and aspirin 81 mg one time a day. R27's medication administration record, dated 3/16 identified R27 received the medications daily as ordered. R27's incident reports identified the following: 1/2/16, multiple bruises on both upper arms, many areas identified as blue in color.	F 309	Regulation 483.25 Tag F309 Provide Care/Services for Highest Well-being Prairie Manor Care Center provides each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. The interdisciplinary care team assesses each resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident's condition indicates. A plan of care is developed, implemented, routinely reevaluated, and revised as necessary based on continuing assessments. The policies and procedures for identifying, reporting, investigating, and monitoring bruises and other skin lesions were reviewed and found appropriate. During the April 14 and 15 mandatory nursing staff meetings, discussion will include the need to observe for skin lesions and the importance of appropriately reporting, documenting and monitoring bruises/ lesions. Procedures related to the above will be reviewed as well as developing care plans to monitor/treat/prevent bruises and other skin lesions. Instruction will be provided to the nursing assistants on the need to be alert to bruising and other skin injuries/lesions and to immediately report	

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F 309	Continued From page 30 1/6/16, new bruises on right elbow and two on bicep. 2/12/16 resident has a bruise on his right hand. 2/20/16 resident has a bruise on his left side upper lip. 3/3/16, bruises reported on top of left hand and left elbow. Resident known to be combative and resistive with cares at times and is prone to bruising. Does use EZ stand mechanical lift for transfers. Resident unable to verbalize how bruising may have occurred. R27's care plan was reviewed and did not include a problem area related to R27's risk for bruising, interventions to prevent bruising, nor interventions to implement if bruising was identified. On 3/10/16 at 12:41 p.m., registered nurse (RN)-A verified the risk of bruising had not been included on R27's care plan. RN-A stated they try to find the source that caused the bruising, but verified they had not implemented interventions to prevent bruising. On 3/11/16, the director of nursing (DON) acknowledged the risk for bruising should have been added to R27's care plan. A policy for non-pressure skin conditions was requested, but not provided. NON-PRESSURE RELATED SKIN CONDITION: R77 had a crusted lesion on the back of right hand without the facility identification, assessment, and investigation of the lesion, and without interventions to promote healing. R77 was admitted to the facility on 2/15/16 with diagnosis that included hemiplegia, hemiparesis,	F 309	the findings to the licensed nurse. Observing and reporting skin problems, including bruises, will continue to be part of the nursing assistant's bathing protocol. Resident number 27 – A registered nurse reassessed the resident's skin-related plan of care. The care plan has been updated to address the resident's risk of bruising, options to prevent bruising, and implementation of interventions in the event of bruising. Resident number 77 – The lesions on the top of the resident's right hand were assessed by a nurse on March 9, 11, and 13. The plan of care included applying antibiotic ointment to the affected area twice a day. The resident was discharged March 18, 2016 to another long term care facility closer to her family. To monitor care plan compliance, the MDS Coordinator will audit the care plans for completeness and accuracy for those residents who have open skin areas, contractures, or are receiving medications such as aspirin, Coumadin or prednisone, or have other risk factors that increase the risk of bruising. To monitor compliance with identification of skin lesions, the Director of Nursing/designee will conduct random skin audits for two weeks. If previously unreported bruises or other skin problems are observed, additional auditing and staff training/counseling will be done. Compliance will be reviewed during the April quarterly Quality Assurance and Assessment Committee	

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F 309	Continued From page 31 and dysphagia following cerebral infarction, according to facility admission record. A body audit conducted for R77 dated 2/15/16, indicated R77 had a rash in the groin area, on the left arm, bruise on left shin, and an open area on the right knee. There was no indication of lesion on back of right hand. During an observations on 3/7/16 at 3:10 p.m., a dark brown crusted lesion approximately one centimeter in size, was noted on the back of R77's right hand. There was no redness to the skin surrounding the area. During observations on 3/8/16 at 8:30 a.m., and 3/9/16 at 11:20 a.m., the lesion to the back of R77's hand remained unchanged. Document review of facility progress notes from 2/26 to 3/8/16, revealed the following: 2/26/16-quarterly skin risk assessment-at high risk for skin breakdown, required extensive to total assist with cares, transferred by mechanical lift, did not ambulate, foley catheter in place, had pink folds at times, reposition every one to two hours sitting and lying. Monitor skin daily with cares, weekly with bath, and as needed. 2/29/16-shower this morning with no new bruising or skin tears. 3/7/16-had shower and weekly skin check this shift. No new skin issues at this time. Review of facility's incident report logs dated 3/1/16 to 3/6/16, revealed no identification of R77's skin lesion.	F 309	meeting.	

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F 309	Continued From page 32	F 309		

During interview on 3/9/16 at 12:15 p.m., nursing assistant (NA)-G acknowledged having first become aware of the lesion on R77's right hand on 3/7/16. NA-G denied knowing how the lesion might have occurred. NA-D was also present during the interview and NA-D stated she'd become aware of the lesion that morning. NA-D also stated she'd document a note about the presence of the lesion and would notify the nurse.

During interview on 3/9/16 at 12:17 p.m., licensed practical nurse (LPN)-B stated she was not aware of the lesion. NA-D, who was also present, stated when staff discover a non-pressure related area, they are supposed to document in a "memo book" and give the white page of the carbon copy to the nurse. Document review of the memo book at that time with NA-D, revealed the lesion had been identified on 3/5/16, as a "sore on top of right hand." There was no carbon copy page included. NA-D verified this.

R77's care plan printed 3/9/16, indicated: skin integrity will be monitored weekly on bath day and as needed. The care plan also indicated staff were to report any changes, problems or redness to nursing.

Review of the nursing assistant kardex printed 3/9/16, also indicated staff were to monitor skin integrity weekly on bath day and as needed, report any changes, problems, redness to nursing.

Although nursing assistant documentation identified the lesion on 3/5/16, there was no further evidence of identification, assessment, treatment or monitoring until surveyor intervened

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F 309	Continued From page 33 on 3/9/16. Following the surveyor's questions, this progress note dated 3/9/16 at 4:22 p.m. was documented: "Staff reported sore to resident's right hand. Two areas were identified as dry patches on back of right hand, one area measured 0.7 centimeter by 0.9 centimeter, the other measured 0.2 centimeter by 0.3 centimeter. The areas were noted to have no drainage and no signs of infection. Triple antibiotic ointment was initiated two times a day and leave open to air." The facility's Skin Tolerance Testing and Body Audit policy dated 9/18/09, revealed the following: Page 1, Purpose: To identify any skin impairment and location on admission or bath day, to identify possible risk factors, causes, and implement appropriate care to resolve skin breakdown. Page 2, #5 on resident's weekly designated bath day nursing assistant will complete a bath day skin check to identify any areas of concern that may affect the resident's overall skin integrity. The bath day skin check sheet is then turned into the licensed staff member in charge of that resident on that shift so that areas of skin concern can be checked, and an incident report filled out if needed and reported to the nurse manager. The licensed staff member is also required to complete the needed documentation in the nurses notes. #6. Daily skin checks are to be completed on all residents that are assisted with dressing, toileting, and repositioning. Nursing assistants are required to report any skin concerns to their immediate supervisor so that issues can be checked, documented and reported to the appropriate personal for interventions to be initiated to prevent further skin breakdown.	F 309		

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During interview on 3/10/16, at 7:38 a.m. registered nurse (RN)-A verified the facility was not aware of R77's right hand lesion until 3/9/16, and the wound nurse assessed the area then. RN-A stated she expected staff to report skin concerns to the wing nurse, the wing nurse was then to complete an incident report, and send emails to notify director of nursing, nurse manager, wound nurse, social services and administrator. RN-A stated she also expected the wing nurse to document skin concerns in the progress notes. RN-A stated skin concerns were monitored by the wound nurse completing an assessment weekly and by the wing nurse who looked at the area daily. RN-A verified a treatment of triple antibiotic ointment had been started the evening of 3/9/16, as documented in facility medication administration record. RN-A verified the nursing assistant memo book-white part of carbon copy was to be given to the wing nurse and yellow part of the carbon copy stayed in the memo book.

During interview on 3/10/16, at 9:50 a.m. the director of nursing (DON) stated she expected nursing assistants to report skin concerns to the wing nurse and to document the concern in the nursing assistant memo book. The DON also stated she expected the wing nurse to assess the concern, complete an incident report, and report to charge nurse, director of nursing, administrator and social services.

During interview on 3/11/16, at 8:55 a.m., R77 was asked how she got the sores on her right hand and she replied very softly, "I don't know."

Document review of facility Care Plan Policy

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F 309	Continued From page 35 dated 8/13/13, revealed Purpose: To develop a plan of care for every resident to ensure care is given per resident preference. Procedure included a care plan would be developed for each resident identifying the needs of each individual resident.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure interventions were implemented to prevent falling for 1 of 4 residents (R27) reviewed for accidents. Findings include: R27 was observed on 3/7/16, at 6:44 p.m. to be sitting in a wheelchair in his room. The call light was observed to be clipped up high on the privacy curtain and was out of R27's reach. On 3/8/16 at 2:54 p.m., R27 was observed to be sitting in a recliner in his room and the call light was observed to be on top of R27's bed. The call light was out of R27's reach. On 3/8/16, at 3:05 p.m., nursing assistant (NA)-A verified R27's call light was not within reach for	F 323	483.25 (h) Tag F323 Accidents, Supervision, Devices Prairie Manor Care Center has policies and procedures to ensure that the residents' environment remains safe and as free of accident hazards as possible and that each resident receives adequate supervision and appropriate assistive devices to reduce the risk of accidents and injury. The facility identifies each resident at risk for accidents and develops a plan of care addressing safety issues with interventions to enhance mobility and promote safety. The resident's use of and need for safety/enabling devices are assessed at	4/19/16

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F 323	Continued From page 36 R27. R27's care plan, print date 3/11/16, indicated the resident required assistance with toileting and personal hygiene. In addition, the care plan indicated R27 was at high risk for falls. The care plan intervention included: Keep call light within reach and encourage resident to call for assistance. On 3/10/16 at 12:41 p.m., registered nurse-A verified R27's call light should be within reach for him to use. On 3/10/16 at 12:51 p.m., the director of nursing also stated she would expect the call light to be within reach for R27 and any resident who needed to use a call light.	F 323	admission and reassessed during the quarterly interdisciplinary care conferences and whenever there is a significant change in the residents behavior, physical condition, and/or mental function. The facility's policies and procedures instruct to provide a means for the resident to call for assistance at all time. During the mandatory meetings April 14, and 15, 2016, the nursing staff will be reminded to ensure that residents have a call light within reach before they leave the room, including resident number 27. The Director of Nurses/designee will conduct random observations of the resident rooms for two weeks to ensure that each resident has a call light within reach. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed at the April Quality Assurance and Assessment Committee quarterly meeting.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		4/19/16

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F 329	Continued From page 37 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based upon interview an document review, the facility failed to identify resident specific mood and behavior symptoms for anxiety, to implement non-pharmacological interventions before use of pain and antianxiety medicaiton, to ensure an analysis of sleep to warrant the use of a hypnotic and failed to ensure a physician's justification for use of psychotropic medication for 1 of 5 residents (R75); failed to identify and monitor mood and behavior symptoms to justify the use of an antianxiety medication for 1 of 5 residents (R34); and failed to identify and monitor mood symptoms to determine effectiveness of and antidepressant medication for for 2 of 5 residents (R45 and R35) who received daily dose of an antidepressant medication. Findings include: R75's Admission Record, dated 3/11/16, revealed	F 329	483.25(l) Tag F329 Unnecessary Drugs Prairie Manor Care Center staff ensure that each resident’s drug regime is free from unnecessary drugs. The resident’s drug regime is reviewed by the interdisciplinary care team, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. An effort is made to identify the lowest effective dose of psychotropic medications and to discontinue the use of psychotropic medications whenever possible.	

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F 329	Continued From page 38 R75 had diagnoses of chronic pain, anxiety, pain in right leg. R75's 30 day Minimum Data Assessment (MDS) dated 2/16/16, identified R75 was cognitively intact, had no behaviors, had mood of feeling tired or having little energy, had pain which had made it hard to sleep at night, frequency of pain daily, received scheduled and as needed (PRN) pain medications, had not received non-medication interventions for pain and had received antidepressant and antianxiety medications. R75's physician orders dated 2/25/16, included the following orders: Lorazepam (antianxiety) tablet 0.5 mg (milligrams) - one tablet at HS (bedtime), may repeat one half tablet in 30 minutes if still having anxiety issues and not able to sleep. Venlafaxine (antidepressant) 75 mg - one capsule once a day related to generalized anxiety disorder. Tramadol (analgesic) 50 mg - two tablets every six hours as needed for pain. Oxycodone (narcotic pain reliever) 5 mg - one tablet every six hours as needed for pain Review of the March 2016 medication administration record (MAR) and progress notes showed the following: R75 had received Ativan as needed (PRN) one time on 3/5/16, with no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered. R75 had received Oxycodone PRN six times from	F 329	Prairie Manor Care Center staff ensures that 1) residents who have not used psychotropic drugs are not given these drugs unless psychotropic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record and 2) residents who use psychotropic drugs receive gradual dose reductions with attempts to manage behaviors using nonpharmacological interventions. Medications are reviewed by the consultant pharmacist monthly and by the attending physician/nurse practitioner during their routine 30/60 day visits and more often as indicated. Based on the resident’s comprehensive assessment, Prairie Manor Care Center staff routinely identify target behaviors that justify the use of psychotropic medications. At the time of the quarterly care conference and more often if needed, residents receiving psychotropic medications are reassessed by licensed nurses and the social worker. The medication type/dose, behavior/mood symptoms, and other related information are reviewed to assure that the record continues to reflect adequate indications for use and that the dose tapering attempts are in compliance with regulatory guidelines. The policies and procedures related to the administration of psychotropic medications were reviewed and revised.	

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F 329	Continued From page 39 3/1/16 to 3/10/16 with no documentation of non-pharmacological interventions attempted prior to the PRN Oxycodone being administered. R75 had received Tramadol PRN four times from 3/1/16 to 3/10/16 with no documentation of non-pharmacological interventions attempted prior to the Tramadol being administered. Review of the February 2016 MAR and progress notes showed the following: R75 had received Ativan PRN one time on 2/11/16, with no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered. R75 had received Oxycodone PRN 34 times, with no documentation of non-pharmacological interventions attempted prior to the PRN Oxycodone being administered. R75 had received Tramadol PRN one time on 2/29/16 with no documentation of non-pharmacological interventions attempted prior to the Tramadol being administered. Review of the January 2016 MAR, from admission on 1/19/16 to 1/31/16, and progress notes showed the following: R75 had received Ativan PRN eight times with no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered. R75 had received Oxycodone PRN 27 times, with no documentation of non-pharmacological interventions attempted prior to the PRN	F 329	Target behaviors justifying the use of antianxiety and antidepressant medications will be documented on the medication administration record and addressed in the care plan. Use of the daily Mood and Behavior Tracking Log to track target behaviors justifying the use of antipsychotics and the effectiveness of listed interventions will continue. The target behavior(s) will be identified in the plan of care. For antipsychotic, antianxiety and hypnotic/sedative medications prescribed on a PRN (as needed) basis, guidelines/parameters are developed for use and are documented on the designated form. Nonpharmacological interventions are addressed. Implementation of electronic tracking of target behaviors, nonpharmacological interventions for management of behaviors and pain control, and the effectiveness of the interventions is tentatively scheduled for May 2016. The electronic system will provide automatic documentation prompts and reminders for the staff. During the mandatory meetings on April 14 and 15, 2016, the licensed nursing staff will be instructed on 1) the new documentation procedures for target behaviors and behavior related interventions 2) the importance of attempting nonpharmacological interventions prior to administration of PRN psychotropic and analgesics 3) ensuring the care plan addresses target behaviors and nonpharmacological	

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Oxycodone being administered.

R75's care plan, print date 3/11/16, identified the following:
Antidepressant and antianxiety medication use related to diagnosis of depression and anxiety with interventions of administer medication per MD's (medical doctor's) order. Monitor for effectiveness and adverse reactions and report to nursing if noted. Medication to be reviewed routinely by pharmacist consultant, primary physician and behavior management nurse. Appropriate changes to be made as needed. Monitor mood/behavior and report to Nurse. Physician to review medication with certification visits for appropriateness and possible dose changes. Refer to Psychotropic Drug Policy and Procedure.
Resident is at risk for pain related to sacroiliac joint dysfunction, spinal stenosis and osteoarthritis with interventions of: administer pain medication as per MD orders and note the effectiveness. Report any unresolved pain to physician. Encourage resident to verbalize any pain. Monitor and report any noted non-verbal signs of discomfort, i.e., facial grimacing, guarding, increase agitation. Pain assessment quarterly and prn. However, the care plan had not addressed non-pharmacological interventions for either the pain or anxiety.

R75's progress note, dated 2/8/16, identified: registered nurse behavior note: Resident was admitted on 1/19/16 with complaints of right leg pain and primary diagnosis of sacroiliacs. During admission resident noted to have orders for Ativan 0.5 mg every hour of sleep (HS) with additional 0.25 mg PRN 30 minutes after scheduled HS dose if needed for Anxiety and

F 329

interventions to manage mood symptoms, anxiety and pain 4) the need to document the effectiveness of interventions and 5) the need for an assessment that analyzes the sleep monitoring data. The direct care staff will be reminded of the importance of being observant for behaviors and reporting target behaviors to the charge nurse.

Resident number 75 – The nurses have been reminded to document nonpharmacological interventions that are attempted prior to administration of PRN medications to treat anxiety and pain. The care plan has been updated to address nonpharmacological interventions and target behaviors related to use of antianxiety medications as well as insomnia. The resident’s sleep/wake patterns are monitored on a routine basis and the effectiveness of the interventions to promote sleep will be assessed by a registered nurse. During the physician’s next visit, documentation addressing anxiety symptoms, insomnia, and justification of the order change from PRN to routine use of lorazepam will be requested. The physician will be contacted if the resident’s medical management of depressed mood, anxiety or insomnia is ineffective.

Resident number 45 – A behavior tracking sheet to monitor mood symptoms related to the diagnoses of major depressive disorder has been implemented. The results will be reviewed by the interdisciplinary team during the quarterly

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Insomnia, and Venlafaxine 75 mg capsule daily for Anxiety. Resident saw her primary physician on 1/26/16. She came back with orders stating to continue scheduled Ativan as is and PRN Ativan as needed. No noted adverse reaction from medications. Primary physician and consulting pharmacist routinely review medications. Will continue with current regimen and will contact MD for medication changes as needed.

The behavior note, physician orders, care plan, or other documents provided by facility had identified resident specific symptoms of anxiety to determine if the Ativan and Venlafaxine was affective to relieve "anxiety."
R75's physician orders, dated 2/25/16, included Lorazepam (antianxiety) tablet 0.5 mg (milligrams) one tablet at HS may repeat one half tablet in 30 minutes if still having anxiety issues and not able to sleep.

R75's record identified sleep tracking sheets dated 1/19/16 through 3/9/16. The sleep tracking monitored hours of sleep from 6:00 p.m. through 9:00 a.m. daily.

However, R75's medical record lacked a comprehensive sleep assessment and analysis of the sleep monitoring for the use of the Ativan. In addition, R75's care plan failed to address insomnia.

R75's physician orders dated 1/19/16, identified an order for Ativan 0.5 mg, take one to two tablets PRN one time daily at HS for symptoms. A physician order on 1/26/16, identified an order to change the Ativan to 0.5 mg every HS, may give an extra one-half tablet PRN after 30 minutes if needed for sleep. In addition, R75's record

care conferences and more frequently if indicated. The physician will be contacted if there is an increase in symptoms of depressed mood. The social worker will complete a depression screen questionnaire every 90 days and with a significant change in condition. The care plan will be reviewed and revised as necessary.

Resident number 34 – The resident was admitted July 21, 2015 with a primary diagnosis of schizoaffective disorder with the physician noting that she is doing well on her current psychotropic medications. A behavior tracking sheet to monitor mood symptoms and target behaviors to determine the effectiveness of the antipsychotic, antianxiety, antidepressant and mood stabilizer medications has been implemented. Nonpharmacological interventions to be implemented prior to administration of PRN (as needed) pain medications are addressed in the plan of care. The nursing staff has been informed of the need to attempt nonpharmacological interventions for pain control and to document the interventions attempted and the resident's response.

During the consultant pharmacist's monthly medication audits and the quarterly care planning process, the residents' medication regimen will continue to be reviewed to assure that the medications used to manage behaviors, mood symptoms, insomnia and pain are appropriately justified and monitored. Compliance will be further monitored by

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F 329	Continued From page 42 identified a physician order for Venlafaxine 75 mg one capsule once a day related to generalized anxiety disorder, which R75 had been receiving since admission. R75's physician note, dated 1/26/16, indicated R75 had Ativan at bedtime. They asked the Ativan be scheduled dose vs. as needed due to her often forgets to ask for it appropriately at bedtime and there is a little language barrier. However, the physician progress note failed to address anxiety symptoms and insomnia needs and lacked physician justification for the increased medication dosages. On 3/10/16, at 12:31 p.m., registered nurse (RN)-A stated we do sleep tracking for R75's insomnia, but we have not completed an assessment for sleep. RN-A verified R75's care plan failed to include non-pharmalogical interventions for the PRN pain and antianxiety medications. RN-A verified R75's record failed to include documentation of non-pharmalogical interventions being offered prior to the PRN medications being administered. RN-A verified R75's record failed to include specific symptoms R75 had for the use of the antianxiety medications. RN-A stated R75's Ativan was changed to scheduled doses because that is what the "family" requested and was how R75 had taken the medication at home. RN-A stated in regards to how the facilities system for monitoring moods and behaviors, the nursing assistants report to the nurse and then the nurse documents the mood and behaviors. On 3/10/16, at 1:00 p.m., the director of nursing (DON) stated they do review the sleep tracking sheets with the physician. I would expect the	F 329	the Director of Nurses/designee by 1) an audit of the records of residents receiving antipsychotic, antianxiety, and antidepressant medications to ensure that the target behaviors/mood symptoms are identified, monitored, and related interventions are documented 2) an audit of the records of residents receiving PRN pain medications and sedatives to ensure that nonpharmacological interventions and monitoring of their effectiveness are included in the plan of care and appropriately documented and 3) a record audit of residents receiving hypnotics/sedatives to ensure sleep assessments have been completed. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the April quarterly Quality Assurance and Assessment Committee meeting and ongoing.	

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F 329	Continued From page 43 sleep tracking sheets to be addressed in the sleep note. The DON stated normally the non-pharmalogical interventions are on the care plan and normally you would try those before giving the PRN medications. The DON stated we have not done specific resident symptoms for antidepressant and antianxiety medications before. The DON stated she did not know why R75's Ativan was changed to being given on a scheduled daily dose vs. as needed. The DON stated she would have expect the reason for the medication being changed is supported by clinical evidence and to be documented and family requesting the change would not be a strong enough reason for the change. On 3/11/16, at 9:52 a.m., the DON stated she would expect the physician to document justification for the use of any medications ordered. The facility Psychotropic Drug Use Policy which includes psychoactive medication use, dated 3/28/14, indicated Purpose: Prairie Manor Care Center (PMCC) assures that each resident's drug regime is free from unnecessary drugs. Resident's receiving psychotropic medication are monitored for: excessive doses, excessive duration, adequate indications, presence of adverse side effects, and target behaviors in accordance with Federal Tag 329. Policy: it is the policy of PMCC to monitor all resident's experiencing behavioral symptoms and that are tacking psychotropic medications (or any other drugs outside of their intended use) for management of mood/behaviors. Procedure: 1. Psychotropic Behavior Management Nurses/Nurse Mangers will track all psychotropic medication changes, medication	F 329		

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F 329	Continued From page 44	F 329		

initiations/discontinuations and dose reductions/increases on resident's individual psychotropic chronological along with indications. 3. Resident's started on any psychotropic medication will be triggered under communications for daily charting times four weeks for target behaviors, or if dose is increased or decreased or the medication is discontinued, charting will be triggered for daily charting times four weeks, then charting will be done quarterly in a RN Behavior Note and as needed. 9. A sleep disruption care plan will be developed for residents with orders for hypnotic/sedative medications (Ambien, Trazodone .....) Non-pharmalogical interventions will be also included. Sleep tracking will be completed before routine certification physician visits for review. 10. A psychotropic care plan will be developed for residents with orders for antidepressants and antianxiety medications (Ativan, Remeron, Celexa, Zoloft .....). All target behaviors and interventions will be included. 12. Residents with orders for PRN antipsychotics, antianxiety and hypnotic will be assessed using Guidelines for Administration worksheet prior to giving this PRN medication and effectiveness will be documented after given.

The facility Pain Management Policy, dated 4/9/14, indicated Purpose: it is the policy of PMCC to ensure residents experiencing pain will have a comprehensive assessment of that pain and will have established plan to treat that pain. Procedure: each resident will have pain addressed on their care plan. Care plans will include individualized interventions for pain as well as non-pharmalogical interventions for pain. LACK OF MOOD/BEHAVIOR MONITORING TO JUSTIFY THE ONGOING USE OF AN

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F 329	Continued From page 45 ANTIDEPRESSANT: R45's admission record revealed a diagnosis of major depressive disorder. Current physician orders signed 2/23/16 included an order for Remeron (antidepressant)15 milligrams at bedtime. Review of R45's medication administration record, treatment administration record, care plan, and progress notes failed to identify mood symptoms for depression. On 3/10/16 at 9:17 a.m. nursing assistant (NA)-D was interviewed for R45's mood symptoms, "Not really anything we track for her [R45]. The only thing is when she was on a walking program she would get moody. She will make facial expressions, I don't really think she is moody." LACK OF IDENTIFYING MOOD/DEPRESSION SYMPTOMS TO DETERMINE IF MEDICATION IS AFFECTIVE; ALSO LACK OF USE OF NON-PHARMACOLOGICAL INTERVENTIONS FOR CONTROL PAIN WERE USED BEFORE AS NEEDED PAIN MEDICATION IS GIVEN: R34's current physician orders signed 2/9/16 included the orders; buspirone tablet 30 mg (anti-anxiety medication) 1 tablet twice daily, Risperdal 4 mg (anti-psychotic medication) 2 tablets at bedtime, Topamax 50 mg (mood stabilizer) twice daily, and fluoxetine 60 mg (anti-depressant medication) daily for a primary diagnosis of schizoaffective disorder. Acetaminophen 500 mg 2 tablets daily as needed for break through pain and Tramadol 50 mg (controlled pain medication) 1 tablet as needed for pain three times daily.	F 329		

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F 329	Continued From page 46 Review of R34's medication administration record, treatment administration record, care plan, and progress notes failed to identify mood symptoms or target behaviors to determine if the antipsychotic, antidepressant and analgesics were affective. Also there was no documentation found or provided by facility in regards to the use of non-pharmalogical interventions prior to the use of as needed pain medication. On 3/10/16 at 9:15 a.m. NA-D was interviewed for R34's mood symptoms and target behaviors; "She doesn't like to walk, that kind of targets her. She isn't on a walking program now cause it would trigger her. She doesn't care for different nursing assistants. She swears, she refuses stuff. She says stuff and then she will say she is just kidding. She will say stuff to try to hurt your feelings." On 3/10/16 10:42 a.m. the DON stated, "Last week we were discussing how we don't have a form of daily tracking [for mood/behavior]. [R34] is one of those that doesn't really have any [target behaviors]. I guess sometimes she doesn't like some staff. I am having someone from point click [electronic medical record] come in and show us how to do behavior tracking. We don't have anything in place for the anti-depressant mood monitoring. If they start a new one or the dose changes the nurses would chart on mood, they would do it for four weeks, but nothing ongoing." On 3/11/16 at 10:21 a.m. the DON added, "The care plan has non-pharmacological interventions listed, but I don't think they [nursing] document what they tried." On 3/11/16 at 11:04 a.m. the facility consultant	F 329		

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F 329	Continued From page 47 pharmacist stated, They should have identified mood symptoms and non-pharmacological should be tried prior to the administration of an as needed pain medication. A facility policy on mood monitoring, target behavior monitoring was requested but was not provided.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 334		4/19/16

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F 334	Continued From page 48 The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 334	Regulation 483.25(n) Tag F334	

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Continued From page 49
failed to ensure residents and or their responsible parties were educated prior to administration of the influenza vaccine for 5 of 5 residents (R27, R38, R42, R52 and R57) reviewed for influenza immunizations. In addition, the facility failed to obtain 1 of 5 residents (R57) pneumococcal vaccination status and/or to offer the vaccine.

Findings Include:

R27 was admitted to the facility on 4/4/12. R27's undated Immunization Record, indicated R27 last received an influenza vaccination on 10/21/15.

R38 was admitted to the facility on 8/7/12. R38's undated Immunization Record, indicated R38 last received an influenza vaccination on 10/22/15.

R42 was admitted to the facility on 5/20/13. R42's undated Immunization Record, indicated R42 last received an influenza vaccination on 10/21/15.

R52 was admitted to the facility on 8/28/14. R52's undated Test/Immunization Record, indicated R52 last received an influenza vaccination on 10/21/15.

R57 was admitted to the facility on 4/1/15. R57's undated Test/Immunization Record, indicated R57 last received an influenza vaccination on 10/21/15.

Although R27, R38, R42, R52 and R57 had each received the influenza vaccine in October 2015 at the facility, their records lacked documentation that the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization.

F 334

Immunizations

Prairie Manor Care Center has developed policies and procedures to ensure that 1) each resident is offered an annual influenza immunization October 1 through March 31 and a pneumococcal immunization unless the immunization is medically contraindicated or the resident has already been immunized 2) before offering the influenza and pneumococcal immunizations, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunizations 3) the resident or the resident's legal representative has the opportunity to refuse immunization and 4) the resident's medical record includes documentation that indicates the following:

- That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza and pneumococcal immunizations; and
- That the resident either received the influenza and pneumococcal immunizations or did not receive the immunizations due to medical contraindications or refusal.

The immunization related policies and procedures were reviewed and revised. A signed consent to administer the influenza vaccination after the resident/responsible party has been informed of the benefits and possible adverse effects will be

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F 334	Continued From page 50 On 3/10/16, at 2:04 p.m., registered nurse (RN)-B stated information is sent out regarding the influenza vaccine and unless a refusal was documented in the resident progress notes, the vaccine would be given. RN-B verified R27, R38, R42, R52 and R57's records failed to include documented evidence that education had been provided regarding the benefits and potential side effects of the influenza vaccine for the residents or their responsible parties. The facility Influenza (resident) Vaccination Policy dated 1/1/15, failed to address obtaining documented consent for the influenza vaccination. R57 was admitted to the facility on 4/1/15. R57's undated Test/Immunization Record and R57's record, lacked documentation to indicate whether R57 had received a pneumococcal vaccine prior to admission, or whether the resident had been offered, received or refused the vaccine since admission. On 3/10/16, at 2:04 p.m. RN-B verfied there was no documentation in R57's record to indicate whether the resident had previously received, or whether the pneumococcal vaccine had been offered to R57 since admission. RN-B stated she was unaware this had been missed, and would follow up. The facility's Pneumococcal Vaccination Policy dated 1/1/15, indicated: policy, minimize the risk of residents acquiring, transmitting, or experiencing complications form the pneumococcal pneumonia be assuring that each resident: is informed about the benefits and risks	F 334	obtained. Currently residents/responsible parties are sent a letter advising them that the influenza vaccination will be administered unless contraindicated or unless the resident/responsible party declines. An information sheet provided by the Center for Disease Control (CDC) outlining the benefits and risks and adverse of the vaccination is enclosed with the letter. During the mandatory meetings April 14 and 15, 2016, the nursing staff were reeducated on the regulatory requirements and the facility's policy/procedures addressing 1) the need to administer/offer influenza and pneumococcal immunizations 2) the related resident/responsible party signed notification, education, and consent and 3) the resident/responsible party right to refuse the immunizations. Resident's number 27, 38, 42, 52, and 57 have information in their record verifying that the responsible parties received the information regarding the administration of the influenza vaccine including the instructions for declining the immunization as well as the CDC risk/benefit information. Resident number 57 will be offered the pneumococcal vaccination after his physician writes an order verifying the type of vaccine that is to be administered (if not contraindicated). This will be addressed with the physician during her upcoming visit.	

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F 334	Continued From page 51 of immunizations and has had the opportunity to receive, unless medically contraindicated or refuse or already immunized. Assure documentation in the resident's medical record of the information/education provided regarding the benefits and risks of immunization and the administration or the refusal of or medical contraindications to the vaccine. All resident's legal representative will be provided educational material in regards to the benefits and potential side effects of the vaccination.	F 334	To monitor compliance, the infection control nurse/designee will 1) audit the records of residents currently residing in the facility and admitted to the facility during the 2016-2017 seasonal influenza vaccination season to assure that there are signed consents and risk/benefit education prior to administering the influenza vaccine and 2) identify residents who have not had the pneumococcal vaccination. If residents are identified, their physician will be contacted for advice on the type of vaccination to administer. Compliance will be reviewed during the April Quality Assurance and Assessment Committee quarterly meeting.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356		4/19/16

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F 356	Continued From page 52 o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a correct resident census was posted daily. This had the potential to effect all 37 residents in the facility. Findings include: Upon entrance to the facility on 3/7/15 at 12:30 p.m. the director of nursing (DON) reported the facility census was 37. On 3/7/16 at 12:40 p.m. during the initial facility tour the Hours Report of Nursing Staff posted in the hallway next to the medication room revealed a facility census of 40. On 3/7/16 at 2:50 p.m. the DON stated, "I'm guessing she just didn't change it. We had one person discharge today so it was 38 and now it is 37." The DON verified that no one updated the census number on the weekend. On 3/7/16 at 2:53 pm. licensed practical nurse (LPN)-C stated, "I put the sheets [census/staffing]	F 356	Regulation 483.30(e) Tag F356 Posted Nurse Staffing Information Prairie Manor Care Center routinely posts the following information on a daily basis in a prominent location in a clear and readable format: (i) Facility name. (ii) The current date. (iii) The number of registered nurses, licensed practical nurses, and certified nursing assistants directly responsible for resident care per shift. (iv) Resident census. The staff member responsible for compiling and posting the staffing data was instructed to update the census information to reflect resident admission/discharges and changes in the	

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F 356	Continued From page 53 out on Friday and I'm the only one who updates it." On 3/10/16 at 11:46 a.m. the DON stated the facility would do the census on Friday for the weekend that included Saturday and Sunday. The staff had not been updating the census to reflect the hours if a staff member had called in sick to reflect actual hours." Facility stated they did not have a policy on staff posting/census.	F 356	scheduled staffing. The Administrator/designee will monitor compliance by random audits of the accuracy of the posted information.	
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based upon interview and document review the facility failed to ensure the consultant pharmacist had identified the lack of resident specific mood and behavior symptoms for use of an anxiety medicaiton, to implement non-pharmacological interventions before use of pain and antianxiety medicaiton, to ensure an analysis of sleep to warrant the use of a hypnotic and failed to ensure a physician's justification for use of psychotropic	F 428	Regulation 483.60(c) Tag F428 Drug Regimen Review The goal of Prairie Manor Care Center is to maintain the resident's highest practicable level of functioning and prevent or minimize adverse consequences related to medication therapy. The drug regimen of each	4/19/16

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F 428	Continued From page 54 medication for 1 of 5 residents (R75); failed to identify and monitor mood and behavior symptoms to justify the use of an antianxiety medication for 1 of 5 residents (R34); and failed to identify and monitor mood symptoms to determine effectiveness of and antidepressant medication for for 2 of 5 residents (R45 and R35) who received daily dose of an antidepressant medication. Findings include: R75's Admission Record, dated 3/11/16, revealed R75 had diagnoses of chronic pain, anxiety, pain in right leg. R75's 30 day Minimum Data Assessment (MDS) dated 2/16/16, identified R75 was cognitively intact, had no behaviors, had mood of feeling tired or having little energy, had pain which had made it hard to sleep at night, frequency of pain daily, received scheduled and as needed (PRN) pain medications, had not received non-medication interventions for pain and had received antidepressant and antianxiety medications. R75's physician orders dated 2/25/16, included the following orders: Lorazepam (antianxiety) tablet 0.5 mg (milligrams) - one tablet at HS (bedtime), may repeat one half tablet in 30 minutes if still having anxiety issues and not able to sleep. Venlafaxine (antidepressant) 75 mg - one capsule once a day related to generalized anxiety disorder. Tramadol (analgesic) 50 mg - two tablets every six hours as needed for pain.	F 428	resident is reviewed at least once a month by a licensed pharmacist. The pharmacist reports irregularities to the attending physician and the director of nursing, and these reports are acted upon. The Director of Nursing and Consultant Pharmacist have reviewed the facility's procedures for identifying and tracking target behaviors and mood symptoms related to psychotropic medication use, documenting nonpharmacological interventions provided/offered to manage pain and anxiety, completing sleep assessments and analyzing sleep monitoring data, and ensuring physician justification for use of psychotropic medications. The pharmacist will continue to review records on a monthly basis and routinely check for appropriate documentation related to the above issues. During the mandatory meetings on April 14 and 15, 2016, the licensed nursing staff will be instructed on 1) the new documentation procedures for target behaviors and behavior related interventions 2) the importance of attempting nonpharmacological interventions prior to administration of PRN psychotropic and analgesics 3) ensuring the care plan addresses target behaviors and nonpharmacological interventions to manage mood symptoms, anxiety, and pain and 4) the need for an assessment that analyzes the sleep monitoring data. The direct care staff will be reminded of the importance of being	

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Oxycodone (narcotic pain reliever) 5 mg - one tablet every six hours as needed for pain

Review of the March 2016 medication administration record (MAR) and progress notes showed the following:

R75 had received Ativan as needed (PRN) one time on 3/5/16, with no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered.

R75 had received Oxycodone PRN six times from 3/1/16 to 3/10/16 with no documentation of non-pharmacological interventions attempted prior to the PRN Oxycodone being administered.

R75 had received Tramadol PRN four times from 3/1/16 to 3/10/16 with no documentation of non-pharmacological interventions attempted prior to the Tramadol being administered.

Review of the February 2016 MAR and progress notes showed the following:

R75 had received Ativan PRN one time on 2/11/16, with no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered.

R75 had received Oxycodone PRN 34 times, with no documentation of non-pharmacological interventions attempted prior to the PRN Oxycodone being administered.

R75 had received Tramadol PRN one time on 2/29/16 with no documentation of non-pharmacological interventions attempted prior to the Tramadol being administered.

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observant for behaviors/moods symptoms and reporting them to the charge nurse.

Resident number 75 – The nurses have been reminded to document nonpharmacological interventions that are attempted prior to administration of PRN medications to treat anxiety and pain. The care plan has been updated to address nonpharmacological interventions and target behaviors related to use of antianxiety medications as well as insomnia. The resident’s sleep/wake patterns are monitored on a routine basis and the effectiveness of the interventions to promote sleep will be assessed by a registered nurse. During the physician’s next visit, documentation addressing anxiety symptoms, insomnia, and justification of the order change from PRN to routine use of lorazepam will be requested. The physician will be contacted if the resident’s medical management of depressed mood, anxiety or insomnia is ineffective.

Resident number 45 – A behavior tracking sheet to monitor mood symptoms related to the diagnoses of major depressive disorder has been implemented. The results will be reviewed by the interdisciplinary team during the quarterly care conferences and more frequently if indicated. The physician will be contacted if there is an increase in symptoms of depressed mood. The social worker will complete a depression screen questionnaire every 90 days and with a significant change in condition. The care

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Review of the January 2016 MAR, from admission on 1/19/16 to 1/31/16, and progress notes showed the following:

R75 had received Ativan PRN eight times with no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered.

R75 had received Oxycodone PRN 27 times, with no documentation of non-pharmacological interventions attempted prior to the PRN Oxycodone being administered.

R75's care plan, print date 3/11/16, identified the following:
Antidepressant and antianxiety medication use related to diagnosis of depression and anxiety with interventions of administer medication per MD's (medical doctor's) order. Monitor for effectiveness and adverse reactions and report to nursing if noted. Medication to be reviewed routinely by pharmacist consultant, primary physician and behavior management nurse. Appropriate changes to be made as needed. Monitor mood/behavior and report to Nurse. Physician to review medication with certification visits for appropriateness and possible dose changes. Refer to Psychotropic Drug Policy and Procedure.
Resident is at risk for pain related to sacroiliac joint dysfunction, spinal stenosis and osteoarthritis with interventions of: administer pain medication as per MD orders and note the effectiveness. Report any unresolved pain to physician. Encourage resident to verbalize any pain. Monitor and report any noted non-verbal signs of discomfort, i.e., facial grimacing,

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plan will be reviewed and revised as necessary.

Resident number 34 – The resident was admitted July 21, 2015 with a primary diagnoses of schizoaffective disorder with the physician noting that she is doing well on her current psychotropic medications. A behavior tracking sheet to monitor mood symptoms and target behaviors to determine the effectiveness of the antipsychotic, antianxiety, antidepressant and mood stabilizer medications has been implemented. Nonpharmacological interventions to be implemented prior to administration of PRN (as needed) pain medications are addressed in the plan of care. The nursing staff has been informed of the need to attempt nonpharmacological interventions for pain control and to document the interventions attempted and the resident’s response.

During the consultant pharmacist’s monthly medication audits and the quarterly care planning process, the residents’ medication regimen will continue to be reviewed to assure that medications used to manage behaviors, mood symptoms, insomnia and pain are appropriately justified and monitored. Compliance will be further monitored by the Director of Nurses/designee by 1) an audit of the records of residents receiving antipsychotic, antianxiety, and antidepressant medications to ensure that target behaviors/mood symptoms are identified, monitored, and related interventions are documented 2) an audit

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F 428	Continued From page 57 guarding, increase agitation. Pain assessment quarterly and prn. However, the care plan had not addressed non-pharmacological interventions for either the pain or anxiety. R75's progress note, dated 2/8/16, identified: registered nurse behavior note: Resident was admitted on 1/19/16 with complaints of right leg pain and primary diagnosis of sacroiliacs. During admission resident noted to have orders for Ativan 0.5 mg every hour of sleep (HS) with additional 0.25 mg PRN 30 minutes after scheduled HS dose if needed for Anxiety and Insomnia, and Venlafaxine 75 mg capsule daily for Anxiety. Resident saw her primary physician on 1/26/16. She came back with orders stating to continue scheduled Ativan as is and PRN Ativan as needed. No noted adverse reaction from medications. Primary physician and consulting pharmacist routinely review medications. Will continue with current regimen and will contact MD for medication changes as needed. The behavior note, physician orders, care plan, or other documents provided by facility had identified resident specific symptoms of anxiety to determine if the Ativan and Venlafaxine was affective to relieve "anxiety." R75's physician orders, dated 2/25/16, included Lorazepam (antianxiety) tablet 0.5 mg (milligrams) one tablet at HS may repeat one half tablet in 30 minutes if still having anxiety issues and not able to sleep. R75's record identified sleep tracking sheets dated 1/19/16 through 3/9/16. The sleep tracking monitored hours of sleep from 6:00 p.m. through 9:00 a.m. daily.	F 428	of the records of residents receiving PRN pain medications and sedatives to ensure nonpharmacological interventions and monitoring of their effectiveness is included in the plan of care and appropriately documented and 3) a record audit of residents receiving hypnotics/sedatives to ensure sleep assessments have been completed. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the April quarterly Quality Assurance and Assessment Committee meeting and ongoing.	

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F 428	Continued From page 58 However, R75's medical record lacked a comprehensive sleep assessment and analysis of the sleep monitoring for the use of the Ativan. In addition, R75's care plan failed to address insomnia. R75's physician orders dated 1/19/16, identified an order for Ativan 0.5 mg, take one to two tablets PRN one time daily at HS for symptoms. A physician order on 1/26/16, identified an order to change the Ativan to 0.5 mg every HS, may give an extra one-half tablet PRN after 30 minutes if needed for sleep. In addition, R75's record identified a physician order for Venlafaxine 75 mg one capsule once a day related to generalized anxiety disorder, which R75 had been receiving since admission. R75's physician note, dated 1/26/16, indicated R75 had Ativan at bedtime. They asked the Ativan be scheduled dose vs. as needed due to her often forgets to ask for it appropriately at bedtime and there is a little language barrier. However, the physician progress note failed to address anxiety symptoms and insomnia needs and lacked physician justification for the increased medication dosages. On 3/10/16, at 12:31 p.m., registered nurse (RN)-A stated we do sleep tracking for R75's insomnia, but we have not completed an assessment for sleep. RN-A verified R75's care plan failed to include non-pharmalogical interventions for the PRN pain and antianxiety medications. RN-A verified R75's record failed to include documentation of non-pharmalogical interventions being offered prior to the PRN medications being administered. RN-A verified R75's record failed to include specific symptoms	F 428		

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R75 had for the use of the antianxiety medications. RN-A stated R75's Ativan was changed to scheduled doses because that is what the "family" requested and was how R75 had taken the medication at home. RN-A stated in regards to how the facilities system for monitoring moods and behaviors, the nursing assistants report to the nurse and then the nurse documents the mood and behaviors.

On 3/10/16, at 1:00 p.m., the director of nursing (DON) stated they do review the sleep tracking sheets with the physician. I would expect the sleep tracking sheets to be addressed in the sleep note. The DON stated normally the non-pharmalogical interventions are on the care plan and normally you would try those before giving the PRN medications. The DON stated we have not done specific resident symptoms for antidepressant and antianxiety medications before. The DON stated she did not know why R75's Ativan was changed to being given on a scheduled daily dose vs. as needed. The DON stated she would have expect the reason for the medication being changed is supported by clinical evidence and to be documented and family requesting the change would not be a strong enough reason for the change.

On 3/11/16, at 9:52 a.m., the DON stated she would expect the physician to document justification for the use of any medications ordered.

The facility Psychotropic Drug Use Policy which includes psychoactive medication use, dated 3/28/14, indicated Purpose: Prairie Manor Care Center (PMCC) assures that each resident's drug regime is free from unnecessary drugs.

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F 428	Continued From page 60 Resident's receiving psychotropic medication are monitored for: excessive doses, excessive duration, adequate indications, presence of adverse side effects, and target behaviors in accordance with Federal Tag 329. Policy: it is the policy of PMCC to monitor all resident's experiencing behavioral symptoms and that are tacking psychotropic medications (or any other drugs outside of their intended use) for management of mood/behaviors. Procedure: 1. Psychotropic Behavior Management Nurses/Nurse Mangers will track all psychotropic medication changes, medication initiations/discontinuations and dose reductions/increases on resident's individual psychotropic chronological along with indications. 3. Resident's started on any psychotropic medication will be triggered under communications for daily charting times four weeks for target behaviors, or if dose is increased or decreased or the medication is discontinued, charting will be triggered for daily charting times four weeks, then charting will be done quarterly in a RN Behavior Note and as needed. 9. A sleep disruption care plan will be developed for residents with orders for hypnotic/sedative medications (Ambien, Trazodone .....) Non-pharmalogical interventions will be also included. Sleep tracking will be completed before routine certification physician visits for review. 10. A psychotropic care plan will be developed for residents with orders for antidepressants and antianxiety medications (Ativan, Remeron, Celexa, Zoloft .....). All target behaviors and interventions will be included. 12. Residents with orders for PRN antipsychotics, antianxiety and hypnotic will be assessed using Guidelines for Administration worksheet prior to giving this PRN medication and effectiveness will be documented	F 428		

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F 428	Continued From page 61 after given. The facility Pain Management Policy, dated 4/9/14, indicated Purpose: it is the policy of PMCC to ensure residents experiencing pain will have a comprehensive assessment of that pain and will have established plan to treat that pain. Procedure: each resident will have pain addressed on their care plan. Care plans will include individualized interventions for pain as well as non-pharmalogical interventions for pain. LACK OF MOOD/BEHAVIOR MONITORING TO JUSTIFY THE ONGOING USE OF AN ANTIDEPRESSANT: R45's admission record revealed a diagnosis of major depressive disorder. Current physician orders signed 2/23/16 included an order for Remeron (antidepressant)15 milligrams at bedtime. Review of R45's medication administration record, treatment administration record, care plan, and progress notes failed to identify mood symptoms for depression. On 3/10/16 at 9:17 a.m. nursing assistant (NA)-D was interviewed for R45's mood symptoms, "Not really anything we track for her [R45]. The only thing is when she was on a walking program she would get moody. She will make facial expressions, I don't really think she is moody." LACK OF IDENTIFYING MOOD/DEPRESSION SYMPTOMS TO DETERMINE IF MEDICATION IS AFFECTIVE; ALSO LACK OF USE OF NON-PHARMACOLOGICAL INTERVENTIONS FOR CONTROL PAIN WERE USED BEFORE AS NEEDED PAIN MEDICATION IS GIVEN:	F 428		

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F 428	Continued From page 62 R34's current physician orders signed 2/9/16 included the orders; buspirone tablet 30 mg (anti-anxiety medication) 1 tablet twice daily, Risperdal 4 mg (anti-psychotic medication) 2 tablets at bedtime, Topamax 50 mg (mood stabilizer) twice daily, and fluoxetine 60 mg (anti-depressant medication) daily for a primary diagnosis of schizoaffective disorder. Acetaminophen 500 mg 2 tablets daily as needed for break through pain and Tramadol 50 mg (controlled pain medication) 1 tablet as needed for pain three times daily. Review of R34's medication administration record, treatment administration record, care plan, and progress notes failed to identify mood symptoms or target behaviors to determine if the antipsychotic, antidepressant and analgesics were affective. Also there was no documentation found or provided by facility in regards to the use of non-pharmalogical interventions prior to the use of as needed pain medication. On 3/10/16 at 9:15 a.m. NA-D was interviewed for R34's mood symptoms and target behaviors; "She doesn't like to walk, that kind of targets her. She isn't on a walking program now cause it would trigger her. She doesn't care for different nursing assistants. She swears, she refuses stuff. She says stuff and then she will say she is just kidding. She will say stuff to try to hurt your feelings." On 3/10/16 10:42 a.m. the DON stated, "Last week we were discussing how we don't have a form of daily tracking [for mood/behavior]. [R34] is one of those that doesn't really have any [target behaviors]. I guess sometimes she doesn't like	F 428		

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F 428	Continued From page 63 some staff. I am having someone from point click [electronic medical record] come in and show us how to do behavior tracking. We don't have anything in place for the anti-depressant mood monitoring. If they start a new one or the dose changes the nurses would chart on mood, they would do it for four weeks, but nothing ongoing." On 3/11/16 at 10:21 a.m. the DON added, "The care plan has non-pharmacological interventions listed, but I don't think they [nursing] document what they tried." On 3/11/16 at 11:04 a.m. the facility consultant pharmacist stated, They should have identified mood symptoms and non-pharmacological should be tried prior to the administration of an as needed pain medication. A facility policy on mood monitoring, target behavior monitoring was requested but was not provided.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		4/19/16

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actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) 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.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure surveillance and analysis of infections and failed to ensure annual infection control education for all employees as outlined in the facility infection control policy. This had the potential to affect all residents, staff and visitors.

Findings include:

SURVEILLANCE AND ANALYSIS OF INFECTIONS:
The facility monthly summary of Infection Control Logs were obtained from June 2015 through February 2016. The logs identified for tracking the

Regulation 483.65 Tag F441
Infection Control

Prairie Manor Care Center has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The facility has an infection control program that 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as

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resident name, site, organism, antibiotic/treatment, date of onset and acquired in house were areas documented on the report. The following information of infections were indicated on the monthly logs:

6/15, two urinary tract infections (UTIs)
7/15, four UTIs, one pneumonia, one bronchitis, one cellulitis
8/15, four UTIs, two cellulitis, one pneumonia
9/15, three UTIs, one pneumonia, one elbow infection
10/15, five UTIs, two pneumonia
11/15, two UTIs, one pneumonia, one respiratory
12/15, five UTIs, one aspiration pneumonia, one cellulitis, two respiratory, one ear infection
1/16, nine UTIs, one cellulitis recurrent
2/16, four UTIs, one pneumonia, one cellulitis

However the logs failed to include specific resident room/s and wing location
that would enable tracking and trending of spread of infection, symptoms
identified, whether culture of the organism was obtained (or rational if not
performed) and date of resolution of the infection.

In addition, the facility failed to document surveillance and analysis of the
information and infection control precautions used to prevent the spread of
the infections.

On 3/10/16, at 2:17 p.m., registered nurse (RN)-B verified the logs failed to include date of resolution and wing the resident was on. RN-B stated she did not have documented surveillance and analysis of the infections. RN-B stated had identified the facility was having a lot of UTIs and

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isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control.

The facility's current monthly infection control log tracks the resident, infection site, causative organism (if cultured), antibiotic/treatment, date of onset, and whether the infection was acquired while at the facility. To improve infection process and outcorme surveillance, the infection control log and related data will identify the room/wing of the resident with the infection, the symptoms identified, whether a culture was obtained (or rationale if not), and the date of the resolution of the infection. Staff who have not participated in an infection control training session in the past year will receive training on April 12 or 14, 2016.

The infection control nurse has reviewed the infection control regulations, with a focus on the requirements for infection surveillance and staff education. A comprehensive infection control resource manual is available for reference. On June 10, 2016, the infection control nurse will attend a seminar presented by Pathway Health addressing system improvements for preventing and controlling infections as well as regulatory requirements and current standards of practice.

Compliance with regulatory requirements and facility policies for an infection control

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she or the charge nurse had been down the halls ensuring the nursing assistants were doing proper peri-cares. RN-B confirmed there was no documentation of monitoring or analysis of effectiveness of ensuring proper peri-cares.

LACK OF INFECTION EDUCATION:

The facility provide documentation of a list of current employees, which totaled 121 employees. The facility provided education attendance sheets, which the facility identified were for infection control, dated 8/18/15, 9/15/15 and October 2015. The sheet for October 2015 failed to include the year and the total number of employees documented to have attended for 8/18/15, 9/15/15 and October 2015 was 65 employees.

The facility failed to provide any further documentation for employee attendance for education of infection control.

On 3/10/16, at 2:17 p.m., RN-B verified the lack of documented education for infection control for all of the facility employees.

On 3/11/16, at 9:55 a.m., the director of nursing stated she would expect infection control education for employees to be done annually.

The facility policy Infection Control Program dated 8/1/12, indicted it is the policy of Prairie Manor Care Center to have an infection control program in place assure a safe, sanitary and comfortable environment for residents and personnel. It is designed to help prevent the development and transmission of disease and infection. Prairie Manor Care Center has established a program

surveillance program will be monitored by the Director of Nursing/designee for the next three months through a review of 1) the infection control tracking data and 2) staff training records. If noncompliance is noted, additional staff training and auditing will be done.

Process/outcome surveillance of infections, frequency/type of infections, and other infection control issues will be continue to be routinely reviewed by the Quality Assurance and Assessment Committee.

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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 441	Continued From page 67 under which it: investigates, controls and prevents infections in the facility, decides what procedures such as isolation, should be applied to an individual resident and maintains a record of incidents and corrective actions related to infections. Basic Responsibility, the infection Preventionist (IP), or designee, is responsible for directing the infection control program. Maintain training records that document training in infection control in employee files. The facility Infection Surveillance policy dated 8/1/12, indicated infection prevention begins with ongoing surveillance to identify infections that are causing, or have the potential to cause outbreak. The facility closely monitors all residents who exhibit signs/symptoms of infections through ongoing surveillance and has a systemic method of collecting, consolidating and analyzing data concerning the frequency an cause of a given disease or event, followed by dissemination of that information to those who can improve the outcomes. The intent of the surveillance is to identify clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. The results should be used to plan infection control activities, direct in-service education, and identify individual resident problems in need of interventions. Other sources of relevant data include laboratory cultures and antibiotic susceptibility profiles. Reporting, analysis and conclusions are reported to appropriate quality assessment and assurance committee on a regular basis and results of surveillance are reported back to nursing units as performance feedback. Data analysis, this data is recorded at least quarterly and included in the nursing homes quality improvement data. It is important that surveillance reports be shared with	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING ______ B. WING ______	03/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	**220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917**

(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 441	Continued From page 68 appropriate individuals including, but not limited to, the director of nursing and medical director. In addition, it is important that he staff and practitioners receive reports that are relevant to their practices to help them recognize the impact of their care in infection rates and outcome. Plan, based on analysis of data, develop and implement action plan, corrective actions, education and/or other strategies. Evaluate the effectiveness of the corrective actions, education provided, prevention measure, etc. Documentation, descriptive documentation provides the nursing home summarized observations related to the investigation of the cause of an infection and/or identifies the underlying cause of infection trends. The facility Infection Control Policy, dated 8/1/12, indicated Prairie Manor Care Center has a facility wide infection control program with effective measures to identify, control and prevent infections acquired or brought to the facility from the community. Policy, responsibility for the management of infection control and prevention has been assigned to the Infection Preventionist. The program exists for reporting, evaluating and maintaining records of infections among residents and any required follow up. Required employee in servicing on infection control prevention are provided to all departments at least annually. The Quality Assurance Committee discusses infection control issues.	F 441		

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

F5482025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245482	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	**220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 3/10/2016, Prairie Manor Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/08/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**03/10/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	**220 THIRD STREET NORTHWEST** **BLOOMING PRAIRIE, MN 55917**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Prairie Manor Care Center is a 1-story building. The original building was constructed in 1970 and was determined to be of Type II(111) construction, with a partial basement. In 1984, addition was constructed and was determined to be of Type II(111) construction. The facility is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 37 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		4/5/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/10/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	**220 THIRD STREET NORTHWEST** **BLOOMING PRAIRIE, MN 55917**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025 SS=F	Continued From page 2 Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: K25: Based on observations and interview, the facility has failed to properly construct and maintain a required 2-hour fire separation, in accordance with NFPA 101 (2000), Chapter 19, Sections 19.1.1.4 and 19.1.2.1. In a fire emergency, this deficient practice could adversely affect the safety of (52) residents, staff and visitors. FINDINGS INCLUDE: During the facility tour between the hours of 09:00 AM and 11:30 PM on 3/10/2016, observation revealed: The smoke barrier separation wall between the Nurses area and the right wing has penetractions from the fire sprinkler system piping.	K 025	Tag K025 The open penetrations in the smoke barrier wall between the nurses area and the right wing has been sealed with mineral wool. All smoke barrier separation walls will be inspected for penetrations in the smoke barrier. The interim Maintenance Director is responsible for monitoring compliance.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This deficient practice could affect all 52 residents.	K 062	The required testing has been completed. The dates of completion of the quarterly fire sprinkler test will be tracked on a log; the test is included on the list of routinely scheduled maintenance tasks.	4/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR CARE CENTER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917

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K 062	Continued From page 3 Findings include: On facility tour between 9:00 AM and 11:30 PM on 3/10/2016, a review of the facility's available fire sprinkler test documentation revealed that the facility failed to conducted the required quarterly testing.	K 062	The interim Maintenance Director is responsible for monitoring compliance.	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6. Findings include: On facility tour between 9:00 AM and 11:30 PM on 3/10/2016, based on observations the fire extinguisher servicing the Lanudry area was not annualy inspected.	K 064	The facility contracts with Austin Fire and Safety Company to conduct the annual inspection of the fire extinguishers. Although the fire extinguisher in the laundry area was on the list of extinguishers to inspect, the contract company failed to inspect it. The company was notified of omission and has since inspected the extinguisher. The interim Maintenance Director is responsible for monitoring compliance.	4/5/16
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified,	K 154	The facility has a plan to ensure safety of the building occupants in the event the automatic sprinkler system is out of	4/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**03/10/2016**

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K 154	Continued From page 4 and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:00 AM and 11:30 PM on 03/10/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (GS) at the time of discovery.	K 154	service for more than four hours in a 24-hour period. The current plan was reviewed and will be updated. The interim Maintenance Director is responsible for monitoring compliance.	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 09:00 AM and 11:30 PM on 03/10/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system.	K 155	The facility has a plan to ensure safety of the building occupants in the event the fire alarm system is out of service for more than four hours in a 24-hour period. The current plan was reviewed and will be updated. The interim Maintenance Director is responsible for monitoring compliance.	4/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/10/2016

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K 155	Continued From page 5 This deficient practice was confirmed by the Facility Maintenance Director (GS) at the time of discovery.	K 155		

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

F5482025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING **02 - CHAPEL** B. WING ______	**03/10/2016**

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PRAIRIE MANOR CARE CENTER	**220 THIRD STREET NORTHWEST** **BLOOMING PRAIRIE, MN 55917**

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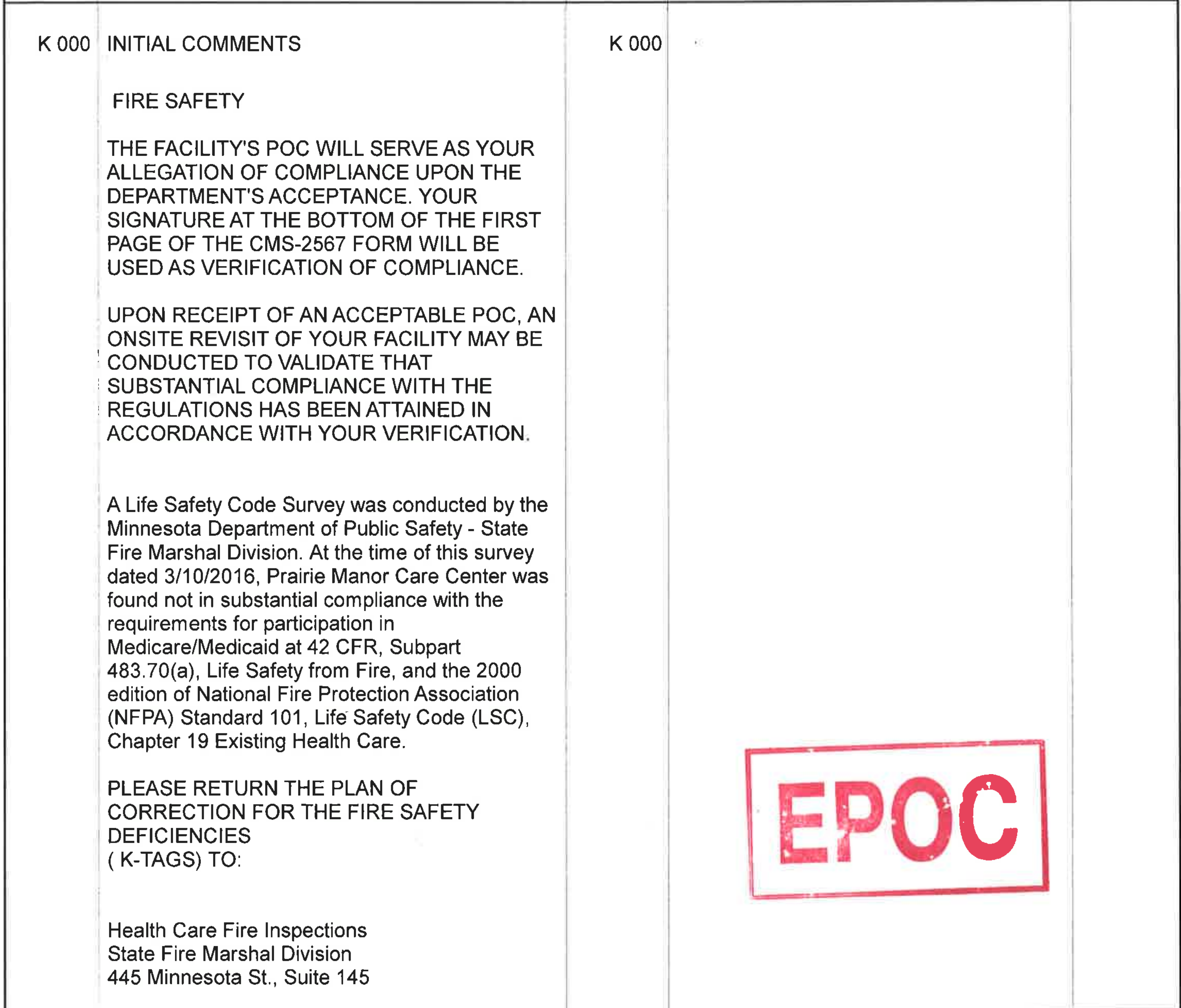

K 000 INITIAL COMMENTS — K 000

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 3/10/2016, Prairie Manor Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/08/2016

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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	245482	A. BUILDING 02 - CHAPEL B. WING	03/10/2016

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K 154	NFPA 101 LIFE SAFETY CODE STANDARD	K 154		4/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING **02 - CHAPEL** B. WING	**03/10/2016**

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K 154 SS=D	Continued From page 2 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:00 AM and 11:30 PM on 03/10/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (GS) at the time of discovery.	K 154	The facility has a plan to ensure safety of the building occupants in the event the automatic sprinkler system is out of service for more than four hours in a 24-hour period. The current plan was reviewed and will be updated. The interim Maintenance Director is responsible for monitoring compliance.	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
March 30, 2016

Mr. Richard Feeney, Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, MN 55917

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5482026

Dear Mr. Feeney:

The above facility was surveyed on March 7, 2016 through March 11, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00650	A. BUILDING: ______ B. WING ______	03/11/2016

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PRAIRIE MANOR CARE CENTER	**220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917**

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On March 7, 8, 9, 10, & 11, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills.	2 302		4/19/16

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2 302	Continued From page 2 (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide dementia training that included all required components for 24 of 24 employees hired between 4/29/15 to 3/2/16; and failed to provide written notice to consumers of facility dementia training. This had the potential to affect all 37 residents in the facility. Findings include: Document review of the facility information provided on the Centers for Medicare and Medicaid Services (CMS) form 672, revealed the facility had 14 residents diagnosed with Alzheimer's disease/dementia. During interview on 3/7/16, at 3:20 p.m., director of nursing stated facility provided dementia training to nursing assistants only. She verified no dementia training was provided to licensed nursing or supervisors. During interview on 3/10/16, at 10:15 a.m., director of nursing verified facility had several residents with diagnosis of Alzheimer's disease /dementia. Director of nursing verified licensed nurses had not received dementia training. She verified none of the new hired employees from	2 302	Minnesota State Statute 144.6503 ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING Policies and procedures have been developed to provide direct care and supervisory staff additional training on caring for residents with Alzheimer s disease and related disorders. The training will include: 1) An explanation of Alzheimer's disease and related disorders 2) Techniques for assisting residents with cognitive impairments with their activities of daily living, especially those who are resistive to cares 3) Techniques to solve/de-escalate challenging and problematic behaviors negatively impacting others and compromising high quality care, and 4) Techniques to effectively communicate with residents with memory deficits and improve the exchange of essential	

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2 302	Continued From page 3 4/29/15, to 3/2/16, had received all the required dementia training. Director of nursing verified the facility did not provide information to consumers, residents/families, regarding facility dementia training. Director of nursing stated she is responsible for the dementia training program. She verified the facility had no policy related to dementia training. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop policies to educate staff on dementia training and policies to provide consumers with a description of facility dementia training. The director of nursing could in-service all direct care staff and their supervisors on how to work with persons with dementia behavior. This should, at a minimum, include explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, and communication skills. The director of nursing could maintain a list of staff attendance and frequency of training. The director of nursing and facility social workers could develop the required dementia training information to give to consumers. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	information. Information about the dementia training will be provided to consumers, residents, and families. Methods for information distribution being considered include an article in the facility newsletter, posting a notice within the facility describing the dementia training, and addressing the dementia training during the family/resident council meetings and care conferences.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing,	2 560		4/19/16

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2 560	Continued From page 4 and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to care plan missing teeth for 1 of 3 residents (R75) reviewed for dental status. Findings include: R75 was observed on 3/7/16 at 6:26 p.m., to have missing teeth on the lower gum line. On 3/10/16, at 7:50 a.m. licensed practical nurse (LPN)-A observed R75's teeth and verified R75 had missing teeth towards the front and on the left side of lower gum line. The Nursing Admission Assessment for R75, dated 1/19/16, identified oral/dental: missing teeth, top partial and noted: has own teeth on bottom and partial uppers. R75's care plan printed 3/11/16, identified a problem area related to dental status. "requires assistance with providing dental care." Interventions included for staff to make sure "dentures are in mouth and cleaned prior to meals. Remove, clean, and soak dentures every bedtime. Last dental appointment 2015. Provide oral hygiene with a.m. (morning) cares, p.m. (evening) cares, and as needed. Resident has upper dentures and own lower teeth. Will continue to offer/encourage a dental appointment	2 560	Prairie Manor Care Center uses the results of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident's needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents' right to refuse cares/services. The care plan related policies/procedures and the staff responsibilities for development and revision of the comprehensive plans of care were reviewed and updated. At the time of admission, a temporary care plan is implemented that addresses the residents' need for assistance with activities of daily living; the interdisciplinary care plan is developed within seven days after completion of the comprehensive assessment. As part of the quarterly care conference process, the interdisciplinary team reviews the care plans for completeness, accuracy, and relevancy.	

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2 560	Continued From page 5 per facility policy." The care plan did not indicate R75 had missing teeth. On 3/10/16 at 12:31 p.m., registered nurse (RN)-A verified R75's care plan failed to include missing teeth. On 3/10/16 at 1:00 p.m., the director of nursing stated she would expect missing teeth to be identified on R75's care plan. The facility's policy, Care Plan Policy dated 8/13/13, indicated a care plan would be developed for each resident identifying the needs of the individual resident. Each resident care plan will address every specific area of care for each resident. SUGGESTED METHOD OF CORRECTION: The facility could review care plan policies/procedures and revise if necessary, the facility could then develop and present education to staff members regarding importance of fully developing/revising the resident's care plan, the facility could then develop and implement an auditing system as part of quality assurance program that would ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560	During the mandatory meetings April 14 and 15, 2016, the nursing staff will be reminded 1) of the facility policies for care plan reviews and updates 2) that the residents' care plans must be current at all times and 3) that care plans must continue to address the residents' dental condition and any dental care needs. A registered nurse assessed the oral cavity and dentition of resident number 75. The care plan was updated to reflect that the resident has missing teeth. Compliance will be monitored by the MDS Coordinator. For the next three months, if dental problems identified during the routine oral assessments or triggered on the minimum data set screening tool, the care plan will be reviewed to ensure that the resident's dental status/condition is appropriately addressed. If noncompliance is noted, additional staff training and auditing will be done. Compliance will be reviewed at the April quarterly Quality Assurance and Assessment Committee meeting.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		4/19/16

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2 565	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement care plan interventions for repositioning for 1 of 1 resident (R27) reviewed for pressure ulcers; and failed to monitor and report skin changes for 1 of 3 residents (R77) reviewed with non-pressure related skin concerns (bruising). Findings include: LACK OF REPOSITIONING ACCORDING TO THE COMPREHENSIVE CARE PLAN: R27's care plan, print date 3/11/16, identified the following: Resident is at risk for skin breakdown related to history of intragluteal ulcer right inner buttock and spongy heels. Intervention of reposition when in chair every two hours. R27 was observed continuously on 3/9/16, from 9:55 a.m. until 12:27 p.m., (a total of 2 hours and 32 minutes), in which R27 had not been repositioned. At 9:55 a.m., nursing assistant (NA)-B and NA-C were observed to transfer R27 from the toilet back into his wheelchair using an EZ stand mechanical lift. R27 was observed to have a red, shiny, open area noted on his left buttock. NA-C confirmed R27 had an open area on his left buttock and applied barrier cream to R27's buttock. At 10:03 a.m., R27 remained sitting in his wheelchair in his room. WAS CREAM APPLIED after he transferred back to his w/c??? 10:12 a.m., R27 remained sitting in his wheelchair in his room. At 10:25 a.m., NA-C entered R27 room, shut off R27 television and	2 565	Prairie Manor Care Center provides services that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each resident's written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes modifications as necessary. The facility has policies and procedures for developing individualized plans of care and communicates the plan to the direct care givers by use of the nursing assistant care instruction Kardex. The care plan policies and procedures were reviewed and revised. During the April 14 and 15, 2016, mandatory meetings, the nursing staff will be reminded/instructed 1) that the residents' plans of care must be followed 2) that repositioning residents according to their plan of care is essential to preserve skin integrity and prevent/treat pressure ulcers and 3) that job performance expectations include being aware of and following the resident's plan of care including timely repositioning. The	

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2 565	Continued From page 7 asked R27 if he would like to go to brunch. NA-C then assisted R27, who remained sitting in his wheelchair, to the dining room. 10:40 a.m., R27 remained sitting in his wheelchair in the dining room. At 10:50 a.m., R27 remained sitting in his wheelchair in the dining room. At 11:05 a.m., R27 remained sitting in his wheelchair in the dining room. NA-B was observed to sit next to R27 at the dining room table and assisted R27 with eating. At 11:36 a.m., R27 remained sitting in his wheelchair in the dining room. NA-B continued to assist R27 with eating. At 11:50 a.m., NA-B was observed to assist R27 from the dining room back to R27's room. R27 remained sitting in his wheelchair. NA-B placed R27's call light within reach, turned on R27's television and stated to R27 I will be right back, in just a few minutes. At 12:05 p.m., R27 remained sitting in his wheelchair in his room. Registered nurse (RN)-C entered R27's room to look at R27's right arm, which had a dressing in place. R27 remained sitting in his wheelchair. At 12:09 p.m., R27 remained sitting in his wheelchair in his room, 12:18 p.m., R27 remained sitting in his wheelchair in his room. 12:25 p.m., R27 remained sitting in his wheelchair in his room, 12:27 p.m., NA-B and NA-C entered R27's room with an EZ stand mechanical lift and transferred R27 from his wheelchair to the toilet. R27's left side buttock area was purple in color, blanchable and the open area looked dry. On 3/9/16, at 12:45 p.m., NA-C stated R27 was to be repositioned every two to three hours. NA-C stated they had care sheets they follow for resident cares. NA-C reviewed R27's care sheet and verified the care sheet read reposition when in chair every two hours (not three hours as previously stated). NA-B stated she was aware	2 565	orientation for new employees will continue to address the importance of following the resident's plan of care for activities of daily living including assistance with repositioning. Resident number 27 – A registered nurse reviewed the resident's skin condition and skin-related plan of care; every two-hour repositioning remains appropriate. The nursing assistants have been reminded of the residents of the need for every two-hour repositioning and the policy for referring to the care Kardex for the resident's repositioning plan of care. Resident number 77 – The lesions on the top of the resident's right hand were assessed by a nurse on March 9, 11, and 13. The plan of care included applying antibiotic ointment to the affected area. The resident was discharged March 18, 2016 to another long term care facility to be closer to her family. Compliance with timely repositioning for residents with mobility dependencies will be monitored by the charge nurses through observation of the direct care staff. Resident care observations will be assigned by the Director of Nurses/designee for two weeks. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the April quarterly Quality Assurance and Assessment Committee meeting.	

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2 565	Continued From page 8	2 565		

R27 was to be repositioned every two hours.

On 3/10/16, at 12:41 p.m., registered nurse (RN)-A stated she would expect the care plan to be followed for repositioning every two hours, because R27's skin is so fragile. We will continue to reposition R27 every two hours even though R27 is healed in reference to an open area on left buttock at this time.

On 3/10/16, at 12:51 p.m., the director of nursing (DON) stated she would expect R27 to be repositioned every two hours if that was care planned for R27, or somewhere in the close vicinity of two hours.
NON-PRESSURE RELATED SKIN CONDITION:

R77 was observed on 3/7/16, at 3:10 p.m., revealed a lesion on the back of R77's right hand, approximately one centimeter in size. The lesion was covered in a dark brown crust, with no red skin surrounding the area. Observations on 3/8/16, at 8:30 a.m., and 3/9/16, at 11:20 a.m., revealed the lesion remained same on back of right hand. R77 was admitted to the facility on 2/15/16 with diagnosis that included hemiplegia, hemiparesis, and dysphagia following cerebral infarction, according to facility admission record.

The facility identified R77 on the body audit dated 2/15/16, with rash in groin and on left arm, bruise on left shin, and open area on right knee. There was no indication of lesion on back of right hand.

Facility care plan print date of 3/9/16, directed staff a focus of required assistance with bathing. Interventions included skin integrity will be monitored weekly on bath day and as needed, report any changes, problems or redness to nursing.

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2 565	Continued From page 9 Document review of nursing assistant kardex, printed 3/9/16, directed staff skin integrity will be monitored weekly on bath day and as needed, report any changes, problems, redness to nursing. Although nursing assistant documentation identified the lesion on 3/5/16, there was no further evidence of monitoring and reporting the lesion to nursing. Document review of facility progress notes dated 2/26/16 to 3/8/16, revealed the following: 2/26/16-quarterly skin risk assessment-at high risk for skin breakdown, required extensive to total assist with cares, transferred by mechanical lift, did not ambulate, foley catheter in place, had pink folds at times, reposition every one to two hours sitting and lying. Monitor skin daily with cares, weekly with bath, and as needed. 2/29/16-shower this morning with no new bruising or skin tears. 3/7/16-had shower and weekly skin check this shift. No new skin issues at this time. Document review of facility incident report log dated 3/1/16 to 3/6/16, revealed no identification of R77's skin lesion. During interview on 3/9/16, at 12:15 p.m., nursing assistant (NA)-G stated she had became aware of R77's hand lesion on 3/7/16. NA-G stated she did not know how the lesion occurred. During interview at that time, NA-D stated was aware of the lesion today, 3/9/16. NA-D stated would document on the lesion and notify the	2 565		

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2 565	Continued From page 10 nurse. During interview on 3/9/16, at 12:17 p.m., licensed practical nurse (LPN)-B stated was not aware of the lesion. During interview at that time, NA-D stated when staff discover a non-pressure related area, staff are to document in the memo book and give the white page of the carbon copy to the nurse. Document review of the memo book at that time with NA-D, revealed the lesion was identified on 3/5/16, as "sore on top of right hand." Document review revealed progress note dated 3/9/16, at 4:22 p.m., "Staff reported sore to resident's right hand." Two areas were identified as dry patches on back of right hand, one area measured 0.7 centimeter by 0.9 centimeter, the other measured 0.2 centimeter by 0.3 centimeter. The areas were noted to have no drainage and no signs of infection. Triple antibiotic ointment was initiated two times a day and leave open to air. During interview on 3/10/16, at 7:38 a.m., registered nurse (RN)-A verified facility was not aware of R77's right hand lesion until 3/9/16, and the wound nurse assessed the area at that time. RN-A stated she expected staff to report skin concerns to the wing nurse, wing nurse to complete an incident report, and send emails to notify director of nursing, nurse manager, wound nurse, social services and administrator. RN-A stated she expected the wing nurse to document skin concerns in progress notes. RN-A stated skin concerns were monitored by the wound nurse completing an assessment weekly and by the wing nurse who looked at the area daily. RN-A verified R77's treatment of triple antibiotic ointment started on evening of 3/9/16, as	2 565		

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2 565	Continued From page 11 documented in facility medication administration record. RN-A verified the nursing assistant memo book-white part of carbon copy was to be given to the wing nurse and yellow part of the carbon copy stayed in the memo book. During interview on 3/10/16, at 9:50 a.m., director of nursing stated she expected nursing assistants to report skin concerns to the wing nurse and to document the concern in the nursing assistant memo book. Director of nursing stated she expected the wing nurse to assess the concern, complete an incident report, and report to charge nurse, director of nursing, administrator and social services. The facility Care Plan Policy, dated 8/13/13, indicated purpose, to develop a plan of care for every resident to ensure care is given per resident preference. Procedure, each resident care plan will address every specific area of care for each individual resident. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop, review, and/or revise policies and procedures to ensure the facility followed care plans according to the residents individualized needs. The director of nursing could educate all appropriate staff on the policies and procedures. The director of nursing could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision	2 570		4/19/16

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2 570	Continued From page 12 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise the care plan to include skin interventions to promote healing and prevent breakdown of skin for 1 of 1 resident (R27) reviewed for pressure ulcers; failed to revise the care plan to include risk for bruising for 1 of 3 residents (R27) reviewed for skin conditions; failed to revise a care plan for 1 of 1 resident (R38) reviewed for contractures; and failed to revise the plan of care for 1 of 1 resident (R39) who demonstrated delusional behaviors and who made frequent inaccurate allegations about other residents being abused. Findings include: LACK OF INTERVENTION/S FOR "SPONGY HEELS:" R27's care plan printed 3/11/16, identified the following: Resident is at risk for skin breakdown related to history of intragluteal ulcer right inner buttock and spongy heels. Interventions included: Apply vanicream to dry skin areas with cares AM	2 570	Tag F282 Services by Qualified Personnel per Care Plan Prairie Manor Care Center provides services that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each resident's written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes modifications as necessary. The facility has policies and procedures for developing individualized plans of care and communicates the plan to the direct care givers by use of the nursing assistant	

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(morning) and PM (evening), report any red or very dry skin areas to nurse, barrier cream to peri-area after all incontinent episodes, bilateral heel cups on while in bed, dressing change to coccyx as ordered PRN (as needed), and use of a medication to alleviate itching. Monitor for effectiveness and side effects, pressure relieving device: Advantage contour mattress on bed and panacea in wheelchair, skin assessment, Braden scale quarterly and PRN (as needed), skin tolerance testing annually, with readmission and PRN, turn and reposition every 2 hours while in bed, turn side to side as much as possible, and reposition when in chair every 2 hours.
A progress note dated 2/5/16, indicated R27 had the following: wound note, assessed residents heels. Heels are spongy and soft to the touch. Left is spongier than the right. Shoes are removed during the day while in recliner. However, this intervention was not added to the current comprehensive care plan.

On 3/9/16, at 12:41 p.m., nursing assistant (NA)-B and nursing assistant (NA)-C were observed to transfer R27 to his recliner using an EZ stand mechanical lift. NA-C elevated R27's feet in the recliner, placed R27's call light within reach and walked out of R27's room without removing R27's shoes.

On 3/9/16, at 12:45 p.m. NA-C confirmed R27's shoes had been left on while R27 sat in the recliner. NA-C and NA-B stated they were not aware R27's shoes were to be removed when R27 was sitting in the recliner. NA-C stated they had care sheets they followed for resident care. NA-C and NA-B reviewed R27's care sheet and verified the care sheet failed to indicate R27's shoes were to be removed during the day while he sat in the recliner.

care instruction Kardex. The care plan policies and procedures were reviewed and revised.

During the April 14 and 15, 2016, mandatory meetings, the nursing staff will be reminded/instructed 1) that the residents' plans of care must be followed 2) that repositioning residents according to their plan of care is essential to preserve skin integrity and prevent/treat pressure ulcers and 3) that job performance expectations include being aware of and following the resident's plan of care including timely repositioning. The orientation for new employees will continue to address the importance of following the resident's plan of care for activities of daily living including assistance with repositioning.

Resident number 27 – A registered nurse reviewed the resident's skin condition and skin-related plan of care; every two-hour repositioning remains appropriate. The nursing assistants have been reminded of the residents of the need for every two-hour repositioning and the policy for referring to the care Kardex for the resident's repositioning plan of care.

Resident number 77 – The lesions on the top of the resident's right hand were assessed by a nurse on March 9, 11, and 13. The plan of care included applying antibiotic ointment to the affected area. The resident was discharged March 18, 2016 to another long term care facility to be closer to her family.

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On 3/10/16, at 9:47 a.m. registered nurse (RN)-C stated removing R27's shoes when in the recliner had been implemented some time ago. RN-C stated the nursing assistants should have been aware R27's shoes were to be removed when he sat in the recliner however, when RN-C reviewed R27's care plan she verified the care plan had not been revised to include the removal of R27's shoes during the day while in the recliner. RN-C stated she did not know why the intervention had not been added to the care plan and stated, "I should have caught that."

On 3/10/16 at 12:51 p.m., the director of nursing (DON) stated she would have expected R27's care plan to be revised to include removal of his shoes during the day when in the recliner, and would have expected the nursing assistant kardex to be updated.

LACK OF IDENTIFYING RISK OF BRUISING AND INTERVENTIONS IF OBSERVED:

R27 was observed on 3/7/16, at 6:42 p.m. to have a purple bruise on top of his left hand.

On 3/8/16, at 2:54 p.m., R27 was observed to be sitting in a recliner in his room. The purple bruised area was observed on R27's left hand, and another purple colored bruise was noted above R27's left elbow.

R27's quarterly Minimum Data Set dated 12/17/15 identified diagnoses of dementia, polymyalgia rheumatic and atrial fibrillation.

R27's physician orders dated 1/19/16, identified an order for prednisone 5 mg (milligrams) one time a day (corticosteroids, side effect; thinning of

Compliance with timely repositioning for residents with mobility dependencies will be monitored by the charge nurses through observation of the direct care staff. Resident care observations will be assigned by the Director of Nurses/designee for two weeks. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the April quarterly Quality Assurance and Assessment Committee meeting.

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the skin) and aspirin 81 mg one time a day. R27's medication administration record, dated 3/16 identified R27 received the medications daily as ordered.

R27's incident reports identified the following:
1/2/16, multiple bruises on both upper arms, many areas identified as blue in color.
1/6/16, new bruises on right elbow and two on bicep.
2/12/16 resident has a bruise on his right hand.
2/20/16 resident has a bruise on his left side upper lip.
3/3/16, bruises reported on top of left hand and left elbow. Resident known to be combative and resistive with cares at times and is prone to bruising. Does use EZ stand mechanical lift for transfers. Resident unable to verbalize how bruising may have occurred.

R27's care plan was reviewed and did not include a problem area related to R27's risk for bruising, interventions to prevent bruising, nor interventions to implement if bruising was identified.

On 3/10/16 at 12:41 p.m., registered nurse (RN)-A verified the risk of bruising had not been included on R27's care plan. RN-A stated they try to find the source that caused the bruising, but verified they had not implemented interventions to prevent bruising.

On 3/11/16, the director of nursing (DON) acknowledged the risk for bruising should have been added to R27's care plan.

LACK OF CURRENT STATUS FOR RIGHT HAND CONTRACTURE INTERVENTIONS:

R38's care plan dated 1/30/16, included diagnosis

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of primary generalized osteoarthritis. Interventions related to the osteoarthritis diagnosis included, "Staff will place rolled up wash cloth in resident's right hand r/t [related to] contractures, to aid with decreasing pain as resident allows."

A restorative nursing Progress Note dated 7/8/15 indicated the resident had been non-compliant with trailing of hand splint/palm roll to the right hand. The note indicated the resident's non compliance had to do with R38 routinely holding her hand in a closed fist position.

On 3/9/16 at 11:58 a.m., licensed practical nurse (LPN)-B stated, "She [R38] can't open her right hand, it's contracted. We tried doing exercises, applying a brace and using a rolled washcloth but she did not tolerate it. We tried doing the exercises but she can get easily combative."

On 3/11/16 at 8:57 a.m. the director of nursing (DON) stated, "I don't see the issue identified anywhere in the care plan except for her experiencing pain with the use of a rolled washcloth." The DON verified the care plan had not been updated to reflect R38's current contracture status with her right hand and refusal of interventions.

LACK OF CARE PLANNED BEHAVIORAL INTERVENTIONS:

R39's admission record dated 5/12/15, indicated the resident had diagnoses including anxiety disorder and unspecified dementia without behavioral disturbance.

R39's Minimum Data Set (MDS) dated 12/30/15, indicated R39 had a Brief Interview for Mental

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Status (BIMS) score of 14, which indicated he was cognitively intact. In addition, the MDS noted R39 had experienced no behaviors. R39's PHQ-9 (a patient health questionnaire used as a tool to monitor the severity of depression) identified a score of 11, which indicated the resident had mild depression. According to the documentation, R39 had stated on the PHQ-9 that he felt down, depressed or hopeless; and that he felt bad about himself.

R39's care plan (no date), indicated he had suffered a chronic/progressive decline in intellectual functioning characterized by memory deficit, judgment, decision making and thought processes related to short term memory loss and dementia. The care plan indicated that if R39's confusion increased suddenly, staff were to assess and evaluate whether there were any signs or symptoms of infection, or any other medical problems. R39's care plan identified the resident at being a low to medium risk of being abused. Interventions indicated R39 was encouraged to report any concerns related to abuse/neglect to social services, nursing and/or appropriate outside agency. However, the care plan did not address the resident's regular habit of making accusations about other residents being abused by staff which occurred over the past six months, which had been unsubstantiated.

During a stage I interview with R39 on 3/8/16 at 10:22 a.m., R39 was asked whether he'd ever seen any other resident abused by staff. R39 stated, "There is one guy that stayed here and he had this one girl, I think he got her pregnant." R39 stated the "guy" resided at the facility [R18]. R39 then stated the girl worked at the facility, "He was an outsider. He was here for a short time. He is

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still residing here. He got an employee pregnant here. She still works here. I told a nurse's aide about it. Well, she moved him down the hallway somewhere else. Well, that didn't help any and she still goes down to him."

When interviewed on 3/8/16 at 11:00 a.m., the director of nursing (DON) stated R39 had thought the employee whom he had referred to during interview was his own girlfriend. The DON explained that R39 thought the employee was having an affair with another staff member. She stated the last time R39 had acted this way he'd been diagnosed with a urinary tract infection (UTI) and that once it had been treated, the behaviors had stopped. The DON stated this had happened twice in the past. The DON also stated the employee in question was an evening shift nursing assistant that R39 had picked as his girlfriend. The DON explained that there was also a male nursing assistant working at the facility, and that when R39 saw those two nursing assistants talking, R39 would get upset. The DON stated social service staff had spoken with R39 and the female nursing assistant, and the DON had spoken with the male nursing assistant, and they'd been unable to substantiate any of R39's allegations.

When interviewed on 3/9/16 at 12:11 p.m., R39 stated that one day he was in the dayroom watching television in the carpeted area. He described the lighting as dark with no lights on. He stated "these girls" came in the area "from the outside" and one of the girls sat on R18's lap and started "loving him up." R39 stated he did not think it was a family member. R39 stated then the girls ran off after that. He described the girls as "grown up."

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When interviewed on 3/8/16 at 3:25 p.m., Social services (SS)-A stated R39's behaviors began back in October (2015). She stated the behaviors appeared to correlate with the advent of a urinary tract infection and that nursing was notified when behaviors appeared, and they tracked for any infections.

When interviewed on 3/8/16 at 3:59 p.m., licensed practical nurse (LPN)-C confirmed R39 had a urinary tract infection in January 2016 and at that time thought he was in a relationship with a staff member. LPN-C stated she'd thought R39's behaviors had ended. In addition, LPN-C stated the nursing staff thought perhaps R39 had been experiencing delusions. LPN-C stated R39 did get a lot of urinary tract infections.

When interviewed on 3/9/16 at 9:18 a.m., the administrator stated that R39's behaviors should have been care planned. He stated that there were instances of R39's behaviors which should have been investigated more.

When interviewed on 3/9/16 at 11:00 a.m., SS-A stated a problem related to R39's behaviors of making allegations about other residents being sexually abused should have been care planned. She stated that she would initiate training for the staff which included reporting abuse allegations.

When interviewed on 3/9/16 at 2:34 p.m., registered nurse (RN)-A stated that social services had been aware of R39's behaviors. She also stated R39 would usually wait for a care conference meeting to bring up any issues, that the nursing assistants would normally report when R39 was experiencing behaviors. RN-A stated she was aware of one episode the DON had investigated that had been reported by R39.

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2 570	Continued From page 20 The facility's policy, Care Plan Policy dated 8/13/13, included: "...A care plan will be developed for each resident identifying the needs of each individual resident. Each resident care plan will address every specific area of care for each resident. The care plan will be reviewed and updated from the nurse manager quarterly, annually, and with a significant change. The care plan will be updated from a registered nurse with any changes in resident care as needed..." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		4/19/16

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2 830	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to monitor bruising for 1 of 3 residents (R27) reviewed for non pressure related skin conditions. In addition, the facility failed to identify and investigate a non-pressure related skin area and provide interventions to promote healing for 1 of 3 residents (R77) reviewed with non-pressure related skin concerns. Also failed to provide access to call light to prevent falls for 1 of 1 resident (R27) who was observed to not have access to call light when unattended by staff. Findings include: R27 was observed on 3/7/16, at 6:42 p.m. to have a purple bruise on top of his left hand. On 3/8/16, at 2:54 p.m., R27 was observed to be sitting in a recliner in his room. The purple bruised area was observed on R27's left hand, and another purple colored bruise was noted above R27's left elbow. R27's quarterly Minimum Data Set dated 12/17/15, identified diagnoses of dementia, polymyalgia rheumatic and atrial fibrillation. R27's physician orders dated 1/19/16, identified an order for prednisone 5 mg (milligrams) one time a day (corticosteroids, side effect; thinning of the skin) and aspirin 81 mg one time a day. R27's medication administration record, dated 3/16 identified R27 received the medications daily as	2 830	Prairie Manor Care Center provides each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. The interdisciplinary care team assesses each resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident's condition indicates. A plan of care is developed, implemented, routinely reevaluated, and revised as necessary based on continuing assessments. The policies and procedures for identifying, reporting, investigating, and monitoring bruises and other skin lesions were reviewed and found appropriate. During the April 14 and 15 mandatory nursing staff meetings, discussion will include the need to observe for skin lesions and the importance of appropriately reporting, documenting and monitoring bruises/ lesions. Procedures related to the above will be reviewed as well as developing care plans to monitor/treat/prevent bruises and other skin lesions. Instruction will be provided to the nursing assistants on the need to be alert to bruising and other skin injuries/lesions and to immediately report the findings to the licensed nurse. Observing and reporting skin problems,	

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2 830	Continued From page 22 ordered. R27's incident reports identified the following: 1/2/16, multiple bruises on both upper arms, many areas identified as blue in color. 1/6/16, new bruises on right elbow and two on bicep. 2/12/16 resident has a bruise on his right hand. 2/20/16 resident has a bruise on his left side upper lip. 3/3/16, bruises reported on top of left hand and left elbow. Resident known to be combative and resistive with cares at times and is prone to bruising. Does use EZ stand mechanical lift for transfers. Resident unable to verbalize how bruising may have occurred. R27's care plan was reviewed and did not include a problem area related to R27's risk for bruising, interventions to prevent bruising, nor interventions to implement if bruising was identified. On 3/10/16 at 12:41 p.m., registered nurse (RN)-A verified the risk of bruising had not been included on R27's care plan. RN-A stated they try to find the source that caused the bruising, but verified they had not implemented interventions to prevent bruising. On 3/11/16, the director of nursing (DON) acknowledged the risk for bruising should have been added to R27's care plan. A policy for non-pressure skin conditions was requested, but not provided. NON-PRESSURE RELATED SKIN CONDITION: R77 had a crusted lesion on the back of right hand without the facility identification, assessment, and investigation of the lesion, and	2 830	including bruises, will continue to be part of the nursing assistant's bathing protocol. Resident number 27 – A registered nurse reassessed the resident's skin-related plan of care. The care plan has been updated to address the resident's risk of bruising, options to prevent bruising, and implementation of interventions in the event of bruising. Resident number 77 – The lesions on the top of the resident's right hand were assessed by a nurse on March 9, 11, and 13. The plan of care included applying antibiotic ointment to the affected area twice a day. The resident was discharged March 18, 2016 to another long term care facility closer to her family. To monitor care plan compliance, the MDS Coordinator will audit the care plans for completeness and accuracy for those residents who have open skin areas, contractures, or are receiving medications such as aspirin, Coumadin or prednisone, or have other risk factors that increase the risk of bruising. To monitor compliance with identification of skin lesions, the Director of Nursing/designee will conduct random skin audits for two weeks. If previously unreported bruises or other skin problems are observed, additional auditing and staff training/counseling will be done. Compliance will be reviewed during the April quarterly Quality Assurance and Assessment Committee meeting.	

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without interventions to promote healing.

R77 was admitted to the facility on 2/15/16 with diagnosis that included hemiplegia, hemiparesis, and dysphagia following cerebral infarction, according to facility admission record.

A body audit conducted for R77 dated 2/15/16, indicated R77 had a rash in the groin area, on the left arm, bruise on left shin, and an open area on the right knee. There was no indication of lesion on back of right hand.

During an observations on 3/7/16 at 3:10 p.m., a dark brown crusted lesion approximately one centimeter in size, was noted on the back of R77's right hand. There was no redness to the skin surrounding the area.

During observations on 3/8/16 at 8:30 a.m., and 3/9/16 at 11:20 a.m., the lesion to the back of R77's hand remained unchanged.

Document review of facility progress notes from 2/26 to 3/8/16, revealed the following:

2/26/16-quarterly skin risk assessment-at high risk for skin breakdown, required extensive to total assist with cares, transferred by mechanical lift, did not ambulate, foley catheter in place, had pink folds at times, reposition every one to two hours sitting and lying. Monitor skin daily with cares, weekly with bath, and as needed.

2/29/16-shower this morning with no new bruising or skin tears.

3/7/16-had shower and weekly skin check this shift. No new skin issues at this time.

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Review of facility's incident report logs dated 3/1/16 to 3/6/16, revealed no identification of R77's skin lesion.

During interview on 3/9/16 at 12:15 p.m., nursing assistant (NA)-G acknowledged having first become aware of the lesion on R77's right hand on 3/7/16. NA-G denied knowing how the lesion might have occurred. NA-D was also present during the interview and NA-D stated she'd become aware of the lesion that morning. NA-D also stated she'd document a note about the presence of the lesion and would notify the nurse.

During interview on 3/9/16 at 12:17 p.m., licensed practical nurse (LPN)-B stated she was not aware of the lesion. NA-D, who was also present, stated when staff discover a non-pressure related area, they are supposed to document in a "memo book" and give the white page of the carbon copy to the nurse. Document review of the memo book at that time with NA-D, revealed the lesion had been identified on 3/5/16, as a "sore on top of right hand." There was no carbon copy page included. NA-D verified this.

R77's care plan printed 3/9/16, indicated: skin integrity will be monitored weekly on bath day and as needed. The care plan also indicated staff were to report any changes, problems or redness to nursing.

Review of the nursing assistant kardex printed 3/9/16, also indicated staff were to monitor skin integrity weekly on bath day and as needed, report any changes, problems, redness to nursing.

Although nursing assistant documentation identified the lesion on 3/5/16, there was no

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further evidence of identification, assessment, treatment or monitoring until surveyor intervened on 3/9/16.

Following the surveyor's questions, this progress note dated 3/9/16 at 4:22 p.m. was documented: "Staff reported sore to resident's right hand. Two areas were identified as dry patches on back of right hand, one area measured 0.7 centimeter by 0.9 centimeter, the other measured 0.2 centimeter by 0.3 centimeter. The areas were noted to have no drainage and no signs of infection. Triple antibiotic ointment was initiated two times a day and leave open to air."

The facility's Skin Tolerance Testing and Body Audit policy dated 9/18/09, revealed the following:
Page 1, Purpose: To identify any skin impairment and location on admission or bath day, to identify possible risk factors, causes, and implement appropriate care to resolve skin breakdown.
Page 2, #5 on resident's weekly designated bath day nursing assistant will complete a bath day skin check to identify any areas of concern that may affect the resident's overall skin integrity. The bath day skin check sheet is then turned into the licensed staff member in charge of that resident on that shift so that areas of skin concern can be checked, and an incident report filled out if needed and reported to the nurse manager. The licensed staff member is also required to complete the needed documentation in the nurses notes.
#6. Daily skin checks are to be completed on all residents that are assisted with dressing, toileting, and repositioning. Nursing assistants are required to report any skin concerns to their immediate supervisor so that issues can be checked, documented and reported to the appropriate personal for interventions to be initiated to

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prevent further skin breakdown.

During interview on 3/10/16, at 7:38 a.m. registered nurse (RN)-A verified the facility was not aware of R77's right hand lesion until 3/9/16, and the wound nurse assessed the area then. RN-A stated she expected staff to report skin concerns to the wing nurse, the wing nurse was then to complete an incident report, and send emails to notify director of nursing, nurse manager, wound nurse, social services and administrator. RN-A stated she also expected the wing nurse to document skin concerns in the progress notes. RN-A stated skin concerns were monitored by the wound nurse completing an assessment weekly and by the wing nurse who looked at the area daily. RN-A verified a treatment of triple antibiotic ointment had been started the evening of 3/9/16, as documented in facility medication administration record. RN-A verified the nursing assistant memo book-white part of carbon copy was to be given to the wing nurse and yellow part of the carbon copy stayed in the memo book.

During interview on 3/10/16, at 9:50 a.m. the director of nursing (DON) stated she expected nursing assistants to report skin concerns to the wing nurse and to document the concern in the nursing assistant memo book. The DON also stated she expected the wing nurse to assess the concern, complete an incident report, and report to charge nurse, director of nursing, administrator and social services.

During interview on 3/11/16, at 8:55 a.m., R77 was asked how she got the sores on her right hand and she replied very softly, "I don't know."

Document review of facility Care Plan Policy

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dated 8/13/13, revealed Purpose: To develop a plan of care for every resident to ensure care is given per resident preference. Procedure included a care plan would be developed for each resident identifying the needs of each individual resident.

LACK OF CALL LIGHT IN REACH TO PREVENT ACCIDENTS:

R27 was observed on 3/7/16, at 6:44 p.m. to be sitting in a wheelchair in his room. The call light was observed to be clipped up high on the privacy curtain and was out of R27's reach.

On 3/8/16 at 2:54 p.m., R27 was observed to be sitting in a recliner in his room and the call light was observed to be on top of R27's bed. The call light was out of R27's reach.

On 3/8/16, at 3:05 p.m., nursing assistant (NA)-A verified R27's call light was not within reach for R27.

R27's care plan, print date 3/11/16, indicated the resident required assistance with toileting and personal hygiene. In addition, the care plan indicated R27 was at high risk for falls. The care plan intervention included: Keep call light within reach and encourage resident to call for assistance.

On 3/10/16 at 12:41 p.m., registered nurse-A verified R27's call light should be within reach for him to use.

On 3/10/16 at 12:51 p.m., the director of nursing also stated she would expect the call light to be within reach for R27 and any resident who needed to use a call light.

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2 830	Continued From page 28 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure resident cares are provided as assessed. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by:	2 910		4/19/16

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2 910	Continued From page 29 Based on interview and record review, the facility failed to identify symptomatic urinary tract infection/s (UTIs) before treating with an antibiotic and/or ensure monitoring and tracking of signs and symptoms, organisms and documentation of resolution for urinary tract infections (UTIs) for 4 of 4 residents (R3, R36, R39 and R57) who had received antibiotic medications for UTIs. Findings include: R3's Admission Record, dated 3/11/16, identified diagnoses of fracture of right patella and history of falling. R3's physician orders, dated 10/5/15, identified an order for Bactrim DS and antibiotic 800/160 mg (milligrams) one tablet twice daily for seven days. R3's medication administration record (MAR), dated 10/15, revealed R3 had received the Bactrim DS as ordered. R3's progress notes dated from 9/29/15 to 10/20/15, identified the following: 9/29/15, admitted to facility, denied having history of urinary tract infections (UTIs) and no signs or symptoms of current UTI. 9/29/15, call received from physician office, ok for sterile UA (urine analysis) to be collected. Will order to be collected on lab day. 10/3/15, urine specimen obtained. 10/5/15, call received from physician office stating resident was positive for UTI. Orders included, Bactrim DS 800/160 mg one tablet BID (twice per day) for seven days.	2 910	Prairie Manor Care Center has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The facility has an infection control program that 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control. The facility's current monthly infection control log tracks the resident, infection site, causative organism (if cultured), antibiotic/treatment, date of onset, and whether the infection was acquired while at the facility. To improve infection process and outcorme surveillance, the infection control log and related data will identify the room/wing of the resident with the infection, the symptoms identified, whether a culture was obtained (or rationale if not), and the date of the resolution of the infection. Staff who have not participated in an infection control training session in the past year will receive training on April 12 or 14, 2016. The infection control nurse has reviewed the infection control regulations, with a focus on the requirements for infection surveillance and staff education. A comprehensive infection control resource manual is available for reference. On June 10, 2016, the infection control nurse will	

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10/6/15, on antibiotic for UTI, temp is stable and no signs or symptoms of confusion.

10/7/15, on antibiotic, temperature was 98.0 Ferenheiht (F).

10/9/15, on antibiotic therapy continues for UTI, no signs or symptoms of infection noted.

10/10/15, quarterly bowel and bladder assessment, resident denies any signs or symptoms of UTI.

10/10/15, resident on antibiotic for UTI, no signs or symptoms of continued UTI.

10/11/15, antibiotic therapy continues, temperature 97.5 F.

R3's record failed to include evidence of at least three signs and symptoms of symptomatic UTI. In addition, R3's record failed to include identification of the organism and susceptibility results to determine if Bactrim was affective or not.

On 3/10/16, at 2:17 p.m., registered nurse (RN)-B stated R3 was admitted on 9/29/15, and she did not know who ordered the UA. RN-B verified R3's record failed to include documented three signs and symptoms of UTI and confirmed R3's record failed to include identification of the organism and susceptibility results of the UA.

R36's Admission Record, dated 3/11/16, identified diagnosis of retention of urine.

R36's physician orders, dated 1/6/16, identified an order for UA with culture if indicated. May obtain via mini cath [catheter] if needed for

attend a seminar presented by Pathway Health addressing system improvements for preventing and controlling infections as well as regulatory requirements and current standards of practice.

Compliance with regulatory requirements and facility policies for an infection control surveillance program will be monitored by the Director of Nursing/designee for the next three months through a review of 1) the infection control tracking data and 2) staff training records. If noncompliance is noted, additional staff training and auditing will be done.

Process/outcome surveillance of infections, frequency/type of infections, and other infection control issues will be continue to be routinely reviewed by the Quality Assurance and Assessment Committee.

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diagnosis of confusion and dated 1/8/16, identified an order for Cipro [antibiotic] 250 mg BID [two times daily] for three days. R36's MAR, dated 1/16, revealed R36 had received the medication as ordered.

R36's progress notes dated from 1/5/16 to 1/12/16, identified the following:

1/6/16, resident is confused, had increased weakness and lethargic.

1/7/16, UA obtained via mini cath, urine is dark amber in color and no odor.

1/8/16, order for Cipro 250 mg BID for three days.

R36's record failed to include identification of the organism and if Cypro was affective to treat the organism. In addition, R36's record failed to include documentation of resolution of signs and symptoms of the UTI, which included confusion, weakness, lethargic and dark amber urine.

On 3/10/16, at 2:17 p.m., registered nurse (RN)-B confirmed R57's record failed to include identification of the organism and susceptibility results of the UA and lacked documentation of resolution of signs and symptoms of the UTI. Surveyor had requested identification of organism and culture results. RN-B provided documentation of a report, faxed to the facility on 3/10/16.

R39's Admission Record, dated 3/11/16, identified diagnoses of retention of urine and history of UTIs.

R39's physician orders, dated 2/21/16, identified

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an for Cipro 500 mg BID for 10 days. R39's MAR, dated 2/16 and 3/16, revealed R39 had received the medication as ordered.

R39's progress notes dated from 2/19/16 to 3/3/16, identified the following:

2/19/16, resident voided cloudy odorous urine. Resident stated he had been up an hour ago to void.

2/21/16, resident has been having increased weakness, lethargy and incontinence. Resident has a history of UTIs that become septic. Temperature 99.2. Physician office contacted for request UA with culture, will await physician response.

2/21/16, physician direction to send to ED (emergency department) for evaluation.

2/22/16, returned from ED with diagnoses of UTI, weakness and mild dehydration. Resident is on Cipro with first dose given at the ED.

2/23/16, receiving Cipro for UTI. Has been up to use urinal twice and has had no incontinence. Afebrile, no signs and symptoms of adverse reaction.

3/2/16, continues on antibiotic for UTI. Resident has been sleeping, offering no complaints. No adverse effects noted.

R39's record failed to include identification of the organism and susceptibility results of the UA. In addition, R39's record failed to include documentation of resolution of signs and symptoms of the UTI, which included increased weakness, lethargy and incontinence.

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2 910	Continued From page 33 On 3/10/16, at 2:17 p.m., registered nurse (RN)-B confirmed R39's record failed to include identification of the organism and susceptibility results of the UA and lacked documentation of resolution of signs and symptoms of the UTI. Surveyor had requested identification of organism and culture results. RN-B provided documentation of a report, faxed to the facility on 3/10/16, which identified the organism of Enterococcus faecalis and was resistant to Cipro. A physician order, dated 3/10/16, identified will treat with doxycycline (antibiotic) 1000 mg twice daily for seven days, as it is presumed that the previous UTI was not treated. R57's Admission Record, dated 3/11/16, identified diagnoses of chronic kidney disease stage three and retention of urine. R57's physician orders, dated 10/1/15, identified an order for obtain a UA and culture if indicated for diagnoses of confusion and dated 10/3/15, identified an order for Keflex 500 mg TID (three times daily) and 10/6/15, clarification Keflex times 14 days. R57's medication administration record (MAR), dated 10/15, revealed R57 had received the medication as ordered. R57's progress notes dated from 9/30/15 to 10/16/15, identified the following: 10/1/15, call placed to nurse care line to report the resident's recent increase in confusion, the continuous need for straight catheterization due to urine retention and history of UTIs. Nurse to pass this on to the nurse practitioner for possible order to obtain UA. 10/1/15, call received form nurse practitioner with	2 910		

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2 910	Continued From page 34	2 910		

orders to obtain UA and culture if indicated due to diagnoses of confusion.

10/2/15, resident returned from the ED with the flowing orders Keflex 500 mg TID times 14 days.

R57's record failed to include evidence of at least three signs and symptoms of UTI before treating with an antibiotic, identification of the organism and susceptibility results. In addition, R57's record failed to include documentation of resolution of signs and symptoms of UTI, including confusion and increase in request to be straight cathed.

On 3/10/16, at 2:17 p.m., registered nurse (RN)-B stated the three signs and symptoms R57 had were confusion, increase of request to be straight cathed and history of UTI however, increased request to be straight cathed and history of UTIs is not included as a reason to use antibiotic medication for symptomatic UTI. RN-B verified R57's record failed to include documentation of three signs and symptoms for obtaining a UA. RN-B confirmed R57's record failed to include identification of the organism and susceptibility results of the UA. Surveyor had requested identification of organism and culture results. RN-B provided documentation of a report, faxed to the facility on 3/10/16.

On 3/11/16, at 9:55 a.m., the director of nursing (DON) stated we do have a protocol UTI tracking, looking for symptoms and documenting before we would get an order for an antibiotic. The DON stated she would expect culture results to be in the resident record. The DON stated she did not expect documentation on resolution, but would expect documentation of three signs and symptoms as we have a protocol.

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2 910	Continued From page 35	2 910		

The facility Urinary Tract Infection Policy and Procedure, dated 1/20/16, indicated it is the policy of Prairie Manor Care Center to try to prevent the unnecessary usage of antibiotics for treatment of urinary tract infection symptoms. Procedure, if a UTI is suspected, nursing staff are to initiate the following steps: initiate 72 hour monitoring packet for suspected UTI. This packet includes fluid needs assessment calculation, fluid intake assessment sheets for each department (activities, nursing, and dietary). Follow the directions on the sheet, note that residents with indwelling catheters need two symptoms if criteria are not met and residents without catheters need three symptoms. If criteria are met initially, notify the physician. If resident does not meet the criteria, continue to monitor for symptoms each shift. If resident continues to have noted symptoms, notify physician direction. Charting will be completed in Point Click (computer program) as usual, indicating symptoms noted.

The facility Infection Control Policy, dated 8/1/12, indicated Prairie Manor Care Center has a facility wide infection control program with effective measures to identify, control and prevent infections acquired or brought to the facility from the community. Policy, responsibility for the management of infection control and prevention has been assigned to the Infection Preventionist. The program exists for reporting, evaluating and maintaining records of infections among residents and any required follow up. Antibiotic use is periodically reviewed by the infection Preventionist and the medical director and monitored for pertinent aspects of antibiotic usage. The Quality Assurance Committee discusses infection control issues. However, the policy lacked centers for medicare/medicaid

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2 910	Continued From page 36 services (CMS) definition of symptomatic UTI that met the criteria of being treated with antibiotics. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service licensed staff on the need to identify three symptoms are needed to treat with an antibiotic therapy, obtaining the results of identification of organisms and culture results and documenting resolution of infections. The director of nursing could Inservice all employees responsible for preventing urinary tract infections on the need to assess and develop interventions to prevent urinary tract infections. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure surveillance and analysis of infections and failed to ensure annual infection control education for all employees as outlined in the facility infection control policy. This had the potential to affect all residents, staff and visitors. Findings include:	21375	Prairie Manor Care Center has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The facility has an infection control program that 1) investigates, controls, and prevents infections in the facility 2) determines the	4/19/16

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21375	Continued From page 37 SURVEILLANCE AND ANALYSIS OF INFECTIONS: The facility monthly summary of Infection Control Logs were obtained from June 2015 through February 2016. The logs identified for tracking the resident name, site, organism, antibiotic/treatment, date of onset and acquired in house were areas documented on the report. The following information of infections were indicated on the monthly logs: 6/15, two urinary tract infections (UTIs) 7/15, four UTIs, one pneumonia, one bronchitis, one cellulitis 8/15, four UTIs, two cellulitis, one pneumonia 9/15, three UTIs, one pneumonia, one elbow infection 10/15, five UTIs, two pneumonia 11/15, two UTIs, one pneumonia, one respiratory 12/15, five UTIs, one aspiration pneumonia, one cellulitis, two respiratory, one ear infection 1/16, nine UTIs, one cellulitis recurrent 2/16, four UTIs, one pneumonia, one cellulitis However the logs failed to include specific resident room/s and wing location that would enable tracking and trending of spread of infection, symptoms identified, whether culture of the organism was obtained (or rational if not performed) and date of resolution of the infection. In addition, the facility failed to document surveillance and analysis of the information and infection control precautions used to prevent the spread of the infections. On 3/10/16, at 2:17 p.m., registered nurse (RN)-B verified the logs failed to include date of	21375	appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control. The facility's current monthly infection control log tracks the resident, infection site, causative organism (if cultured), antibiotic/treatment, date of onset, and whether the infection was acquired while at the facility. To improve infection process and outcorme surveillance, the infection control log and related data will identify the room/wing of the resident with the infection, the symptoms identified, whether a culture was obtained (or rationale if not), and the date of the resolution of the infection. Staff who have not participated in an infection control training session in the past year will receive training on April 12 or 14, 2016. The infection control nurse has reviewed the infection control regulations, with a focus on the requirements for infection surveillance and staff education. A comprehensive infection control resource manual is available for reference. On June 10, 2016, the infection control nurse will attend a seminar presented by Pathway Health addressing system improvements for preventing and controlling infections as well as regulatory requirements and current standards of practice. Compliance with regulatory requirements and facility policies for an infection control surveillance program will be monitored by	

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resolution and wing the resident was on. RN-B stated she did not have documented surveillance and analysis of the infections. RN-B stated had identified the facility was having a lot of UTIs and she or the charge nurse had been down the halls ensuring the nursing assistants were doing proper peri-cares. RN-B confirmed there was no documentation of monitoring or analysis of effectiveness of ensuring proper peri-cares.

LACK OF INFECTION EDUCATION:

The facility provide documentation of a list of current employees, which totaled 121 employees. The facility provided education attendance sheets, which the facility identified were for infection control, dated 8/18/15, 9/15/15 and October 2015. The sheet for October 2015 failed to include the year and the total number of employees documented to have attended for 8/18/15, 9/15/15 and October 2015 was 65 employees.

The facility failed to provide any further documentation for employee attendance for education of infection control.

On 3/10/16, at 2:17 p.m., RN-B verified the lack of documented education for infection control for all of the facility employees.

On 3/11/16, at 9:55 a.m., the director of nursing stated she would expect infection control education for employees to be done annually.

The facility policy Infection Control Program dated 8/1/12, indicted it is the policy of Prairie Manor Care Center to have an infection control program in place assure a safe, sanitary and comfortable environment for residents and personnel. It is

the Director of Nursing/designee for the next three months through a review of 1) the infection control tracking data and 2) staff training records. If noncompliance is noted, additional staff training and auditing will be done.

Process/outcome surveillance of infections, frequency/type of infections, and other infection control issues will be continue to be routinely reviewed by the Quality Assurance and Assessment Committee.

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designed to help prevent the development and transmission of disease and infection. Prairie Manor Care Center has established a program under which it: investigates, controls and prevents infections in the facility, decides what procedures such as isolation, should be applied to an individual resident and maintains a record of incidents and corrective actions related to infections. Basic Responsibility, the infection Preventionist (IP), or designee, is responsible for directing the infection control program. Maintain training records that document training in infection control in employee files.

The facility Infection Surveillance policy dated 8/1/12, indicated infection prevention begins with ongoing surveillance to identify infections that are causing, or have the potential to cause outbreak. The facility closely monitors all residents who exhibit signs/symptoms of infections through ongoing surveillance and has a systemic method of collecting, consolidating and analyzing data concerning the frequency an cause of a given disease or event, followed by dissemination of that information to those who can improve the outcomes. The intent of the surveillance is to identify clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. The results should be used to plan infection control activities, direct in-service education, and identify individual resident problems in need of interventions. Other sources of relevant data include laboratory cultures and antibiotic susceptibility profiles. Reporting, analysis and conclusions are reported to appropriate quality assessment and assurance committee on a regular basis and results of surveillance are reported back to nursing units as performance feedback. Data analysis, this data is recorded at least quarterly and included in the

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nursing homes quality improvement data. It is important that surveillance reports be shared with appropriate individuals including, but not limited to, the director of nursing and medical director. In addition, it is important that he staff and practitioners receive reports that are relevant to their practices to help them recognize the impact of their care in infection rates and outcome. Plan, based on analysis of data, develop and implement action plan, corrective actions, education and/or other strategies. Evaluate the effectiveness of the corrective actions, education provided, prevention measure, etc. Documentation, descriptive documentation provides the nursing home summarized observations related to the investigation of the cause of an infection and/or identifies the underlying cause of infection trends.

The facility Infection Control Policy, dated 8/1/12, indicated Prairie Manor Care Center has a facility wide infection control program with effective measures to identify, control and prevent infections acquired or brought to the facility from the community. Policy, responsibility for the management of infection control and prevention has been assigned to the Infection Preventionist. The program exists for reporting, evaluating and maintaining records of infections among residents and any required follow up. Required employee in servicing on infection control prevention are provided to all departments at least annually. The Quality Assurance Committee discusses infection control issues.

SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff on the need to follow the facility policy and procedure for a functioning infection program to prevent the spread of infections.

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21375	Continued From page 41 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a policy and procedure for Tuberculosis (TB) infection control program, develop a written infection control plan that includes procedures for handling persons with active TB disease and failed to ensure TB education for all the facility employees. This had	21426	Minnesota State Statute 144A.04 Subd. 3 Tuberculosis Prevention and Control Prairie Manor Care Center has established and maintains a comprehensive tuberculosis infection control program according to the most	4/19/16

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the potential to affect all residents, staff and visitors.

Findings include:

LACK OF TB INFECTION CONTROL PROGRAM:
On 3/11/16, at 8:47 a.m., registered nurse (RN)-B stated she had no policy and procedure for a TB infection control program.

LACK OF TB INFECTION CONTROL PLAN:
On 3/11/16, at 8:47 a.m., RN-B stated she had no written infection control plan that includes procedures for handling persons with active TB disease.

LACK OF STAFF EDUCATION:
The facility provide documentation of a list of current employees, which totaled 121 employees. The facility provided education attendance sheets, which the facility identified were for infection control and included TB education content, dated 8/18/15, 9/15/15 and October. The sheet for October failed to include the year and the total number of employees documented to have attended for the dates as above was 65 employees.

The facility failed to provide any further documentation for employee attendance for education of infection control, which included TB education content.

On 3/11/16, at 8:47 a.m., RN-B verified all employees had not completed TB education.

On 3/11/16, at 9:55 a.m., the director of nursing (DON) stated she would expect TB education for employees to be done annually. The DON stated

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current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC) and the Regulations for Tuberculosis Control in Minnesota Health Care Settings published by the Minnesota Department of Health. The program includes a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The policy addresses the procedures for handling persons with active TB disease.

All employees are trained on tuberculosis detection and prevention at the time of hire and annually. The training includes the following topics:

• TB pathogenesis and transmission,

• Signs and symptoms of active TB disease, and

• The facility’s infection control plan (i.e., early recognition, isolation, and referral procedures).

The employees who have not had TB training within the past twelve months will be trained on the above topics during the mandatory infection control meetings that will be scheduled in the near future.

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she knows the facility had a policy and procedure for TB infection control program and a written infection control plan for TB. The DON stated she would have to look for it.

The facility Tuberculosis, Annual Education for Employees policy, dated 8/1/12, indicated it is the policy of Prairie Manor Care Center to annually educate employees on the potential for exposure to TB. Record of employee training will be kept in the infection control office. The policy failed to address training on the facility infection control plan for TB.

SUGGESTED METHOD OF CORRECTION:
The director of nursing could review tuberculosis policies and procedures to ensure compliance. The director of nursing could educate all employees regarding TB education and the facility infection control plan.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

21530	MN Rule 4658.1310 A.B.C Drug Regimen Review	21530		4/19/16

A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.
B. The pharmacist must report any

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irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician.

C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.

This MN Requirement is not met as evidenced by:
Based upon interview and document review the facility failed to ensure the consultant pharmacist had identified the lack of resident specific mood and behavior symptoms for use of an anxiety medicaiton, to implement non-pharmacological interventions before use of pain and antianxiety medicaiton, to ensure an analysis of sleep to warrant the use of a hypnotic and failed to ensure a physician's justification for use of psychotropic medication for 1 of 5 residents (R75); failed to identify and monitor mood and behavior

The goal of Prairie Manor Care Center is to maintain the resident's highest practicable level of functioning and prevent or minimize adverse consequences related to medication therapy. The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. The pharmacist reports irregularities to the attending physician and the director of nursing, and these reports are acted upon.

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21530	Continued From page 45 symptoms to justify the use of an antianxiety medication for 1 of 5 residents (R34); and failed to identify and monitor mood symptoms to determine effectiveness of and antidepressant medication for for 2 of 5 residents (R45 and R35) who received daily dose of an antidepressant medication. Findings include: R75's Admission Record, dated 3/11/16, revealed R75 had diagnoses of chronic pain, anxiety, pain in right leg. R75's 30 day Minimum Data Assessment (MDS) dated 2/16/16, identified R75 was cognitively intact, had no behaviors, had mood of feeling tired or having little energy, had pain which had made it hard to sleep at night, frequency of pain daily, received scheduled and as needed (PRN) pain medications, had not received non-medication interventions for pain and had received antidepressant and antianxiety medications. R75's physician orders dated 2/25/16, included the following orders: Lorazepam (antianxiety) tablet 0.5 mg (milligrams) - one tablet at HS (bedtime), may repeat one half tablet in 30 minutes if still having anxiety issues and not able to sleep. Venlafaxine (antidepressant) 75 mg - one capsule once a day related to generalized anxiety disorder. Tramadol (analgesic) 50 mg - two tablets every six hours as needed for pain. Oxycodone (narcotic pain reliever) 5 mg - one tablet every six hours as needed for pain	21530	The Director of Nursing and Consultant Pharmacist have reviewed the facility's procedures for identifying and tracking target behaviors and mood symptoms related to psychotropic medication use, documenting nonpharmacological interventions provided/offered to manage pain and anxiety, completing sleep assessments and analyzing sleep monitoring data, and ensuring physician justification for use of psychotropic medications. The pharmacist will continue to review records on a monthly basis and routinely check for appropriate documentation related to the above issues. During the mandatory meetings on April 14 and 15, 2016, the licensed nursing staff will be instructed on 1) the new documentation procedures for target behaviors and behavior related interventions 2) the importance of attempting nonpharmacological interventions prior to administration of PRN psychotropic and analgesics 3) ensuring the care plan addresses target behaviors and nonpharmacological interventions to manage mood symptoms, anxiety, and pain and 4) the need for an assessment that analyzes the sleep monitoring data. The direct care staff will be reminded of the importance of being observant for behaviors/moods symptoms and reporting them to the charge nurse. Resident number 75 – The nurses have been reminded to document nonpharmacological interventions that are	

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21530	Continued From page 46 Review of the March 2016 medication administration record (MAR) and progress notes showed the following: R75 had received Ativan as needed (PRN) one time on 3/5/16, with no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered. R75 had received Oxycodone PRN six times from 3/1/16 to 3/10/16 with no documentation of non-pharmacological interventions attempted prior to the PRN Oxycodone being administered. R75 had received Tramadol PRN four times from 3/1/16 to 3/10/16 with no documentation of non-pharmacological interventions attempted prior to the Tramadol being administered. Review of the February 2016 MAR and progress notes showed the following: R75 had received Ativan PRN one time on 2/11/16, with no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered. R75 had received Oxycodone PRN 34 times, with no documentation of non-pharmacological interventions attempted prior to the PRN Oxycodone being administered. R75 had received Tramadol PRN one time on 2/29/16 with no documentation of non-pharmacological interventions attempted prior to the Tramadol being administered. Review of the January 2016 MAR, from admission on 1/19/16 to 1/31/16, and progress notes showed the following:	21530	attempted prior to administration of PRN medications to treat anxiety and pain. The care plan has been updated to address nonpharmacological interventions and target behaviors related to use of antianxiety medications as well as insomnia. The resident’s sleep/wake patterns are monitored on a routine basis and the effectiveness of the interventions to promote sleep will be assessed by a registered nurse. During the physician’s next visit, documentation addressing anxiety symptoms, insomnia, and justification of the order change from PRN to routine use of lorazepam will be requested. The physician will be contacted if the resident’s medical management of depressed mood, anxiety or insomnia is ineffective. Resident number 45 – A behavior tracking sheet to monitor mood symptoms related to the diagnoses of major depressive disorder has been implemented. The results will be reviewed by the interdisciplinary team during the quarterly care conferences and more frequently if indicated. The physician will be contacted if there is an increase in symptoms of depressed mood. The social worker will complete a depression screen questionnaire every 90 days and with a significant change in condition. The care plan will be reviewed and revised as necessary. Resident number 34 – The resident was admitted July 21, 2015 with a primary diagnoses of schizoaffective disorder with the physician noting that she is doing well	

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21530	Continued From page 47 R75 had received Ativan PRN eight times with no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered. R75 had received Oxycodone PRN 27 times, with no documentation of non-pharmacological interventions attempted prior to the PRN Oxycodone being administered. R75's care plan, print date 3/11/16, identified the following: Antidepressant and antianxiety medication use related to diagnosis of depression and anxiety with interventions of administer medication per MD's (medical doctor's) order. Monitor for effectiveness and adverse reactions and report to nursing if noted. Medication to be reviewed routinely by pharmacist consultant, primary physician and behavior management nurse. Appropriate changes to be made as needed. Monitor mood/behavior and report to Nurse. Physician to review medication with certification visits for appropriateness and possible dose changes. Refer to Psychotropic Drug Policy and Procedure. Resident is at risk for pain related to sacroiliac joint dysfunction, spinal stenosis and osteoarthritis with interventions of: administer pain medication as per MD orders and note the effectiveness. Report any unresolved pain to physician. Encourage resident to verbalize any pain. Monitor and report any noted non-verbal signs of discomfort, i.e., facial grimacing, guarding, increase agitation. Pain assessment quarterly and prn. However, the care plan had not addressed non-pharmacological interventions for either the pain or anxiety.	21530	on her current psychotropic medications. A behavior tracking sheet to monitor mood symptoms and target behaviors to determine the effectiveness of the antipsychotic, antianxiety, antidepressant and mood stabilizer medications has been implemented. Nonpharmacological interventions to be implemented prior to administration of PRN (as needed) pain medications are addressed in the plan of care. The nursing staff has been informed of the need to attempt nonpharmacological interventions for pain control and to document the interventions attempted and the resident's response. During the consultant pharmacist's monthly medication audits and the quarterly care planning process, the residents' medication regimen will continue to be reviewed to assure that medications used to manage behaviors, mood symptoms, insomnia and pain are appropriately justified and monitored. Compliance will be further monitored by the Director of Nurses/designee by 1) an audit of the records of residents receiving antipsychotic, antianxiety, and antidepressant medications to ensure that target behaviors/mood symptoms are identified, monitored, and related interventions are documented 2) an audit of the records of residents receiving PRN pain medications and sedatives to ensure nonpharmacological interventions and monitoring of their effectiveness is included in the plan of care and appropriately documented and 3) a record audit of residents receiving hypnotics/sedatives to ensure sleep	

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21530	Continued From page 48 R75's progress note, dated 2/8/16, identified: registered nurse behavior note: Resident was admitted on 1/19/16 with complaints of right leg pain and primary diagnosis of sacroiliacs. During admission resident noted to have orders for Ativan 0.5 mg every hour of sleep (HS) with additional 0.25 mg PRN 30 minutes after scheduled HS dose if needed for Anxiety and Insomnia, and Venlafaxine 75 mg capsule daily for Anxiety. Resident saw her primary physician on 1/26/16. She came back with orders stating to continue scheduled Ativan as is and PRN Ativan as needed. No noted adverse reaction from medications. Primary physician and consulting pharmacist routinely review medications. Will continue with current regimen and will contact MD for medication changes as needed. The behavior note, physician orders, care plan, or other documents provided by facility had identified resident specific symptoms of anxiety to determine if the Ativan and Venlafaxine was affective to relieve "anxiety." R75's physician orders, dated 2/25/16, included Lorazepam (antianxiety) tablet 0.5 mg (milligrams) one tablet at HS may repeat one half tablet in 30 minutes if still having anxiety issues and not able to sleep. R75's record identified sleep tracking sheets dated 1/19/16 through 3/9/16. The sleep tracking monitored hours of sleep from 6:00 p.m. through 9:00 a.m. daily. However, R75's medical record lacked a comprehensive sleep assessment and analysis of the sleep monitoring for the use of the Ativan. In addition, R75's care plan failed to address insomnia.	21530	assessments have been completed. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the April quarterly Quality Assurance and Assessment Committee meeting and ongoing.	

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R75's physician orders dated 1/19/16, identified an order for Ativan 0.5 mg, take one to two tablets PRN one time daily at HS for symptoms. A physician order on 1/26/16, identified an order to change the Ativan to 0.5 mg every HS, may give an extra one-half tablet PRN after 30 minutes if needed for sleep. In addition, R75's record identified a physician order for Venlafaxine 75 mg one capsule once a day related to generalized anxiety disorder, which R75 had been receiving since admission.

R75's physician note, dated 1/26/16, indicated R75 had Ativan at bedtime. They asked the Ativan be scheduled dose vs. as needed due to her often forgets to ask for it appropriately at bedtime and there is a little language barrier. However, the physician progress note failed to address anxiety symptoms and insomnia needs and lacked physician justification for the increased medication dosages.

On 3/10/16, at 12:31 p.m., registered nurse (RN)-A stated we do sleep tracking for R75's insomnia, but we have not completed an assessment for sleep. RN-A verified R75's care plan failed to include non-pharmalogical interventions for the PRN pain and antianxiety medications. RN-A verified R75's record failed to include documentation of non-pharmalogical interventions being offered prior to the PRN medications being administered. RN-A verified R75's record failed to include specific symptoms R75 had for the use of the antianxiety medications. RN-A stated R75's Ativan was changed to scheduled doses because that is what the "family" requested and was how R75 had taken the medication at home. RN-A stated in regards to how the facilities system for monitoring moods and behaviors, the nursing

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assistants report to the nurse and then the nurse documents the mood and behaviors.

On 3/10/16, at 1:00 p.m., the director of nursing (DON) stated they do review the sleep tracking sheets with the physician. I would expect the sleep tracking sheets to be addressed in the sleep note. The DON stated normally the non-pharmalogical interventions are on the care plan and normally you would try those before giving the PRN medications. The DON stated we have not done specific resident symptoms for antidepressant and antianxiety medications before. The DON stated she did not know why R75's Ativan was changed to being given on a scheduled daily dose vs. as needed. The DON stated she would have expect the reason for the medication being changed is supported by clinical evidence and to be documented and family requesting the change would not be a strong enough reason for the change.

On 3/11/16, at 9:52 a.m., the DON stated she would expect the physician to document justification for the use of any medications ordered.

The facility Psychotropic Drug Use Policy which includes psychoactive medication use, dated 3/28/14, indicated Purpose: Prairie Manor Care Center (PMCC) assures that each resident's drug regime is free from unnecessary drugs. Resident's receiving psychotropic medication are monitored for: excessive doses, excessive duration, adequate indications, presence of adverse side effects, and target behaviors in accordance with Federal Tag 329. Policy: it is the policy of PMCC to monitor all resident's experiencing behavioral symptoms and that are tacking psychotropic medications (or any other

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drugs outside of their intended use) for management of mood/behaviors. Procedure: 1. Psychotropic Behavior Management Nurses/Nurse Mangers will track all psychotropic medication changes, medication initiations/discontinuations and dose reductions/increases on resident's individual psychotropic chronological along with indications. 3. Resident's started on any psychotropic medication will be triggered under communications for daily charting times four weeks for target behaviors, or if dose is increased or decreased or the medication is discontinued, charting will be triggered for daily charting times four weeks, then charting will be done quarterly in a RN Behavior Note and as needed. 9. A sleep disruption care plan will be developed for residents with orders for hypnotic/sedative medications (Ambien, Trazodone .....) Non-pharmalogical interventions will be also included. Sleep tracking will be completed before routine certification physician visits for review. 10. A psychotropic care plan will be developed for residents with orders for antidepressants and antianxiety medications (Ativan, Remeron, Celexa, Zoloft .....). All target behaviors and interventions will be included. 12. Residents with orders for PRN antipsychotics, antianxiety and hypnotic will be assessed using Guidelines for Administration worksheet prior to giving this PRN medication and effectiveness will be documented after given.

The facility Pain Management Policy, dated 4/9/14, indicated Purpose: it is the policy of PMCC to ensure residents experiencing pain will have a comprehensive assessment of that pain and will have established plan to treat that pain. Procedure: each resident will have pain addressed on their care plan. Care plans will

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include individualized interventions for pain as well as non-pharmalogical interventions for pain.

LACK OF MOOD/BEHAVIOR MONITORING TO JUSTIFY THE ONGOING USE OF AN ANTIDEPRESSANT:

R45's admission record revealed a diagnosis of major depressive disorder. Current physician orders signed 2/23/16 included an order for Remeron (antidepressant)15 milligrams at bedtime.

Review of R45's medication administration record, treatment administration record, care plan, and progress notes failed to identify mood symptoms for depression.

On 3/10/16 at 9:17 a.m. nursing assistant (NA)-D was interviewed for R45's mood symptoms, "Not really anything we track for her [R45]. The only thing is when she was on a walking program she would get moody. She will make facial expressions, I don't really think she is moody."

LACK OF IDENTIFYING MOOD/DEPRESSION SYMPTOMS TO DETERMINE IF MEDICATION IS AFFECTIVE; ALSO LACK OF USE OF NON-PHARMACOLOGICAL INTERVENTIONS FOR CONTROL PAIN WERE USED BEFORE AS NEEDED PAIN MEDICATION IS GIVEN:

R34's current physician orders signed 2/9/16 included the orders; buspirone tablet 30 mg (anti-anxiety medication) 1 tablet twice daily, Risperdal 4 mg (anti-psychotic medication) 2 tablets at bedtime, Topamax 50 mg (mood stabilizer) twice daily, and fluoxetine 60 mg (anti-depressant medication) daily for a primary diagnosis of schizoaffective disorder.

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Acetaminophen 500 mg 2 tablets daily as needed for break through pain and Tramadol 50 mg (controlled pain medication) 1 tablet as needed for pain three times daily.

Review of R34's medication administration record, treatment administration record, care plan, and progress notes failed to identify mood symptoms or target behaviors to determine if the antipsychotic, antidepressant and analgesics were affective. Also there was no documentation found or provided by facility in regards to the use of non-pharmalogical interventions prior to the use of as needed pain medication.

On 3/10/16 at 9:15 a.m. NA-D was interviewed for R34's mood symptoms and target behaviors; "She doesn't like to walk, that kind of targets her. She isn't on a walking program now cause it would trigger her. She doesn't care for different nursing assistants. She swears, she refuses stuff. She says stuff and then she will say she is just kidding. She will say stuff to try to hurt your feelings."

On 3/10/16 10:42 a.m. the DON stated, "Last week we were discussing how we don't have a form of daily tracking [for mood/behavior]. [R34] is one of those that doesn't really have any [target behaviors]. I guess sometimes she doesn't like some staff. I am having someone from point click [electronic medical record] come in and show us how to do behavior tracking. We don't have anything in place for the anti-depressant mood monitoring. If they start a new one or the dose changes the nurses would chart on mood, they would do it for four weeks, but nothing ongoing." On 3/11/16 at 10:21 a.m. the DON added, "The care plan has non-pharmacological interventions listed, but I don't think they [nursing] document

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21530	Continued From page 54 what they tried." On 3/11/16 at 11:04 a.m. the facility consultant pharmacist stated, They should have identified mood symptoms and non-pharmacological should be tried prior to the administration of an as needed pain medication. A facility policy on mood monitoring, target behavior monitoring was requested but was not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure the consultant pharmacist monitors and reports irregularities in resident's medications. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.	21535		4/19/16

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21535	Continued From page 55 In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based upon interview an document review, the facility failed to identify resident specific mood and behavior symptoms for anxiety, to implement non-pharmacological interventions before use of pain and antianxiety medicaiton, to ensure an analysis of sleep to warrant the use of a hypnotic and failed to ensure a physician's justification for use of psychotropic medication for 1 of 5 residents (R75); failed to identify and monitor mood and behavior symptoms to justify the use of an antianxiety medication for 1 of 5 residents (R34); and failed to identify and monitor mood symptoms to determine effectiveness of and antidepressant medication for for 2 of 5 residents (R45 and R35) who received daily dose of an antidepressant medication. Findings include: R75's Admission Record, dated 3/11/16, revealed R75 had diagnoses of chronic pain, anxiety, pain in right leg. R75's 30 day Minimum Data Assessment (MDS) dated 2/16/16, identified R75	21535	The goal of Prairie Manor Care Center is to maintain the resident's highest practicable level of functioning and prevent or minimize adverse consequences related to medication therapy. The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. The pharmacist reports irregularities to the attending physician and the director of nursing, and these reports are acted upon. The Director of Nursing and Consultant Pharmacist have reviewed the facility's procedures for identifying and tracking target behaviors and mood symptoms related to psychotropic medication use, documenting nonpharmacological interventions provided/offered to manage pain and anxiety, completing sleep assessments and analyzing sleep monitoring data, and ensuring physician justification for use of psychotropic	

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was cognitively intact, had no behaviors, had mood of feeling tired or having little energy, had pain which had made it hard to sleep at night, frequency of pain daily, received scheduled and as needed (PRN) pain medications, had not received non-medication interventions for pain and had received antidepressant and antianxiety medications.

R75's physician orders dated 2/25/16, included the following orders:
Lorazepam (antianxiety) tablet 0.5 mg (milligrams) - one tablet at HS (bedtime), may repeat one half tablet in 30 minutes if still having anxiety issues and not able to sleep.

Venlafaxine (antidepressant) 75 mg - one capsule once a day related to generalized anxiety disorder.

Tramadol (analgesic) 50 mg - two tablets every six hours as needed for pain.

Oxycodone (narcotic pain reliever) 5 mg - one tablet every six hours as needed for pain

Review of the March 2016 medication administration record (MAR) and progress notes showed the following:

R75 had received Ativan as needed (PRN) one time on 3/5/16, with no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered.

R75 had received Oxycodone PRN six times from 3/1/16 to 3/10/16 with no documentation of non-pharmacological interventions attempted prior to the PRN Oxycodone being administered.

medications. The pharmacist will continue to review records on a monthly basis and routinely check for appropriate documentation related to the above issues.

During the mandatory meetings on April 14 and 15, 2016, the licensed nursing staff will be instructed on 1) the new documentation procedures for target behaviors and behavior related interventions 2) the importance of attempting nonpharmacological interventions prior to administration of PRN psychotropic and analgesics 3) ensuring the care plan addresses target behaviors and nonpharmacological interventions to manage mood symptoms, anxiety, and pain and 4) the need for an assessment that analyzes the sleep monitoring data. The direct care staff will be reminded of the importance of being observant for behaviors/moods symptoms and reporting them to the charge nurse.

Resident number 75 – The nurses have been reminded to document nonpharmacological interventions that are attempted prior to administration of PRN medications to treat anxiety and pain. The care plan has been updated to address nonpharmacological interventions and target behaviors related to use of antianxiety medications as well as insomnia. The resident’s sleep/wake patterns are monitored on a routine basis and the effectiveness of the interventions to promote sleep will be assessed by a registered nurse. During the physician’s next visit, documentation addressing

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21535	Continued From page 57 R75 had received Tramadol PRN four times from 3/1/16 to 3/10/16 with no documentation of non-pharmacological interventions attempted prior to the Tramadol being administered. Review of the February 2016 MAR and progress notes showed the following: R75 had received Ativan PRN one time on 2/11/16, with no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered. R75 had received Oxycodone PRN 34 times, with no documentation of non-pharmacological interventions attempted prior to the PRN Oxycodone being administered. R75 had received Tramadol PRN one time on 2/29/16 with no documentation of non-pharmacological interventions attempted prior to the Tramadol being administered. Review of the January 2016 MAR, from admission on 1/19/16 to 1/31/16, and progress notes showed the following: R75 had received Ativan PRN eight times with no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered. R75 had received Oxycodone PRN 27 times, with no documentation of non-pharmacological interventions attempted prior to the PRN Oxycodone being administered. R75's care plan, print date 3/11/16, identified the following: Antidepressant and antianxiety medication use	21535	anxiety symptoms, insomnia, and justification of the order change from PRN to routine use of lorazepam will be requested. The physician will be contacted if the resident's medical management of depressed mood, anxiety or insomnia is ineffective. Resident number 45 – A behavior tracking sheet to monitor mood symptoms related to the diagnoses of major depressive disorder has been implemented. The results will be reviewed by the interdisciplinary team during the quarterly care conferences and more frequently if indicated. The physician will be contacted if there is an increase in symptoms of depressed mood. The social worker will complete a depression screen questionnaire every 90 days and with a significant change in condition. The care plan will be reviewed and revised as necessary. Resident number 34 – The resident was admitted July 21, 2015 with a primary diagnoses of schizoaffective disorder with the physician noting that she is doing well on her current psychotropic medications. A behavior tracking sheet to monitor mood symptoms and target behaviors to determine the effectiveness of the antipsychotic, antianxiety, antidepressant and mood stabilizer medications has been implemented. Nonpharmacological interventions to be implemented prior to administration of PRN (as needed) pain medications are addressed in the plan of care. The nursing staff has been informed of the need to attempt	

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21535	Continued From page 58 related to diagnosis of depression and anxiety with interventions of administer medication per MD's (medical doctor's) order. Monitor for effectiveness and adverse reactions and report to nursing if noted. Medication to be reviewed routinely by pharmacist consultant, primary physician and behavior management nurse. Appropriate changes to be made as needed. Monitor mood/behavior and report to Nurse. Physician to review medication with certification visits for appropriateness and possible dose changes. Refer to Psychotropic Drug Policy and Procedure. Resident is at risk for pain related to sacroiliac joint dysfunction, spinal stenosis and osteoarthritis with interventions of: administer pain medication as per MD orders and note the effectiveness. Report any unresolved pain to physician. Encourage resident to verbalize any pain. Monitor and report any noted non-verbal signs of discomfort, i.e., facial grimacing, guarding, increase agitation. Pain assessment quarterly and prn. However, the care plan had not addressed non-pharmacological interventions for either the pain or anxiety. R75's progress note, dated 2/8/16, identified: registered nurse behavior note: Resident was admitted on 1/19/16 with complaints of right leg pain and primary diagnosis of sacroiliacs. During admission resident noted to have orders for Ativan 0.5 mg every hour of sleep (HS) with additional 0.25 mg PRN 30 minutes after scheduled HS dose if needed for Anxiety and Insomnia, and Venlafaxine 75 mg capsule daily for Anxiety. Resident saw her primary physician on 1/26/16. She came back with orders stating to continue scheduled Ativan as is and PRN Ativan as needed. No noted adverse reaction from medications. Primary physician and consulting	21535	nonpharmacological interventions for pain control and to document the interventions attempted and the resident's response. During the consultant pharmacist's monthly medication audits and the quarterly care planning process, the residents' medication regimen will continue to be reviewed to assure that medications used to manage behaviors, mood symptoms, insomnia and pain are appropriately justified and monitored. Compliance will be further monitored by the Director of Nurses/designee by 1) an audit of the records of residents receiving antipsychotic, antianxiety, and antidepressant medications to ensure that target behaviors/mood symptoms are identified, monitored, and related interventions are documented 2) an audit of the records of residents receiving PRN pain medications and sedatives to ensure nonpharmacological interventions and monitoring of their effectiveness is included in the plan of care and appropriately documented and 3) a record audit of residents receiving hypnotics/sedatives to ensure sleep assessments have been completed. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the April quarterly Quality Assurance and Assessment Committee meeting and ongoing.	

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pharmacist routinely review medications. Will continue with current regimen and will contact MD for medication changes as needed.

The behavior note, physician orders, care plan, or other documents provided by facility had identified resident specific symptoms of anxiety to determine if the Ativan and Venlafaxine was affective to relieve "anxiety."
R75's physician orders, dated 2/25/16, included Lorazepam (antianxiety) tablet 0.5 mg (milligrams) one tablet at HS may repeat one half tablet in 30 minutes if still having anxiety issues and not able to sleep.

R75's record identified sleep tracking sheets dated 1/19/16 through 3/9/16. The sleep tracking monitored hours of sleep from 6:00 p.m. through 9:00 a.m. daily.

However, R75's medical record lacked a comprehensive sleep assessment and analysis of the sleep monitoring for the use of the Ativan. In addition, R75's care plan failed to address insomnia.

R75's physician orders dated 1/19/16, identified an order for Ativan 0.5 mg, take one to two tablets PRN one time daily at HS for symptoms. A physician order on 1/26/16, identified an order to change the Ativan to 0.5 mg every HS, may give an extra one-half tablet PRN after 30 minutes if needed for sleep. In addition, R75's record identified a physician order for Venlafaxine 75 mg one capsule once a day related to generalized anxiety disorder, which R75 had been receiving since admission.

R75's physician note, dated 1/26/16, indicated R75 had Ativan at bedtime. They asked the Ativan

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be scheduled dose vs. as needed due to her often forgets to ask for it appropriately at bedtime and there is a little language barrier. However, the physician progress note failed to address anxiety symptoms and insomnia needs and lacked physician justification for the increased medication dosages.

On 3/10/16, at 12:31 p.m., registered nurse (RN)-A stated we do sleep tracking for R75's insomnia, but we have not completed an assessment for sleep. RN-A verified R75's care plan failed to include non-pharmalogical interventions for the PRN pain and antianxiety medications. RN-A verified R75's record failed to include documentation of non-pharmalogical interventions being offered prior to the PRN medications being administered. RN-A verified R75's record failed to include specific symptoms R75 had for the use of the antianxiety medications. RN-A stated R75's Ativan was changed to scheduled doses because that is what the "family" requested and was how R75 had taken the medication at home. RN-A stated in regards to how the facilities system for monitoring moods and behaviors, the nursing assistants report to the nurse and then the nurse documents the mood and behaviors.

On 3/10/16, at 1:00 p.m., the director of nursing (DON) stated they do review the sleep tracking sheets with the physician. I would expect the sleep tracking sheets to be addressed in the sleep note. The DON stated normally the non-pharmalogical interventions are on the care plan and normally you would try those before giving the PRN medications. The DON stated we have not done specific resident symptoms for antidepressant and antianxiety medications before. The DON stated she did not know why

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21535	Continued From page 61 R75's Ativan was changed to being given on a scheduled daily dose vs. as needed. The DON stated she would have expect the reason for the medication being changed is supported by clinical evidence and to be documented and family requesting the change would not be a strong enough reason for the change. On 3/11/16, at 9:52 a.m., the DON stated she would expect the physician to document justification for the use of any medications ordered. The facility Psychotropic Drug Use Policy which includes psychoactive medication use, dated 3/28/14, indicated Purpose: Prairie Manor Care Center (PMCC) assures that each resident's drug regime is free from unnecessary drugs. Resident's receiving psychotropic medication are monitored for: excessive doses, excessive duration, adequate indications, presence of adverse side effects, and target behaviors in accordance with Federal Tag 329. Policy: it is the policy of PMCC to monitor all resident's experiencing behavioral symptoms and that are tacking psychotropic medications (or any other drugs outside of their intended use) for management of mood/behaviors. Procedure: 1. Psychotropic Behavior Management Nurses/Nurse Mangers will track all psychotropic medication changes, medication initiations/discontinuations and dose reductions/increases on resident's individual psychotropic chronological along with indications. 3. Resident's started on any psychotropic medication will be triggered under communications for daily charting times four weeks for target behaviors, or if dose is increased or decreased or the medication is discontinued, charting will be triggered for daily charting times	21535		

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four weeks, then charting will be done quarterly in a RN Behavior Note and as needed. 9. A sleep disruption care plan will be developed for residents with orders for hypnotic/sedative medications (Ambien, Trazodone .....) Non-pharmalogical interventions will be also included. Sleep tracking will be completed before routine certification physician visits for review. 10. A psychotropic care plan will be developed for residents with orders for antidepressants and antianxiety medications (Ativan, Remeron, Celexa, Zoloft .....). All target behaviors and interventions will be included. 12. Residents with orders for PRN antipsychotics, antianxiety and hypnotic will be assessed using Guidelines for Administration worksheet prior to giving this PRN medication and effectiveness will be documented after given.

The facility Pain Management Policy, dated 4/9/14, indicated Purpose: it is the policy of PMCC to ensure residents experiencing pain will have a comprehensive assessment of that pain and will have established plan to treat that pain. Procedure: each resident will have pain addressed on their care plan. Care plans will include individualized interventions for pain as well as non-pharmalogical interventions for pain.

LACK OF MOOD/BEHAVIOR MONITORING TO JUSTIFY THE ONGOING USE OF AN ANTIDEPRESSANT:

R45's admission record revealed a diagnosis of major depressive disorder. Current physician orders signed 2/23/16 included an order for Remeron (antidepressant)15 milligrams at bedtime.

Review of R45's medication administration

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record, treatment administration record, care plan, and progress notes failed to identify mood symptoms for depression.

On 3/10/16 at 9:17 a.m. nursing assistant (NA)-D was interviewed for R45's mood symptoms, "Not really anything we track for her [R45]. The only thing is when she was on a walking program she would get moody. She will make facial expressions, I don't really think she is moody."

LACK OF IDENTIFYING MOOD/DEPRESSION SYMPTOMS TO DETERMINE IF MEDICATION IS AFFECTIVE; ALSO LACK OF USE OF NON-PHARMACOLOGICAL INTERVENTIONS FOR CONTROL PAIN WERE USED BEFORE AS NEEDED PAIN MEDICATION IS GIVEN:

R34's current physician orders signed 2/9/16 included the orders; buspirone tablet 30 mg (anti-anxiety medication) 1 tablet twice daily, Risperdal 4 mg (anti-psychotic medication) 2 tablets at bedtime, Topamax 50 mg (mood stabilizer) twice daily, and fluoxetine 60 mg (anti-depressant medication) daily for a primary diagnosis of schizoaffective disorder. Acetaminophen 500 mg 2 tablets daily as needed for break through pain and Tramadol 50 mg (controlled pain medication) 1 tablet as needed for pain three times daily.

Review of R34's medication administration record, treatment administration record, care plan, and progress notes failed to identify mood symptoms or target behaviors to determine if the antipsychotic, antidepressant and analgesics were affective. Also there was no documentation found or provided by facility in regards to the use of non-pharmalogical interventions prior to the use of as needed pain medication.

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On 3/10/16 at 9:15 a.m. NA-D was interviewed for R34's mood symptoms and target behaviors; "She doesn't like to walk, that kind of targets her. She isn't on a walking program now cause it would trigger her. She doesn't care for different nursing assistants. She swears, she refuses stuff. She says stuff and then she will say she is just kidding. She will say stuff to try to hurt your feelings."

On 3/10/16 10:42 a.m. the DON stated, "Last week we were discussing how we don't have a form of daily tracking [for mood/behavior]. [R34] is one of those that doesn't really have any [target behaviors]. I guess sometimes she doesn't like some staff. I am having someone from point click [electronic medical record] come in and show us how to do behavior tracking. We don't have anything in place for the anti-depressant mood monitoring. If they start a new one or the dose changes the nurses would chart on mood, they would do it for four weeks, but nothing ongoing." On 3/11/16 at 10:21 a.m. the DON added, "The care plan has non-pharmacological interventions listed, but I don't think they [nursing] document what they tried."

On 3/11/16 at 11:04 a.m. the facility consultant pharmacist stated, They should have identified mood symptoms and non-pharmacological should be tried prior to the administration of an as needed pain medication.

A facility policy on mood monitoring, target behavior monitoring was requested but was not provided.

SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service

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21535	Continued From page 65 all staff responsible for medication use on the need to meet the requirements as written under this licensing order. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a call light was within reach for 1 of 30 residents (R27), observed during stage one. Findings include: R27 was observed on 3/7/16, at 6:44 p.m. to be sitting in a wheelchair in his room. R27's call light was clipped up high on the privacy curtain in R27's room, out of reach for R27. On 3/8/16 at 2:54 p.m., R27 was observed to be sitting in a recliner in his room R27's call light was laid on top of R27's bed, again fully out of reach for R27 use. On 3/8/16, at 3:05 p.m., nursing assistant (NA)-A verified R27's call light was on R27's bed and not within reach for R27. R27's care plan, print date 3/11/16, identified the following: resident requires assistance with	21665	Prairie Manor Care Center has policies and procedures to ensure that the residents' environment remains safe and as free of accident hazards as possible and that each resident receives adequate supervision and appropriate assistive devices to reduce the risk of accidents and injury. The facility identifies each resident at risk for accidents and develops a plan of care addressing safety issues with interventions to enhance mobility and promote safety. The resident's use of and need for safety/enabling devices are assessed at admission and reassessed during the quarterly interdisciplinary care conferences and whenever there is a significant change in the residents behavior, physical condition, and/or mental function. The facility's policies and procedures instruct to provide a means for	4/19/16

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21665	Continued From page 66 mobility and intervention of keep call light within reach and encourage resident to call for assist as needed. Resident requires assistance with toileting and intervention of keep call light within reach and remind resident to call for assist when needing to use the toilet. Requires assistance for personal hygiene and intervention of keep call light within reach and encourage resident to call for assistance as needed. Resident is a high risk for falls and intervention of keep call light within reach and encourage resident to call for assistance as needed. On 3/10/16, at 12:41 p.m., registered nurse (RN)-A stated she would expect the call light to be within reach for R27. On 3/10/16, at 12:51 p.m., the director of nursing (DON) stated she would expect the call light to be within reach, if the residents need to use the call light. SUGGESTED METHOD OF CORRECTION: Administrator or Director of Nursing could in-service staff responsible for cares to always provide call light for resident use if needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665	the resident to call for assistance at all time. During the mandatory meetings April 14, and 15, 2016, the nursing staff will be reminded to ensure that residents have a call light within reach before they leave the room, including resident number 27. The Director of Nurses/designee will conduct random observations of the resident rooms for two weeks to ensure that each resident has a call light within reach. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be reviewed at the April Quality Assurance and Assessment Committee quarterly meeting.	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of	21850		4/19/16

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21850	Continued From page 67 physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to conduct an investigation of an allegation of maltreatment/abuse for 1 of 17 residents (R18) reviewed for abuse. Findings include: During a stage I interview with R39 on 3/8/16 at 10:22 a.m., R39 was asked whether he'd ever seen any other resident abused by staff. R39 stated, "There is one guy that stayed here and he had this one girl, I think he got her pregnant." R39 stated the "guy" resided at the facility [R18]. R39 then stated the girl worked at the facility, "He was an outsider. He was here for a short time. He is still residing here. He got an employee pregnant here. She still works here. I told a nurse's aide about it. Well, she moved him down the hallway somewhere else. Well, that didn't help any and she still goes down to him." A social services (SS) progress note dated 1/7/16 addressed concerns reported by R39; "[R39] told the group [at a care conference meeting] about an incident that happen [sic] out in the day room. He said that [R18] was out there and there was 2 girls. One of the girls walked over and sat on his	21850	Prairie Manor Care Center does not knowingly employ individuals who have been found guilty of abusing, neglecting, or mistreating residents. Any knowledge of actions against an employee which would indicate unfitness for service in a resident care position is investigated and reported to the State nurse aid registry or licensing authorities. The facility's policies and procedures for investigation/reporting of incidents were reviewed and found appropriate. Prairie Manor Care Center policy requires that all alleged violations involving resident mistreatment, neglect, abuse, injuries of unknown source and misappropriation of property be 1) reported immediately to the administrator and appropriate state agencies and 2) thoroughly investigated in a timely manner with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action will be taken. The facility intervenes to prevent further potential abuse while the investigation is in process.	

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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) COMPLETE DATE
21850	Continued From page 68 lap [sic] He said they were having a great time. He said the other girl just watched. He said the girl ran off and that was the last he saw of her. He chuckled when he talked about the incident. He said he was sure his eyes were not playing tricks on him because he was right there and saw it all. [R39] had brought this up to SS before. As far as Can [sic] tell this incident did not happen. [R39] has before accuse [sic] staff or other resident of having sex. [R39] had no other concerns for CC [care conference]. SS will continue to inform and invite [R39] and his family to CC with the goal they will attend and or express concerns. SS-A was interviewed on 3/8/16 at 3:25 p.m., SS-A stated she had not spoken with the R18 about the allegation that a girl had sat on his lap. SS-A stated, "I didn't because I didn't feel it was something that I needed to bring up with [R18]." SS-A also stated she had no other documentation regarding the episode that had been reported on 1/7/16 except for the progress note she'd documented in the medical record. When asked whether she had reported the allegation to the administrator, Office of Health Facility Complaints (OHFC), or whether she'd initiated an investigation, SS-A verified she hadn't. The director of nursing (DON) was interviewed on 3/8/16 at 4:06 p.m., and questioned about whether or not the allegation reported 1/7/16 by R39 (regarding R18) had been reported in accordance with facility policy. The DON stated they hadn't determined R39's report from 1/7/16 to be a reportable event, but stated they would report now. When interviewed on 3/8/16 at 5:08 p.m., social services (SS)-A stated that she had no idea who the alleged girls R39 said he saw sitting on R18's	21850	On April 12 and 14, 2016 all Prairie Manor Care Center staff will be instructed on the following: 1) the definition of a vulnerable adult 2) who is a mandated reporter of actual or suspected resident abuse/neglect/misappropriation of property 3) the types of incidents that must be reported to the common entry point and/or the Minnesota Department of Health 4) the requirements of immediate reporting of alleged abuse/neglect and misappropriation of funds to the supervisory/administrative staff and appropriate governmental agencies and 5) forms and procedures for appropriate and timely reporting. The staff is educated on vulnerable adult issues at least every twelve months; vulnerable adult investigation and reporting are addressed during new employee orientation. At the time Resident Number 39 alleged that there were girls sitting on the lap of Resident Number 18 in the day room (a common area frequently occupied by other residents and visitors), the social worker assessed the situation and determined there was no abuse to Resident Number 18. Resident Number 39 had previously accused the staff and other residents of sexual behaviors, and since there was no additional evidence that this incident had occurred as reported, it was felt to be a false allegation and a report was not submitted to the Office of Health Facility Complaints (OHFC). After discussion with the state surveyors, a report was made to the OHFC March 8, 2016 regarding possible	

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	00650	A. BUILDING: ______ B. WING ______	03/11/2016

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21850	Continued From page 69 lap were. She stated that R39 had said he'd never seen them before. When interviewed on 3/8/16 at 6:13 p.m. the administrator, DON, SS-A were present when the administrator stated that R18 could make his own decisions and stated, "Who knows who those girls were, they could have been anyone...it could have been his granddaughters, how do we know?" When interviewed on 3/9/16 at 9:18 a.m., the administrator stated the allegation of potential sexual abuse for R18 should have been more thoroughly investigated. However, he reiterated there was nothing in the SS progress note 1/7/16 regarding R39's allegation that indicated any inappropriate behavior had taken place. The administrator stated since there was nothing about lewd behavior, they hadn't thought the incident was reportable. An investigative report, dated 3/9/16, indicated that the facility did follow up with R18 regarding the abuse allegation which had allegedly occurred on 1/7/16. The 3/9/16 report indicated R18 had denied any sexual abuse. The Facility Abuse Prevention Plan Policy/Procedure (11/12/15), included: "All reports of suspected abuse are reported immediately according to current regulation. The Administrator is immediately notified of all reports. All reports of suspected abuse are investigated promptly under the direction of the Administrator. Social Services and the Director of Nursing will work closely together on these investigations. All interviews will be appropriately documented and maintained with investigated reports...the investigating team or Designee shall thoroughly	21850	abuse. The federal auditor did not support the state surveyor's request to file a vulnerable adult report and instructed the lead state surveyor to "take this back to your team for another review." The March 9, 2016 OHFC response indicated that no further action was needed by their office. During the Social Worker's March 9, 2016 interview with Resident Number 18 regarding possible sexual mistreatment, he denied being mistreated by the staff or others. He stated that he "has been treated find here and is very satisfied here. The care plan for Resident Number 39 was updated to address the resident's regular habit of making unsubstantiated allegations about other residents being abused by the staff. Allegations by Resident Number 39 will continue to be investigated to ensure that no resident is being mistreated. Compliance with the facility's vulnerable adult policies and procedures and related regulatory requirements will be monitored by both social workers for the next three months. The social workers will collaborate in the investigation of all alleged incidents that have a possible risk of sexually-related resident abuse. All incidents of alleged sexually inappropriateness will also be discussed with the Administrator and/or Director of Nurses and an interdisciplinary decision will be made whether the incident is reportable to the Office of Health Facility Complaints. Compliance will be reviewed during the April Quality Assurance and Assessment Committee quarterly meeting and ongoing.	

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21850	Continued From page 70 investigate the complaint, determining whether it is true or false or not possible to substantiate or disprove through interviews and examination with involved parties...Any person with the knowledge or suspicion of suspected violations shall report immediately..." SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the requirements for reporting and investigating allegations of abuse. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide privacy during a transfer from a resident's room to the shower room for 1 of 1 resident (R79). Findings include:	21855	Prairie Manor Care Center staff respects the resident's right to personal privacy including accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings with family and resident groups.	4/19/16

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21855	Continued From page 71 R79 was observed in the left hall on 3/9/16 at 9:17 a.m. transported in a shower chair from her room to the shower room. R79 was wearing a long sleeved top and a bath blanket was draped over the shower chair. R79 was exposed on her bottom half from the waist down on both sides. A male resident was in the hallway and a female resident in the room across the hall was within full view of R79. On 3/9/16 at 12:20 p.m. R79 was surprised to learn she was exposed in the hallway stating, "Oh really? Usually there is nobody in the hallway anyway. It's up to the nurse that brings you there [shower room] how covered up you are. As long as the most important parts are covered I guess that is what is important." On 3/10/16 at 8:30 a.m. nursing assistant (NA)-F was interviewed via telephone and stated, "We have bath blankets and we do have to make sure they are covered up as much as possible. That [transporting R79] was a little more difficult, we are trying to order a new shower chair. I can't get it [bath blanket] tucked into the sides and I try to get as much covered up as I can. I guess I could try wrapping it around her top half around her shoulders." On 3/10/16 at 10:38 a.m. the director of nursing (DON) stated, "You want them [residents] to be covered up. I wouldn't expect areas to be showing." The DON verified R79's exposed sides from the waist down should have been covered up. The facility policy; Bath, Shower dated 6/4/09, included: "1. Place resident in shower chair and cover with appropriate drape."	21855	The facility has policies and procedures appropriately addressing the residents' right to privacy and confidentiality. During the April 14 and 15, 2015 mandatory meeting, all staff were reminded of the state and federal regulations and facility policies addressing residents' privacy rights. The nurses and nursing assistants were counseled regarding being sensitive to care delivery practices that could compromise resident dignity. The supervisory nursing staff have been instructed to be observant of resident privacy during cares/transport and to counsel with the direct care staff if privacy rights are compromised. Procedures to assure respect for the residents' privacy during personal cares were reinforced (e.g., closing doors, pulling divider curtains, covering residents when in view from common areas, knocking before entering, providing personal cares/treatments out of view of others). The residents' right to privacy, confidentiality, and dignified treatment is included in the orientation training for new employees and is addressed during the annual mandatory in-service training. Compliance will be monitored by the Director of Nurses or her designee. Weekly tours of the nursing care unit will be made for six weeks, if privacy/confidentiality problems are noted, additional monitoring and staff counseling will be done. Compliance will be further monitored by the social service staff through direct observation and resident interview. If noncompliance is noted,	

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21855	Continued From page 72 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring residents are treated with dignity and respect. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care in a dignified and respectful manner. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21855	additional staff counseling will be done. Compliance will be reviewed during the April quarterly Quality Assurance and Assessment meeting.	