DEPARTMENT OF HEALTH AND H	UMAN SERVICES	CENTERS FOR MEI	CENTERS FOR MEDICARE & MEDICAID SERVICES			
	DICARE/MEDICAID CERTIFICAT		ID: JKSG			
PAI	RT I - TO BE COMPLETED BY THE	STATE SURVEY AGENCY	Facility ID: 00650			
1. MEDICARE/MEDICAID PROVIDER NO.(L 1) 245482	3. NAME AND ADDRESS OF FACILIT (L3) PRAIRIE MANOR CARE CE	NTER	4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification			
 STATE VENDOR OR MEDICAID NO. (L 2) 122343700 	(L4) 220 THIRD STREET NORTH (L5) BLOOMING PRAIRIE, MN	(L6) 55917	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On Site Visit 0. Other			
5. EFFECTIVE DATE CHANGE OF OWNERSHI (L9)		Z <u>02</u> (L7) ESRD 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
6. DATE OF SURVEY 5/19/2016 (I 8. ACCREDITATION STATUS: (L 0 Unaccredited 1 TJC 2 AOA 3 Other	10) 03 SNF/NF/Distinct 07 X-Ray 11	NF 14 CORF ICF/IID 15 ASC RHC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30			
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 52		 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code 	 7. Medical Director NF)8. Patient Room Size 9. Beds/Room 			
14. LTC CERTIFIED BED BREAKDOWN	Requirements and/or Applied waiv	ers: * Code: A 15. FACILITY MEETS	(L12)			
	SNF ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37) (L38) (L	L39) (L42) (L43)					
16. STATE SURVEY AGENCY REMARKS (IF AI Post certification revisit (PCR) of Health a 17. SURVEYOR SIGNATURE Kvla Einertson. HFE NE II	PLICABLE SHOW LTC CANCELLATION DAT nd Life Safety Code Surveys completed on 5/1 Date : 6/6/2016	9/2016. Refer to CMS form 2567B.	6/6/0046			
· ·		L19) Kamala Fiske-Downing. Heal	(L20)			
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible 	20. COMPLETED BY HCFA REGI 20. COMPLIANCE WITH CI RIGHTS ACT: L21)	VIL 21. 1. Statement of Fina	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)			
22. ORIGINAL DATE 23 LTC A	GREEMENT 24. LTC AGREEMEN	Γ 26. TERMINATION ACTION	: (L30)			
	NNING DATE ENDING DATE	VOLUNTARY 00 01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety			
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburs	5			
	RNATIVE SANCTIONS pension of Admissions: (L44)	03-Risk of Involuntary Terminatic 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active			
(L27) B. Res	cind Suspension Date:		00 100/0			
	(L45)					
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS				
	03001					
(L28)	(L31)				
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DA	ГЕ				
(L32)	(L33) DETERMINATION APP	ROVAL			



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 <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112



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

Prairie Manor Care Center June 2, 2016 Page 2

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,

Kumala Fiske Downing

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DA	TE OF REVIS	IT
	B. Wing	Y2	5/1	9/2016	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	DATE	ITEM	DATE	ITEM		DATE
Y4	Y5	Y4	Y5	Y4		Y5
ID Prefix F0247	Correction	ID Prefix	Correction	ID Prefix		Correction
483.15(e)(2)	Completed	Reg. #	Completed	Reg. #		Completed
LSC	05/13/2016	LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC				LSC _		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC _		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR		DATE	
	GPN/kfd	6/2/2016	3122 ⁻			19/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY 3/11/2016	COMPLETED ON	CHECK FOR UNCORREC	R ANY UNCORRECTED DEFICIEN TED DEFICIENCIES (CMS-2567)	ICIES. WAS A SENT TO THE		5 🗌 NO

DEPARTMENT OF HEALTH AN	ND HUMA	N SERVICES		CENTERS FOR MEDICARE & MEDICAID SERVICES				
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	N AND TRANSMITTAL ID: JKSG			
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00650		
1. MEDICARE/MEDICAID PROVIDER NO.(L 1) 245482		3. NAME AND AD (L3) PRAIRIE M				 TYPE OF ACTION: <u>7</u>(L8) Initial Recertification 		
2. STATE VENDOR OR MEDICAID NO. (L 2) 122343700		(L4) 220 THIRD (L5) BLOOMINC			(L6) 55917	3. Termination4. CHOW5. Validation6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 9. Other 8. Full Survey After Complaint 		
 6. DATE OF SURVEY 04/28/20 8. ACCREDITATION STATUS: 	-	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	04 SNF	07 A-Ray 08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of J	The Following Requirements:		
To (b) :		Ŭ	equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director		
12. Total Facility Beds	52 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	F) 8. Patient Room Size		
5	52 (L17)	x B. Not in Comp	liance with Progra	am	5. Life Safety Code	9. Beds/Room		
			and/or Applied V		* Code: B	(L12)		
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
52								
(L37) (L38)	(L39)	(L42)	(L43)					
Based on the PCR, it has been determined that the facility has not achieved substantial comp Refer to the CMS 2567 (For health), CMS 2567b for both health and life safety code 17. SURVEYOR SIGNATURE Date : Kvla Einertson. HFE NE II 05/05/2016					18. STATE SURVEY AGENCY APPROVAL Date:			
				(L19) EGIONAI	Kamala Fiske-Downing. Health Program Representative 5/12/2016 AL OFFICE OR SINGLE STATE AGENCY			
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH		21. 1. Statement of Financial Solvency (HCFA-2572)			
1. Facility is Eligible to Particip	anta		ITS ACT:	I CIVIL	2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)			
 1. Facility is Englishe to Failuring 2. Facility is not Eligible 	Jale				3. Both of the Above			
2. Tuenty is not Englote	(L21)							
22. ORIGINAL DATE 23.	LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 05/01/1987	BEGINNINC	J DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure			
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ment 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE: 27.	ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	1 <u>OTHER</u>		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)	B Resaind Su	spension Date:	(L44)			00-Active		
	D. Resenia St	ispension Date.	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
(1	L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				
[]	L32)			(L33)	DETERMINATION APPR	ROVAL		



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

Prairie Manor Care Center May 5, 2016 Page 2

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 <u>https://dab.efile.hhs.gov</u> 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

Prairie Manor Care Center May 5, 2016 Page 3 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 <u>Email: gary.nederhoff@state.mn.us</u> 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;

Prairie Manor Care Center May 5, 2016 Page 4

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- 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. Prairie Manor Care Center May 5, 2016 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumala Fiske Downing

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

		AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM /	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE COMF	SURVEY PLETED
		245482	B. WING			F 04/2	₹ 2 8/2016
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER			0 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	ſS	{F 00	00}			
	completed on April certification tags tha found on the CMS2 that were not found PCR which are loca Because you are en signature is not req	at were corrected can be 567B. Also there are tag/s corrected at the time of onsite ated on the CMS2567. nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic					
{F 247} SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.15(e)(2) RIGH ⁻ ROOM/ROOMMAT	acceptable electronic POC, an ur facility will be conducted to ntial compliance with the en attained in accordance with T TO NOTICE BEFORE	{F 24	47}			5/13/16
	the resident's room changed. This REQUIREMEN by: Based on interview facility failed to ensi to a roommate chan reviewed for admiss Findings Include: R9 had a new room 4/26/16. R9 and far roommate on 4/27/	or roommate in the facility is NT is not met as evidenced and document review, the ure notification was given prior nge for 1 of 1 resident (R9) sion, transfer and discharge.	IATUDE		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 the move or change of roommate can can a resident and attempt to be as accommodating as possible. The resi	e at a use ident	
	r DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(x6) DATE 2/2016

Electronically Signed

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.

PRINTED: 05/12/2016

		AND HUMAN SERVICES				05/12/201 APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	СОМ	E SURVEY PLETED
		245482	B. WING _			₹ 2 8/2016
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CC	DE	
PRAIRIE	MANOR CARE CENT	ER		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)			D PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{F 247}	review and social s R9 's social service 4/27/16, included, [social services] wa 4-26-16. [R9] did g 4-26-16. SS did inf 4-27-16 that she did that the roommate 4-27-16 from her [p On 4/27/16, at 12:3 stated R9 received SS-A stated social building and the fac getting a new room talked to her the da moved in. SS-A state department will be ensure room chang notification are com out of the building. The facility's policy dated 4/6/16 includ inform the resident resident's family mo	according to medical record ervice interview. e progress noted dated " Should be noted that SS as out of the building on jet a new roommate on form [R9] and her family on d [have a] new roommate and would be moving [in] on orevious] room. " 66 p.m. social services (SS)-A a new roommate on 4/26/16. services was out of the cility did not inform R9 she was mate until 4/27/16, when SS-A ay after the new roommate ted family was also notified on ed the social service implementing a system to ge and new roommate npleted when social services is Policy for Room Assignments ed: "1. Social Services will and/or, if known, the ember or legal representative ange in room or roommate	{F 24	 7} is asked about his/her prefer are then taken into account we discussing changes of rooms roommates and the timing of changes. When a resident is facility's request, an explanative reason for the move is provider resident is given the opportune new location, ask questions a move, and meet the new rood possible. When a resident re- roommate, the resident is given notice and information about person as possible, while mat confidentiality regarding med information. The facility provi- to a resident whose roommat and whenever possible provi- adjustment before moving ar- into the room. The policy for notifying the re- family/legal representative of room/roommate and was rev- revised to include assignment notification responsibilities w- services staff is unavailable. A services admission references been developed and includes notifying the resident of room and new roommates in a tim- more detailed reference sheet tasks for admitting a resident when the social service staff available to direct the admiss has also been developed. Th- includes notifying the resider family/legal representative of room/roommate changes. 	vhen s or such moved at the tion of the ded. The hity to see the about the mmate when ceives a new ven as much the new vintaining lical des support te has died, des time for nother person esident, changes in riewed and ht of hen the social s sheet has s the task of a changes ely manner. A et listing the t to the facility is not sion process he task list at and	

Facility ID: 00650

If continuation sheet Page 2 of 3

		AND HUMAN SERVICES			PRINTED: 05/12/2 FORM APPROV OMB NO. 0938-0	VED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	(
		245482	B. WING		04/28/2016	5
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		<u>. </u>
PRAIRIE	MANOR CARE CENT	FER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		JLD BE COMPLÉT	TION
{F 247}	Continued From pa	age 2	{F 2	47}		
				The Administrator counseled wit social service staff regarding the regulations and facility polices for notification of residents and fam representatives of room and roo changes. The social workers par to the policy and procedure developments/revisions and are the requirements for timely notifi room and roommate changes. Resident number nine was satis her new roommate. The roomma moved to another room the next according to her preference. Res number nine as well as all other will be informed in a timely man subsequent changes in room or roommates. The nurse manager/designee wi the records of residents changin and getting new roommates for weeks to verify that the residents adequate notice prior to room/ro changes initiated by the facility. I noncompliance is noted, additior auditing and staff training will be Compliance will be reviewed at t quarterly Quality Assurance and Assessment Committee meeting Completion date: May 13, 2016	er timely ilies/legal mmate rticipated aware of cation of fied with ate day sident residents her of any Il audit g rooms four s received ommate f nal done. he	

Facility ID: 00650

If continuation sheet Page 3 of 3

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		I	DATE OF REVISI	Т
IDENTIFICATION NUMBER	A. Building				
245482 _{Y1}	B. Wing	Y2	2	4/28/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
PRAIRIE MANOR CARE CENT	ER	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).

ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0164		Correction	ID Prefix	F0225	i	Correction	ID Prefix			Correction
Reg. #	483.10(e), 483.	75(l)(4)	Completed	Reg. #	483.13 - (4)	(c)(1)(ii)-(iii), (c)(2)	Completed	Reg. #	483.13(c)		Completed
LSC			04/19/2016	LSC			04/19/2016	LSC			04/08/2016
ID Prefix	F0279		Correction	ID Prefix	F0280	•	Correction	ID Prefix	F0282		Correction
Reg. #	483.20(d), 483.2	20(k)(1)	Completed	Reg. #	483.20 (2)	(d)(3), 483.10(k)	Completed	Reg. #	483.20(k)(3)(ii)		Completed
LSC			04/19/2016	LSC			04/19/2016	LSC			04/19/2016
ID Prefix	F0309		Correction	ID Prefix	F0323		Correction	ID Prefix	F0329		Correction
Reg. #	483.25		Completed	Reg. #	483.25	i(h)	Completed	Reg. #	483.25(l)		Completed
LSC			04/19/2016	LSC			04/19/2016	LSC			04/19/2016
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.25(n)		Completed	Reg. #	483.30	(e)	Completed	Reg. #	483.60(c)		Completed
LSC			04/19/2016	LSC			04/19/2016	LSC			04/19/2016
ID Prefix	F0441		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.65		Completed	Reg. #			Completed	Reg. #			Completed
LSC			04/19/2016	LSC				LSC			
REVIEWI STATE A		REVIEW (INITIAL		DATE 05/05/2	016	SIGNATURE OF	SURVEYOR			DATE	/2016
REVIEWI CMS RO	ED BY	REVIEW (INITIAL	/ED BY	DATE		TITLE				DATE	
FOLLOW 3/11/201	/UP TO SURVE 6	YCOMPL	ETED ON			R ANY UNCORREC				T YE	s 🔲 no

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVIS	ыт
IDENTIFICATION NUMBER	A. Building 02 - CHAPEL				
245482 _{Y1}	B. Wing	Y2	2	4/13/2016	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	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
NFPA 101 Reg. #	Completed	Reg. #	101 Completed	Reg. #	Completed
LSC K0154	04/05/2016	LSC K0155	04/05/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC				LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC				LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR		DATE
STATE AGENCY	TL/kfd	05/05/2016	3700)8	4/13/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVE 3/10/2016	Y COMPLETED ON		R ANY UNCORRECTED DEFICIEN CTED DEFICIENCIES (CMS-2567)		



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,

Kumala Fiske Downing

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

STATE FORM: REVISIT REPORT

				DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building			1	
00650 _{Y1}	B. Wing		Y2	4/28/2016	Y3
				L	
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).

ITE Y4			DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
			10				10				10
ID Prefix	20302		Correction	ID Prefix	20560		Correction	ID Prefix	20565		Correction
Reg. #	MN State Statu 144.6503	te	Completed	Reg. #	MN Ru Subp. 2	le 4658.0405 2	Completed	Reg. #	MN Rule 4658.04 Subp. 3	05	Completed
LSC			04/19/2016	LSC			04/19/2016	LSC			04/19/2016
ID Prefix	20570		Correction	ID Prefix	20830		Correction	ID Prefix	20910		Correction
Reg. #	MN Rule 4658.0 Subp. 4	0405	Completed	Reg. #	MN Ru Subp.	le 4658.0520 I	Completed	Reg. #	MN Rule 4658.05 Subp. 5 A.B	25	Completed
LSC			04/19/2016	LSC			04/19/2016	LSC			04/19/2016
ID Prefix	21375		Correction	ID Prefix	21426		Correction	ID Prefix	21530		Correction
Reg. #	MN Rule 4658. Subp. 1	0800	Completed	Reg. #	MN St. Subd. 3	Statute 144A.04	Completed	Reg. #	MN Rule 4658.13 A.B.C	10	Completed
LSC			04/19/2016	LSC			04/19/2016	LSC			04/19/2016
ID Prefix	21535		Correction	ID Prefix	21665		Correction	ID Prefix	21850		Correction
Reg. #	MN Rule4658.1 Subp.1 ABCD	315	Completed	Reg. #	MN Ru	le 4658.1400	Completed	Reg. #	MN St. Statute 14 Subd. 14	4.651	Completed
LSC			04/19/2016	LSC			04/19/2016	LSC			04/19/2016
ID Prefix	21855		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	MN St. Statute Subd. 15	144.651	Completed	Reg. #			Completed	Reg. #			Completed
LSC			04/19/2016	LSC				LSC			
REVIEW		REVIEW (INITIAL		DATE		SIGNATURE OF				DATE	
		•	GPN/kfd		2016		3122	1			3/2016
REVIEW	ED BY	REVIEW (INITIAL		DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/11/2016					RANY UNCORRECTED DEFICIENCI					s 🗌 no	

DEPARTMENT OF HEALTH AN	D HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDIC	AID SERVICES
	MEDICA	ARE/MEDICAID) CERTIFIC	CATION A	AND TRANSMITTAL	П	D: JKSG
	PART I -	TO BE COMPL	ETED BY T	THE STAT	TE SURVEY AGENCY	F	acility ID: 00650
1. MEDICARE/MEDICAID PROVIDER NO.(L 1) 245482		3. NAME AND ADD (L3) PRAIRIE M A				 TYPE OF ACTION Initial 	N: <u>2(</u> L8) 2. Recertification
2. STATE VENDOR OR MEDICAID NO. (L 2) 122343700		(L4) 220 THIRD S (L5) BLOOMING			(L6) 55917	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNER (L9)	RSHIP	7. PROVIDER/SUP 01 Hospital	PPLIER CATEC	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 8. Full Survey After 	9. Other Complaint
 bate of survey 03/11/201 accreditation status: 	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDIN	IG DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complian			And/Or Approved Waivers Of		
To (b):		Program Rec Compliance			2. Technical Personnel	6. Scope of Ser	
		•			3. 24 Hour RN	7. Medical Dire	
12. Total Facility Beds 52	2 (L18)	1. Ac	ceptable POC		4. 7-Day RN (Rural SN	_	1 Size
13.Total Certified Beds 52	2 (L17)	X B. Not in Com	pliance with Prop	gram	5. Life Safety Code	9. Beds/Room	
		Requirements a	and/or Applied V	Waivers:	* Code: B	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
52							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARKS ((IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Justin Main, HFE NE II		04	4/11/2016	(L19)	Kamala Fiske-Downing. Healt	th Program Representati	ve 04/25/2016 (L20)
PART II	- TO BE (COMPLETED B	Y HCFA RI	EGIONAL	OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH	H CIVIL	21. 1. Statement of Finan	2 (,
 Facility is Eligible to Participa 	te	RIGH	TS ACT:		 Ownership/Control Both of the Above 	bl Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible							
	(L21)						
22. ORIGINAL DATE 23. L	TC AGREEN	MENT 24.	LTC AGREEN	MENT	26. TERMINATION ACTION:	(1	L30)
OF PARTICIPATION I 05/01/1987	BEGINNING	6 DATE	ENDING DA	TE	VOLUNTARY0001-Merger, Closure		<u>TARY</u> 1eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to M	feet Agreement
25. LTC EXTENSION DATE: 27. A	ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>	
А	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provide	r Status Change
(L27)	D. D. 1. 1.0		(L44)			00-Active	
(/) E	3. Rescind Su	spension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS		
		03001					
(L2	28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAI	DATE			
(L3	32)			(L33)	DETERMINATION APPI	ROVAL	



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:

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

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

<u>Remedies</u> - 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.

Prairie Manor Care Center March 30, 2016 Page 4

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

Prairie Manor Care Center March 30, 2016 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Prairie Manor Care Center March 30, 2016 Page 6

> 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

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		· ·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-	0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
		245482	B. WING		03/	/11/2016
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	ס		
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to antial compliance with the				
F 164 SS=D	regulations has bee your verification. 483.10(e), 483.75(l	en attained in accordance with	F 164	4		4/19/16
		e right to personal privacy and s or her personal and clinical				
	medical treatment, communications, p meetings of family	cludes accommodations, written and telephone ersonal care, visits, and and resident groups, but this e facility to provide a private lent.				
	section, the resider	in paragraph (e)(3) of this at may approve or refuse the and clinical records to any ne facility.				
	and clinical records resident is transferr	to refuse release of personal does not apply when the red to another health care d release is required by law.				
LABORATOR	L Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE
	ically 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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STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	(3) DATE	0938-039	
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILD	NG.		COMPLETED		
		245482	B. WING			03 /1	1/2016	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
PRAIRIE	MANOR CARE CENT	ER			20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917			
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F 164	The facility must ke contained in the res the form or storage release is required healthcare institutio contract; or the resi This REQUIREMEN by: Based on observat review, the facility f	Pep confidential all information sident's records, regardless of methods, except when by transfer to another on; law; third party payment ident. NT is not met as evidenced tion, interview and document ailed to provide privacy during	" F 1	164	483.10(e) 483.75(l) (4) Tag F164 Prairie Manor Care Center staff respo	ects		
	 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 				the resident's right to personal privace including accommodations, medical treatment, written and telephone communications, personal care, visits and meetings with family and residen groups. The facility has policies and procedur appropriately addressing the resident right to privacy and confidentiality. Du the April 14 and 15, 2015 mandatory meeting, all staff were reminded of the state and federal regulations and face policies addressing residents' privacy rights. The nurses and nursing assist were counseled regarding being sense 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 pr rights are compromised. Procedures to assure respect for the residents' privacy during personal care	s, nt res ts' uring ne ility / tants sitive t		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'		(3) DATE	0938-039 SURVEY PLETED
		245482	B. WING _		03/1	1/2016
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	TER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
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F 164	are trying to order a it [bath blanket] tuc get as much covere try wrapping it arou shoulders." On 3/10/16 at 10:3 (DON) stated, "You covered up. I would showing." The DON from the waist dow up. The facility policy; I	was a little more difficult, we a new shower chair. I can't get ked into the sides and I try to ed up as I can. I guess I could ind her top half around her 8 a.m. the director of nursing i want them [residents] to be dn't expect areas to be N verified R79's exposed sides in should have been covered Bath, Shower dated 6/4/09, resident in shower chair and	F 16	 were reinforced (e.g., closing doors, pulling divider curtains, covering residuhent in view from common areas, knocking before entering, providing personal cares/treatments out of view others). The residents' right to private confidentiality, and dignified treatmer included in the orientation training for employees and is addressed during annual mandatory in-service training Compliance will be monitored by the Director of Nurses or her designee. Weekly tours of the nursing care unit be made for six weeks, if privacy/confidentiality problems are r additional monitoring and staff counse will be done. Compliance will be furth monitored by the social service staff through direct observation and reside interview. If noncompliance is noted, additional staff counseling will be dore Compliance will be reviewed during t April quarterly Quality Assurance and 	v of y, nt is new he will noted, eling ner ent ne. he	
F 225 SS=D	483.13(c)(1)(ii)-(iii) INVESTIGATE/RE ALLEGATIONS/INI	PORT	F 22	Assessment meeting. 25		4/19/16
	been found guilty of mistreating resident had a finding enter registry concerning of residents or mist and report any kno court of law agains	ot employ individuals who have if abusing, neglecting, or its by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a t an employee, which would or service as a nurse aide or				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER			20 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	or licensing authorit The facility must en involving mistreatm including injuries of misappropriation of immediately to the a to other officials in a through established State survey and ce The facility must ha violations are thoro prevent further pote investigation is in p The results of all inv to the administrator representative and with State law (inclu certification agency incident, and if the a appropriate correction	the State nurse aide registry ties. sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency). we evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported to other officials in accordance uding to the State survey and) within 5 working days of the alleged violation is verified ive action must be taken.	F 2	25			
	by: Based on interview facility failed to con- allegation of abuse reviewed for abuse Findings include: During a stage I interview	erview with R39 on 3/8/16 at			Regulation 483.13(c) Tag F225 Staff Treatment of Residents Prairie Manor Care Center does not knowingly employ individuals who h been found guilty of abusing, negled or mistreating residents. Any knowle of actions against an employee whic	ave cting, edge ch	
		is asked whether he'd ever dent abused by staff. R39			would indicate unfitness for service resident care position is investigated		

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		AND HUMAN SERVICES			FORM	04/09/2016 APPROVED	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED	
		245482	B. WING		03/-	11/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
PRAIRIE	MANOR CARE CENT	ER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE	
F 225	Continued From pa	•	F 2	225			
	had this one girl, I t	he guy that stayed here and he hink he got her pregnant." R39 sided at the facility [R18]. R39		reported to the State nurse a licensing authorities.	aid registry or		
	then stated the girl an outsider. He was still residing here. H here. She still work about it. Well, she r	worked at the facility, "He was s here for a short time. He is le got an employee pregnant s here. I told a nurse's aide moved him down the hallway Vell, that didn't help any and		The facility's policies and pro investigation/reporting of inc reviewed and found appropr Manor Care Center policy re alleged violations involving r mistreatment, neglect, abus	idents were iate. Prairie equires that all esident		
	she still goes down A social services (S			unknown source and misapp property be 1) reported imm administrator and appropriat agencies and 2) thoroughly	propriation of ediately to the te state		
	the group [at a care an incident that hap He said that [R18] y girls. One of the gir lap [sic] He said the He said the other g girl ran off and that chuckled when he f	e conference meeting] about open [sic] out in the day room. was out there and there was 2 ls walked over and sat on his ey were having a great time. irl just watched. He said the was the last he saw of her. He calked about the incident. He is eyes were not playing tricks		a timely manner with the inv results reported to the admin and state officials as require alleged violation is verified, a corrective action will be take intervenes to prevent further abuse while the investigation process.	estigative histrative staff d. If the appropriate m. The facility potential		
	on him because he [R39] had brought to Can [sic] tell this in has before accuse having sex. [R39] h [care conference]. S invite [R39] and his	was right there and saw it all. this up to SS before. As far as cident did not happen. [R39] [sic] staff or other resident of ad no other concerns for CC SS will continue to inform and family to CC with the goal or express concerns.		On April 12 and 14, 2016 all Care Center staff will be inst following: 1) the definition of adult 2) who is a mandated actual or suspected resident abuse/neglect/misappropria property 3) the types of incid must be reported to the com point and/or the Minnesota I	tructed on the a vulnerable reporter of t tion of lents that mon entry		
	SS-A stated she ha about the allegation SS-A stated, "I didn something that I ne SS-A also stated sh regarding the episo	ed on 3/8/16 at 3:25 p.m., d not spoken with the R18 n that a girl had sat on his lap. I't because I didn't feel it was eded to bring up with [R18]." he had no other documentation de that had been reported on he progress note she'd		Health 4) the requirements of reporting of alleged abuse/n misappropriation of funds to supervisory/administrative s appropriate governmental ag 5) forms and procedures for and timely reporting. The sta on vulnerable adult issues a	of immediate eglect and the taff and gencies and appropriate aff is educated		

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PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
MANOR CARE CENT	ER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETIO DATE
	-	F 22		dult	
administrator, Offic (OHFC), or whethe	e of Health Facility Complaints r she'd initiated an		during new employee orienta	ation.	
-			that there were girls sitting o	n the lap of	
whether or not the a R39 (regarding R18	allegation reported 1/7/16 by 3) had been reported in		other residents and visitors), worker assessed the situation	the social on and	
they hadn't determi	ned R39's report from 1/7/16		Resident Number 18. Reside 39 had previously accused the second s	ent Number ne staff and	
services (SS)-A sta the alleged girls R3	ted that she had no idea who 9 said he saw sitting on R18's		that this incident had occurre reported, it was felt to be a fa and a report was not submitt	ed as alse allegation ted to the	
never seen them be	efore.		(OHFC). After discussion with surveyors, a report was made	h the state le to the	
administrator, DON administrator stated decisions and state girls were, they cou	, SS-A were present when the d that R18 could make his own d, "Who knows who those Id have been anyoneit could		abuse. The federal auditor d the state surveyor's request vulnerable adult report and in lead state surveyor to "take t your team for another review 9, 2016 OHFC response ind	id not support to file a nstructed the his back to " The March icated that no	
administrator stated sexual abuse for R thoroughly investiga there was nothing in regarding R39's alle	d the allegation of potential 18 should have been more ated. However, he reiterated n the SS progress note 1/7/16 egation that indicated any		During the Social Worker's N interview with Resident Num regarding possible sexual m he denied being mistreated h others. He stated that he "ha treated find here and is very	March 9, 2016 ber 18 istreatment, by the staff or is been satisfied	
	MANOR CARE CENT SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From par documented in the whether she had re administrator, Offic (OHFC), or whethe investigation, SS-A The director of nurs 3/8/16 at 4:06 p.m., whether or not the a R39 (regarding R18 accordance with fact they hadn't determin to be a reportable of report now. When interviewed of services (SS)-A stat the alleged girls R3 lap were. She state never seen them bo When interviewed of administrator, DON administrator stated decisions and state girls were, they cout have been his grant know?" When interviewed of administrator stated decisions and state girls were, they cout have been his grant know?"	ANDR CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 anyoneit could have been his granddaughters, how do we	245482B. WINGPROVIDER ON SUPPLIERMANOR CARE CENTERSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)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.F 22The 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 R18 could make his own decisions and stated, "Who knows who those girls were, they could have been anyoneit 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	245482 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CC MANOR CARE CENTER DECOMING PRAIRLE, MN 55917 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DR Continued From page 5 DECOMING PRAIRLE, MN 55917 Continued From page 5 (EACH CORRECTIVE ACTION) Continued From page 5 (EACH CORRECTIVE ACTION) Continued From page 5 (F 225) Continued From page 5 (COHFC), 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 in accordance with facility Dolicy. The DON stated they hadn't determined B3's report from 1/7/16 to be a reportable event, but stated they would report now. Resident Number 18. Reside determined there was no addition active seen them before. 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 R18 could make his own decisions and stated, "Who knows who those girls were, they could have been anyoneit could have been his grandaughters, how do we know?" OHFC March 8, 2016 regarc abuse. The federal auditor durt react find here and severy or take 11 wescident Number seval abuse for R18 should have been more thoroughly investigated. However, he reiterated there was nothing in the SS progress not 1/7/16 re	245482 B. WING 203/7 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PROVIDER SPLAND C CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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 in accordance with facility policy. The DON stated they hadn't determined R39's report from 1/7/16 by Ba reportable event, but stated they would report now. F 225 When interviewed on 3/8/16 at 5:08 p.m., social services (SS)-A stated that SN bag p.m., social services (SS)-A stated that SN bag p.m., social services (SS)-A stated that SN bag p.m., social services (SS)-A stated that SN bad said he'd never seen them before. F 225 When interviewed on 3/8/16 at 6:13 p.m. the administrator, DON, SS-A wereip resent when the dirdinistrator stated that 18 could make his own decisions and stated, "Who knows who those prifs were, they could have been anyone it could have been his granddaughters, how do we know?" F 2016 Mach Racitla possible abuse. The faderal audit report and instructed the lead state surveyors 'request to file a vulnerable adult report and instructed the sourceyors, a report was needed by their office. During the Social Worker's March 9, 2016 OHFC response indicat

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				a CC		
		245482	B. WING		8/11/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST		
PRAIRIE	MANOR CARE CEN	TER		BLOOMING PRAIRIE, MN 55917		
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F 225	Continued From pa	age 6	F 225	5		
	that the facility did the abuse allegatio on 1/7/16. The 3/9/ denied any sexual The Facility Abuse Policy/Procedure (reports of suspecte immediately accord Administrator is im All reports of suspect promptly under the Social Services and work closely togeth interviews will be a	Prevention Plan 11/12/15), included: "All ed abuse are reported ding to current regulation. The mediately notified of all reports. ected abuse are investigated direction of the Administrator. d the Director of Nursing will her on these investigations. All ppropriately documented and		 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 		
F 226 SS=D	investigating team investigate the com is true or false or n disprove through in involved partiesA or suspicion of sus immediately" 483.13(c) DEVELC ABUSE/NEGLECT The facility must de policies and proced mistreatment, negl and misappropriati	, ETC POLICIES	F 226	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 meetin and ongoing.		

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		& MEDICAID SERVICES	0.00			MB NO. 0938-03
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F 226	Continued From pa	ige 7	F 22	26		
	facility failed to imp	ement their policies for tigation related to an allegation			Staff Treatment of Residents	
	of abuse for 1 of 17 abuse.	residents (R18) reviewed for			Prairie Manor Care Center has dev and implemented written policies a	nd
	Findings include:				procedures that prohibit mistreatmened neglect, and abuse of residents an misappropriation of resident proper	d
	The Facility Abuse Policy/Procedure (1	Prevention Plan 1/12/15), included: "All			policies and procedures address th seven following components: scree	ne
	reports of suspecte	d abuse are reported			training, prevention, identification,	3,
		ling to current regulation. The mediately notified of all reports.			investigation, protection and reporting/response.	
		ected abuse are investigated				
		direction of the Administrator. d the Director of Nursing will			Prairie Manor Care Center staff rec and respect each resident's right to	
		er on these investigations. All			free from mistreatment and	J De
	interviews will be a	opropriately documented and			misappropriation of property and d	
		estigated reportsthe			that is within their control to preven	
		or Designee shall thoroughly plaint, determining whether it			occurrences. The staff 1) identifies residents who are at risk for abuse	
		ot possible to substantiate or			neglect and/or misappropriation of	,
		terviews and examination with			property as well as those at risk of	
		ny person with the knowledge			abusing others 2) develops interve	
	or suspicion of suspinition of suspicion of	pected violations shall report			strategies to prevent occurrences a continually reassesses the effective of the interventions.	
		erview with R39 on 3/8/16 at				
		as asked whether he'd ever			The policies, procedures, and form	is for
		dent abused by staff. R39			identifying, reporting and internally	vod and
		he guy that stayed here and he hink he got her pregnant." R39			investigating incidents were review found appropriate. During the man	
		sided at the facility [R18]. R39			staff meetings April 12 and 14, 201	
	then stated the girl	worked at the facility, "He was			Vulnerable Adult Awareness and	
		s here for a short time. He is			Prevention Plan will be reviewed an	
		le got an employee pregnant			staff will be instructed on: 1) the de	etinition
		s here. I told a nurse's aide moved him down the hallway			of a vulnerable adult 2) who is a mandated reporter of actual or sus	nected
		Vell, that didn't help any and			resident abuse/neglect/ misapprop	
	she still goes down				of property 3) the types of incidents	s that

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		AND HUMAN SERVICES				04/09/201 APPROVE 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245482	B. WING _		03/-	11/2016
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE,	ZIP CODE	
PRAIRIE	MANOR CARE CENT	ER		220 THIRD STREET NORTHWE BLOOMING PRAIRIE, MN &		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE
F 226	Continued From pa	-	F 22	must be reported to the		
	addressed concern the group [at a care an incident that hap He said that [R18] g girls. One of the gir lap [sic] He said the He said the other g girl ran off and that chuckled when he said he was sure h on him because he [R39] had brought Can [sic] tell this in has before accuse having sex. [R39] h [care conference]. invite [R39] and his they will attend and SS-A was interview SS-A stated she has about the allegation SS-A stated she has about the allegation SS-A also stated sh regarding the episo	S) progress note dated 1/7/16 is reported by R39; "[R39] told conference meeting] about open [sic] out in the day room. was out there and there was 2 ls walked over and sat on his ey were having a great time. irl just watched. He said the was the last he saw of her. He talked about the incident. He is eyes were not playing tricks was right there and saw it all. this up to SS before. As far as cident did not happen. [R39] [sic] staff or other resident of ad no other concerns for CC SS will continue to inform and family to CC with the goal or express concerns. red on 3/8/16 at 3:25 p.m., id not spoken with the R18 in that a girl had sat on his lap. It because I didn't feel it was beded to bring up with [R18]." he had no other documentation de that had been reported on he progress note she'd medical record. When asked		 point and/or the Minnes point and/or the Minnes Health 4) timely reporting the policies and proced communicating/docume concerns/incidents and reporting of vulnerable staff are educated on v issues at least every tw vulnerable adult reporting investigation are addressed employee orientation. At the time Resident National there were girls sitt Resident Number 18 in common area frequent other residents and visit worker assessed the sidetermined there was reported there was no add that this incident had or reported, it was felt to be and a report was not su Office of Health Facility (OHFC). After discussion 	acta Department of ng of incidents 5) ures for enting resident 6) internal adult issues. The ulnerable adult relve months and ng and assed during new umber 39 alleged ting on the lap of the day room (a ly occupied by tors), the social tuation and no abuse to Resident Number sed the staff and al behaviors, and itional evidence ccurred as be a false allegation ubmitted to the Complaints	
	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			surveyors, a report was OHFC March 8, 2016 r abuse. The federal aud the state surveyor's rec vulnerable adult report lead state surveyors to your team for another r 9, 2016 OHFC respons further action was need	egarding possible litor did not support juest to file a and instructed the "take this back to eview." The March e indicated that no	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/09/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245482	B. WING _		03 /-	11/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226 F 247 SS=D	they hadn't determine to be a reportable of report now. When interviewed of services (SS)-A state the alleged girls R3 lap were. She state never seen them be When interviewed of administrator, DON administrator, DON administrator, DON administrator, DON administrator, administrator decisions and state girls were, they coun have been his gran know?" When interviewed of administrator stated sexual abuse for R ⁻¹ thoroughly investigat there was nothing in regarding R39's allow inappropriate behave administrator stated about lewd behavior incident was reportate An investigative report that the facility did for the abuse allegation on 1/7/16. The 3/9/ denied any sexual a 483.15(e)(2) RIGHT	cility policy. The DON stated ned R39's report from 1/7/16 event, but stated they would on 3/8/16 at 5:08 p.m., social ted that she had no idea who 9 said he saw sitting on R18's d that R39 had said he'd efore. On 3/8/16 at 6:13 p.m. the l, SS-A were present when the d that R18 could make his own d, "Who knows who those ld have been anyoneit could ddaughters, how do we on 3/9/16 at 9:18 a.m., the d the allegation of potential 18 should have been more ated. However, he reiterated n the SS progress note 1/7/16 egation that indicated any vior had taken place. The d since there was nothing r, they hadn't thought the able. oort, dated 3/9/16, indicated ollow up with R18 regarding n which had allegedly occurred 16 report indicated R18 had abuse. T TO NOTICE BEFORE	F 22	Compliance with the facility's vuln adult policies and procedures and regulatory requirements will be mo by both social workers for the nex months. The social workers will collaborate in the investigation of alleged incidents that have a poss of sexually-related resident abuse incidents of alleged sexually inappropriateness will also be disc with the Administrator and/or Direc Nurses and an interdisciplinary de will be made whether the incident reportable to the Office of Health I Complaints. Compliance will be re during the April Quality Assurance Assessment Committee quarterly and ongoing.	related onitored t three all ible risk . All cussed ctor of cision is Facility viewed and meeting	4/19/16

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					MB NO. 0938-03	
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/11/2016	
	245482					
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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	HOULD BE COMPLETION	
F 247	Continued From pa	age 10	F 24	7		
	A resident has the	right to receive notice before or roommate in the facility is				
	by: Based on interviev facility failed to ens	NT is not met as evidenced v and document review, the ure notification was given prior		Regulation 483.15(e)(2) Tag F247 Notice Before Room/Roommate Cl		
		nge for 1 of 2 residents (R39) sion, transfer and discharge.		The staff at Prairie Manor Care Ce respect the residents' right to receive		
	Findings include:			notice before the resident's room or roommate is changed.		
	given notice of a ch 3/11/16 at 8:53 a.m anything about my	a.m. R39 stated he was not hange in roommate. On h. R39 added, "I didn't know last roommate he just showed anyone that he was coming."		The staff is sensitive to the trauma move or change of roommate can a resident and attempt to be as accommodating as possible. The r is asked about his/her preferences	cause esident	
	dated 12/25/15 ide Interview for Menta	hange Minimum Data Set ntified R39 had a Brief I Status (BIMS) score of 14, 9 had intact cognition.		are then taken into account when discussing changes of rooms or roommates and the timing of such changes. When a resident is move	d at the	
	stated, "We don't d roommate change] [residents]. We usu that morning they a can't guarantee tha	p.m. social services (SS)-A ocument it [informing of every time that we tell them ually just stop in and tell them are getting a new roommate. I the document that it is done		facility's request, an explanation of reason for the move is provided. Th resident is given the opportunity to new location, ask questions about the move, and meet the new roommate possible. When a resident receives roommate, the resident is given as	he see the the e when s a new much	
	dated 10/19/11 incl inform the resident resident's family m	Policy for Room Assignments uded: "1. Social Services will and/or, if known, the ember or legal representative ange in room or roommate		notice and information about the net person as possible, while maintaining confidentiality regarding medical information. The facility provides su to a resident whose roommate has and whenever possible provides tir adjustment before moving another into the room.	ng upport died, ne for	

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		AND HUMAN SERVICES			F	ORM	04/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X		E SURVEY PLETED
		245482	B. WING			03/ ⁻	11/2016
NAME OF F	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER			20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 247	Continued From pa	ge 11	F 2	247			
					The policy for room change notification and documentation was reviewed and revised to include the documentation the notification of changes in room and roommate. The social workers participated to the policy revision and aware of the need to document when residents are notified of room change and new roommates. Resident number 39 was interviewed the social worker and was satisfied w his roommate; they are conversant w each other. The resident will be inform in a timely manner of any subsequent change in room or roommates.	d of are s by rith ith med	
F 070	400 00(d) 400 00/			170	The nurse manager/designee will aud the records of residents changing roo and getting new roommates for four weeks to verify that the residents rece adequate notice prior to room/roomm 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.	oms eived hate e.	4/10/10
F 279 SS=D	483.20(d), 483.20(k COMPREHENSIVE	É CÁRE PLANS	F 2	279			4/19/16
		he results of the assessment and revise the resident's n of care.					
	The facility must de	evelop a comprehensive care					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 04/09/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DAT	E SURVEY IPLETED
		245482	B. WING	ì		11/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
PRAIRIE	MANOR CARE CENT	ER			20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident §483.10, including t under §483.10(b)(4) This REQUIREMEN by:	ent that includes measurable tables to meet a resident's and mental and psychosocial tified in the comprehensive describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise (483.25 but are not provided s exercise of rights under the right to refuse treatment	F	279	Tag F279 – Comprehensive Care Plans	
	teeth for 1 of 3 resid dental status. Findings include: R75 was observed have missing teeth On 3/10/16, at 7:50 (LPN)-A observed F had missing teeth to left side of lower gu The Nursing Admis dated 1/19/16, iden	sion Assessment for R75, tified oral/dental: missing d noted: has own teeth on			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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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245482 03/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST PRAIRIE MANOR CARE CENTER **BLOOMING PRAIRIE, MN 55917** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 279 | Continued From page 13 F 279 R75's care plan printed 3/11/16, identified a comprehensive plans of care were problem area related to dental status. "requires reviewed and updated. At the time of assistance with providing dental care.' admission, a temporary care plan is Interventions included for staff to make sure implemented that addresses the "dentures are in mouth and cleaned prior to residents' need for assistance with meals. Remove, clean, and soak dentures every activities of daily living: the bedtime. Last dental appointment 2015. Provide interdisciplinary care plan is developed oral hygiene with a.m. (morning) cares, p.m. within seven days after completion of the (evening) cares, and as needed. Resident has comprehensive assessment. As part of upper dentures and own lower teeth. Will the quarterly care conference process, the continue to offer/encourage a dental appointment interdisciplinary team reviews the care per facility policy." The care plan did not indicate plans for completeness, accuracy, and R75 had missing teeth. relevancy. On 3/10/16 at 12:31 p.m., registered nurse During the mandatory meetings April 14 (RN)-A verified R75's care plan failed to include and 15, 2016, the nursing staff will be reminded 1) of the facility policies for care missing teeth. plan reviews and updates 2) that the On 3/10/16 at 1:00 p.m., the director of nursing residents' care plans must be current at stated she would expect missing teeth to be all times and 3) that care plans must identified on R75's care plan. continue to address the residents' dental condition and any dental care needs. The facility's policy, Care Plan Policy dated 8/13/13, indicated a care plan would be A registered nurse assessed the oral developed for each resident identifying the needs cavity and dentition of resident number 75. The care plan was updated to reflect of the individual resident. Each resident care plan will address every specific area of care for each that the resident has missing teeth. resident. 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

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 04/09/2016

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	(3) DATE	E SURVEY PLETED
		245482	B. WING			03/ [.]	11/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER			20 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 279	Continued From pa	ge 14	F 2	79	quarterly Quality Assurance and		
F 280 SS=D	483.20(d)(3), 483.1 PARTICIPATE PLA	0(k)(2) RIGHT TO NNING CARE-REVISE CP	F 2	80	Assessment Committee meeting.		4/19/16
	incompetent or othe incapacitated under	r the laws of the State, to ng care and treatment or					
	within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	are plan must be developed he completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after					
	by: Based on observat review, the facility fa include skin interve prevent breakdown (R27) reviewed for revise the care plan 1 of 3 residents (R2 conditions; failed to	NT is not met as evidenced ion, interview and record ailed to revise the care plan to ntions to promote healing and of skin for 1 of 1 resident pressure ulcers; failed to to include risk for bruising for 27) reviewed for skin revise a care plan for 1 of 1 ewed for contractures; and			Regulation 483.20 (d)(3) 483.10(k)(2) Tag F280 Comprehensive Care Plans Prairie Manor Care Center staff devel comprehensive care plans within seve days after the completion of the comprehensive assessment. Care pla are prepared by an interdisciplinary te	lop en ans	

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GENTER	IS FOR MEDICARE	& MEDICAID SERVICES	1		OM	1 <u>B NO. 0</u>	938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION ((X3) DATE S COMPL	
		245482	B. WING _			03/11	/2016
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ſER			0 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 280	Continued From pa	age 15	F 2	80			
	failed to revise the (R39) who demons and who made free about other resider Findings include: LACK OF INTERVI HEELS:" R27's care plan pri following: Resident related to history of buttock and spongy Apply vanicream to (morning) and PM very dry skin areas peri-area after all ir heel cups on while coccyx as ordered a medication to alle effectiveness and s device: Advantage panacea in wheelcl scale quarterly and tolerance testing ar PRN, turn and repo bed, turn side to sid reposition when in A progress note da the following: woun heels. Heels are sp Left is spongier tha removed during the However, this inter- current comprehen	plan of care for 1 of 1 resident trated delusional behaviors uent inaccurate allegations its being abused. ENTION/S FOR "SPONGY nted 3/11/16, identified the is at risk for skin breakdown intragluteal ulcer right inner y heels. Interventions included: dry skin areas with cares AM (evening), report any red or to nurse, barrier cream to noontinent episodes, bilateral in bed, dressing change to PRN (as needed), and use of eviate itching. Monitor for side effects, pressure relieving contour mattress on bed and hair, skin assessment, Braden PRN (as needed), skin nnually, with readmission and osition every 2 hours while in de as much as possible, and chair every 2 hours. ted 2/5/16, indicated R27 had d note, assessed residents bongy and soft to the touch. In the right. Shoes are e day while in recliner. vention was not added to the sive care plan.			which includes the attending physicial registered nurse with responsibility for resident, and other appropriate staff. Professional disciplines work together plan and provide necessary services enhance the residents' functional ab and quality of life. The residents and families/legal representative are encouraged to participate in the care planning process and the quarterly of 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 procedure were reviewed and updated. During April 14 and 15, 2016, mandatory meetings, the nursing staff will be 1) informed of the regulatory requirement that the residents' care plans be curr all times 2) reinstructed on the facilit policies for care plan reviews and up and 3) reminded of the importance of addressing the following in the plan of care: resident behaviors including fa allegations about other residents/sta of bruising, contractures, and skin re- interventions to promote healing/pre- breakdown. Resident number 27 – A registered re- reassessed the resident's skin-related plan of care. The intervention to rem the resident's shoes while the reside	or the er to s to illities I their ecare y es the ent rent at y odates of of lse tiff, risk elated vent nurse ed nove ent is	
		p.m., nursing assistant assistant (NA)-C were			in the recliner to prevent skin breakd on the resident's heels was added to		

TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
		245482	B. WING		03/1	1/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PRAIRIE	MANOR CARE CENT	rer (in the second s		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 280	observed to transfe EZ stand mechanic feet in the recliner, reach and walked or removing R27's sho On 3/9/16, at 12:45 shoes had been lef recliner. NA-C and aware R27's shoes R27 was sitting in the had care sheets the NA-C and NA-B rev- verified the care shi shoes were to be re- he sat in the recliner On 3/10/16, at 9:47 stated removing R2 had been implement stated the nursing a aware R27's shoes sat in the recliner h R27's care plan shi been revised to inc shoes during the da stated she did not k not been added to should have caugh On 3/10/16 at 12:5 (DON) stated she w care plan to be revised would have expect kardex to be updat	 ar R27 to his recliner using an eal lift. NA-C elevated R27's placed R27's call light within out of R27's room without oes. b p.m. NA-C confirmed R27's to n while R27 sat in the NA-B stated they were not were to be removed when he recliner. NA-C stated they ey followed for resident care. viewed R27's care sheet and eet failed to indicate R27's emoved during the day while er. a.m. registered nurse (RN)-C 27's shoes when in the recliner need some time ago. RN-C assistants should have been were to be removed when he owever, when RN-C reviewed e verified the care plan had not lude the removal of R27's ay while in the recliner. RN-C know why the intervention had the care plan and stated, "I that." 1 p.m., the director of nursing vould have expected R27's seed to include removal of his ay when in the recliner, and ed the nursing assistant 	F 28	 plan of care and the nursing assi care instruction Kardex. The care has been updated to address the resident's risk of bruising, interver prevent bruising, and interventior implement if bruising is identified monitoring by the direct care staf charge nurses is part of the week bathing process. Resident number 38 – A register reviewed the resident's care plan statement was added addressing resident's right-hand contractures refusal of related interventions. Resident number 39 – A register and social worker reviewed the re plan of care. The care plan was r include a focus statement address resident's regular habit of making unsubstantiated allegations about residents being abused by the star related resident goals, and interdisciplinary interventions to a the behaviors/allegations. Allegat continue to be investigated to en- no resident is being abused. Sigr escalations in behavior will be rep the resident's attending physiciar To monitor compliance the MDS Coordinator will audit the care pla completeness and accuracy for r who have open skin areas, contra and are receiving medications su aspirin, Coumadin or prednisone other risk factors that increase th bruising. The social worker will a 	e plan ntions to is to . Skin f and dy ed nurse . A focus g the s and ed nurse esident's revised to ssing the g t other aff, address tions will sure that hificant ported to n. ans for esidents actures, ich as , or have e risk of	

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		AND HUMAN SERVICES				FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245482	B. WING			03/	11/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From pa	.ge 17	F 2	80			
	R27 was observed have a purple bruis On 3/8/16, at 2:54 p sitting in a recliner i bruised area was of and another purple above R27's left elk R27's quarterly Min 12/17/15 identified of polymyalgia rheuma R27's physician ord an order for prednis time a day (corticos the skin) and aspirin medication adminis identified R27 recei ordered. R27's incident repo 1/2/16, multiple bru many areas identified	on 3/7/16, at 6:42 p.m. to be on top of his left hand. p.m., R27 was observed to be in his room. The purple bserved on R27's left hand, colored bruise was noted bow. himum Data Set dated diagnoses of dementia, atic and atrial fibrillation. ders dated 1/19/16, identified sone 5 mg (milligrams) one steroids, side effect; thinning of n 81 mg one time a day. R27's stration record, dated 3/16 ived the medications daily as			psychotropic medications to ensure related behaviors are addressed. If plan omissions or inaccuracies are identified, additional care plan audit staff training will be done. During th interdisciplinary care conferences (conducted at least quarterly and w significant change in the resident's condition), the care plans will contir be reviewed to assure the plans accurately reflect the resident's cor and the care and services needed/provided. Compliance will be reviewed during the April Quality Assessment and Assurance Comm quarterly meeting.	care ts and he rith nue to ndition pe	
	bicep. 2/12/16 resident ha 2/20/16 resident ha upper lip. 3/3/16, bruises repo left elbow. Resident resistive with cares bruising. Does use transfers. Resident bruising may have o	as a bruise on his right hand. Is a bruise on his left side orted on top of left hand and t known to be combative and at times and is prone to EZ stand mechanical lift for unable to verbalize how occurred.					
		s reviewed and did not include ated to R27's risk for bruising,					

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		AND HUMAN SERVICES				FORM	04/09/2016 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY IPLETED
		245482	B. WING	i		03/	11/2016
NAME OF	PROVIDER OR SUPPLIER	•		e,	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PRAIRIE	E MANOR CARE CENT	ſER			220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	interventions to pre to implement if brui On 3/10/16 at 12:4 (RN)-A verified the included on R27's of to find the source th verified they had no prevent bruising. On 3/11/16, the dire acknowledged the re been added to R27 LACK OF CURREN HAND CONTRACT R38's care plan dat of primary generaliz Interventions relate diagnosis included, wash cloth in reside contractures, to aid resident allows." A restorative nursin indicated the reside with trailing of hand hand. The note ind compliance had to her hand in a close On 3/9/16 at 11:58 (LPN)-B stated, "Sh hand, it's contracted applying a brace ar but she did not tole exercises but she of	event bruising, nor interventions ising was identified. 1 p.m., registered nurse risk of bruising had not been care plan. RN-A stated they try hat caused the bruising, but of implemented interventions to ector of nursing (DON) risk for bruising should have "s care plan. NT STATUS FOR RIGHT TURE INTERVENTIONS: ted 1/30/16, included diagnosis zed osteoarthritis. ed to the osteoarthritis , "Staff will place rolled up ent's right hand r/t [related to] d with decreasing pain as an progress Note dated 7/8/15 ent had been non-compliant d splint/palm roll to the right dicated the resident's non do with R38 routinely holding	F	280			

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	TOF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MUIT	IPLE CONSTRUCTION		. 0938-039 TE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:		NG	· /	PLETED		
		245482	B. WING _		03	/11/2016		
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE				
PRAIRIE	MANOR CARE CEN	TER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE		
F 280	anywhere in the ca experiencing pain washcloth." The Du not been updated to contracture status of interventions. LACK OF CARE P INTERVENTIONS R39's admission ret the resident had di disorder and unspe- behavioral disturbat R39's Minimum Da indicated R39 had Status (BIMS) score was cognitively inta R39 had experience (a patient health qu monitor the severit score of 11, which depression. Accore had stated on the F depressed or hope himself. R39's care plan (ne suffered a chronic/ intellectual function deficit, judgment, co processes related dementia. The care confusion increase assess and evalua signs or symptoms medical problems.	on't see the issue identified are plan except for her with the use of a rolled ON verified the care plan had to reflect R38's current with her right hand and refusal LANNED BEHAVIORAL cecord dated 5/12/15, indicated agnoses including anxiety ecified dementia without	F 28	30				

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		AND HUMAN SERVICES			FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245482	B. WING		03/	11/2016
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PRAIRIE	MANOR CARE CENT	ſER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
				,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	Continued From pa	ige 20	F 280			
	-	ons indicated R39 was				
		ort any concerns related to				
		ocial services, nursing and/or				
		e agency. However, the care				
		s the resident's regular habit ons about other residents				
		aff which occurred over the				
	past six months, wh					
	unsubstantiated.					
	During a stage List	antion with D20 an 2/2/16 at				
		erview with R39 on 3/8/16 at as ked whether he'd ever				
	-	ident abused by staff. R39				
		ne guy that stayed here and he				
		hink he got her pregnant." R39				
		sided at the facility [R18]. R39				
		worked at the facility, "He was				
		s here for a short time. He is He got an employee pregnant				
		s here. I told a nurse's aide				
		moved him down the hallway				
	somewhere else. W	Vell, that didn't help any and				
	she still goes down	to him."				
	When interviewed	2/2/16 at 11:00 a m that				
		on 3/8/16 at 11:00 a.m., the (DON) stated R39 had thought				
		n he had referred to during				
		wn girlfriend. The DON				
		thought the employee was				
		h another staff member. She				
		R39 had acted this way he'd				
		th a urinary tract infection thad been treated, the				
		ped. The DON stated this had				
		the past. The DON also stated				
	the employee in que	estion was an evening shift				
		hat R39 had picked as his				
		l explained that there was also				
	a male nursing ass	istant working at the facility,				

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		AND HUMAN SERVICES				FORM	04/09/2016 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245482	B. WING	i		03/ ⁻	11/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	FER			220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	and that when R39 assistants talking, F stated social servic and the female nurs had spoken with the they'd been unable allegations. When interviewed of stated that one day watching television described the lightin He stated "these gin outside" and one of started "loving him think it was a family girls ran off after tha "grown up." When interviewed of services (SS)-A state back in October (20 appeared to correlate tract infection and the behaviors appeared infections. When interviewed of licensed practical in had a urinary tract if at that time thought a staff member. LP R39's behaviors has stated the nursing se been experiencing of did get a lot of urinate When interviewed of when interviewed of stated the nursing se been experiencing of did get a lot of urinate When interviewed of	 a saw those two nursing R39 would get upset. The DON re staff had spoken with R39 sing assistant, and the DON e male nursing assistant, and to substantiate any of R39's an 3/9/16 at 12:11 p.m., R39 r he was in the dayroom in the carpeted area. He ng as dark with no lights on. rls" came in the area "from the f the girls sat on R18's lap and up." R39 stated he did not r member. R39 stated then the at. He described the girls as an 3/8/16 at 3:25 p.m., Social ted R39's behaviors began 015). She stated the behaviors ate with the advent of a urinary that nursing was notified when d, and they tracked for any an 3/8/16 at 3:59 p.m., nurse (LPN)-C confirmed R39 infection in January 2016 and the was in a relationship with N-C stated she'd thought id ended. In addition, LPN-C staff thought perhaps R39 had delusions. LPN-C stated R39 	F	280			

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		AND HUMAN SERVICES			FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245482	B. WING		03/	11/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER		20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280 F 282 SS=D	have been care pla were instances of F have been investiga When interviewed of stated a problem re- making allegations sexually abused sh She stated that she staff which included When interviewed of registered nurse (R services had been also stated R39 wo conference meeting the nursing assistant when R39 was exp stated she was awa had investigated that The facility's policy, 8/13/13, included: " developed for each of each individual re- plan will address ex- each resident. The updated from the n annually, and with a plan will be updated any changes in resi 483.20(k)(3)(ii) SEF PERSONS/PER CA	nned. He stated that there R39's behaviors which should ated more. on 3/9/16 at 11:00 a.m., SS-A elated to R39's behaviors of about other residents being ould have been care planned. e would initiate training for the d reporting abuse allegations. on 3/9/16 at 2:34 p.m., RN)-A stated that social aware of R39's behaviors. She uld usually wait for a care g to bring up any issues, that nts would normally report eriencing behaviors. RN-A are of one episode the DON at had been reported by R39. Care Plan Policy dated A care plan will be resident identifying the needs esident. Each resident care very specific area of care for care plan will be reviewed and urse manager quarterly, a significant change. The care d from a registered nurse with ident care as needed" RVICES BY QUALIFIED	F 280			4/19/16

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		AND HUMAN SERVICES & MEDICAID SERVICES	PRINTED: 04/09/201 FORM APPROVE OMB NO. 0938-039				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED	
		245482	B. WING	i		11/2016	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From pa	ge 23	F 2	282			
	by: Based on observat review, the facility fa interventions for rep (R27) reviewed for monitor and report residents (R77) rev related skin concern Findings include: LACK OF REPOSIT THE COMPREHEN R27's care plan, pri following: Resident related to history of buttock and spongy reposition when in of R27 was observed 9:55 a.m. until 12:2 32 minutes), in whic repositioned. At 9:5 (NA)-B and NA-C w from the toilet back EZ stand mechanic have a red, shiny, of buttock. NA-C confi on his left buttock at R27's buttock. At 10 sitting in his wheelc CREAM APPLIED a w/c??? 10:12 a.m., R27 ref	FIONING ACCORDING TO ISIVE CARE PLAN: Int date 3/11/16, identified the is at risk for skin breakdown intragluteal ulcer right inner heels. Intervention of chair every two hours. continuously on 3/9/16, from 7 p.m., (a total of 2 hours and ch R27 had not been 5 a.m., nursing assistant rere observed to transfer R27 into his wheelchair using an al lift. R27 was observed to pen area noted on his left rmed R27 had an open area nd applied barrier cream to 0:03 a.m., R27 remained hair in his room. WAS after he transfered back to his			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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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245482	B. WING			03/1	1/2016
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	TER			20 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETI DATE
F 282	entered R27 room, asked R27 if he wo then assisted R27, wheelchair, to the o remained sitting in room. At 10:50 a.m wheelchair in the d remained sitting in room. NA-B was of the dining room tak eating. At 11:36 a.m wheelchair in the d assist R27 with eat observed to assist to R27's room. R27 wheelchair. NA-B p reach, turned on R R27 I will be right b 12:05 p.m., R27 re wheelchair in his ro entered R27's room which had a dressi sitting in his wheeld remained sitting in 12:18 p.m., R27 re wheelchair in his ro 12:25 p.m., R27 re wheelchair in his ro NA-C entered R27' mechanical lift and wheelchair to the to	shut off R27 television and ould like to go to brunch. NA-C who remained sitting in his dining room. 10:40 a.m., R27 his wheelchair in the dining n., R27 remained sitting in his ining room. At 11:05 a.m., R27 his wheelchair in the dining bserved to sit next to R27 at ole and assisted R27 with m., R27 remained sitting in his ining room. NA-B continued to ting. At 11:50 a.m., NA-B was R27 from the dining room back 7 remained sitting in his olaced R27's call light within 27's television and stated to back, in just a few minutes. At mained sitting in his oom. Registered nurse (RN)-C n to look at R27's right arm, ng in place. R27 remained chair. At 12:09 p.m., R27 his wheelchair in his room, mained sitting in his	F 2	82	pressure ulcers and 3) that job performance expectations include aware of and following the resident of care including timely repositionin orientation for new employees will continue to address the importance following the resident's plan of care activities of daily living including assistance with repositioning. Resident number 27 – A registered reviewed the resident's skin condit skin-related plan of care; every two repositioning remains appropriate. nursing assistants have been remi the residents of the need for every two-hour repositioning and the poli referring to the care Kardex for the resident's repositioning plan of care assessed by a nurse on March 9, 1 3. The plan of care included apply antibiotic ointment to the affected a The resident was discharged Marc 2016 to another long term care fac be closer to her family.	t's plan ng. The e of e for d nurse ion and p-hour The nded of cy for e. on the e l1, and ving area. h 18, illity to ng for es will are	
	be repositioned even stated they had can resident cares. NA	5 p.m., NA-C stated R27 was to ery two to three hours. NA-C re sheets they follow for -C reviewed R27's care sheet re sheet read reposition when			staff. Resident care observations w assigned by the Director of Nurses/designee for two weeks. If noncompliance is noted, additional auditing and staff training will be do Compliance will be reviewed during	one.	

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	COF DEFICIENCIES	& MEDICAID SERVICES		יוסו	E CONSTRUCTION		0938-039
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				· · /	PLETED
		245482	B. WING _			03/-	1/2016
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	TER			20 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 282	Continued From pa	age 25	F 2	82			
	previously stated).	nours (not three hours as NA-B stated she was aware ositioned every two hours.			April quarterly Quality Assurance a Assessment Committee meeting.	nd	
	(RN)-A stated she be followed for repu- because R27's skin to reposition R27 e	11 p.m., registered nurse would expect the care plan to ositioning every two hours, n is so fragile. We will continue very two hours even though ference to an open area on left					
	(DON) stated she w repositioned every planned for R27, or vicinity of two hours	51 p.m., the director of nursing would expect R27 to be two hours if that was care r somewhere in the close s. RELATED SKIN CONDITION:					
	revealed a lesion of hand, approximate lesion was covered red skin surroundir 3/8/16, at 8:30 a.m revealed the lesion right hand. R77 wa 2/15/16 with diagno hemiparesis, and of	on 3/7/16, at 3:10 p.m., on the back of R77's right ly one centimeter in size. The d in a dark brown crust, with no ng the area. Observations on ., and 3/9/16, at 11:20 a.m., remained same on back of s admitted to the facility on osis that included hemiplegia, hysphagia following cerebral ig to facility admission record.					
	2/15/16, with rash i on left shin, and op	ed R77 on the body audit dated n groin and on left arm, bruise oen area on right knee. There of lesion on back of right hand.					
	staff a focus of req	rint date of 3/9/16, directed uired assistance with bathing. ded skin integrity will be					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245482	B. WING			03 / [.]	11/2016
NAME OF	PROVIDER OR SUPPLIER	<u>.</u>			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PRAIRIE	MANOR CARE CENT	ſER			20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	monitored weekly or report any changes nursing. Document review of printed 3/9/16, direct monitored weekly or report any changes nursing. Although nursing as identified the lesion further evidence of lesion to nursing. Document review of 2/26/16 to 3/8/16, re 2/26/16 to 3/8/16, re 2/29/16 shower this or skin tears. 3/7/16 had shower shift. No new skin Document review of dated 3/1/16 to 3/6/ of R77's skin lesion During interview on nursing assistant (N	on bath day and as needed, s, problems or redness to of nursing assistant kardex, cted staff skin integrity will be on bath day and as needed, s, problems, redness to ssistant documentation n on 3/5/16, there was no monitoring and reporting the of facility progress notes dated revealed the following: kin risk assessment-at high lown, required extensive to res, transferred by mechanical re, foley catheter in place, had reposition every one to two ing. Monitor skin daily with bath, and as needed. s morning with no new bruising and weekly skin check this issues at this time. of facility incident report log /16, revealed no identification	F 2	282			

Facility ID: 00650

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		I AND HUMAN SERVICES E & MEDICAID SERVICES					FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION		(X3) DATE	E SURVEY IPLETED
		245482	B. WING _				03 / [.]	11/2016
NAME OF	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODI	E	-	
PRAIRIE	MANOR CARE CENT	ſER		-	IRD STREET NORTHWEST MING PRAIRIE, MN 55917			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD) BE	(X5) COMPLETION DATE
F 282	stated she did not k During interview at aware of the lesion would document or nurse. During interview on licensed practical n aware of the lesion NA-D stated when related area, staff a book and give the w to the nurse. Docur at that time with NA identified on 3/5/16 hand." Document review re 3/9/16, at 4:22 p.m. resident's right han as dry patches on b measured 0.7 centi other measured 0.2 The areas were not no signs of infection was initiated two tim air. During interview on registered nurse (R aware of R77's right the wound nurse as RN-A stated she ex concerns to the win complete an incider notify director of nu nurse, social servic	Age 27 know how the lesion occurred. that time, NA-D stated was today, 3/9/16. NA-D stated in the lesion and notify the a 3/9/16, at 12:17 p.m., hurse (LPN)-B stated was not . During interview at that time, staff discover a non-pressure are to document in the memo white page of the carbon copy ment review of the memo book A-D, revealed the lesion was b, as "sore on top of right evealed progress note dated ., "Staff reported sore to d." Two areas were identified pack of right hand, one area imeter by 0.9 centimeter, the 2 centimeter by 0.3 centimeter. ted to have no drainage and n. Triple antibiotic ointment mes a day and leave open to a 3/10/16, at 7:38 a.m., RN)-A verified facility was not a thand lesion until 3/9/16, and ssessed the area at that time. Appended staff to report skin ng nurse, wing nurse to nt report, and send emails to arsing, nurse manager, wound area and administrator. RN-A d the wing nurse to document ogress notes. RN-A stated	F 28	32				

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		AND HUMAN SERVICES				FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245482	B. WING	i		03 / [.]	11/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PRAIRIE	MANOR CARE CENT	ER			20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 309 SS=D	skin concerns were nurse completing at the wing nurse who RN-A verified R77's ointment started on documented in facil record. RN-A verifie book-white part of of the wing nurse and stayed in the memo During interview on of nursing stated sh to report skin conce document the conce memo book. Directe expected the wing r complete an incider nurse, director of nu social services. The facility Care Pla indicated purpose, f every resident to er resident preference care plan will addre for each individual r 483.25 PROVIDE O HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho	e monitored by the wound in assessment weekly and by o looked at the area daily. Is treatment of triple antibiotic nevening of 3/9/16, as lity medication administration ed the nursing assistant memo carbon copy was to be given to yellow part of the carbon copy o book. 0 3/10/16, at 9:50 a.m., director ne expected nursing assistants erns to the wing nurse and to eern in the nursing assistant or of nursing stated she nurse to assess the concern, nt report, and report to charge ursing, administrator and an Policy, dated 8/13/13, to develop a plan of care for nsure care is given per e. Procedure, each resident ess every specific area of care resident. CARE/SERVICES FOR		282			4/19/16

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CENTER	-	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	OM	FORM IB NO.	04/09/2016 APPROVED 0938-0391 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED
		245482	B. WING			03/1	1/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER			0 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From pa	ge 29	F 3	09			
	This REQUIREMEN	NT is not met as evidenced					
	Based on observat review, the facility fa of 3 residents (R27) related skin condition failed to identify and related skin area and promote healing for reviewed with non-pe concerns. Findings include: R27 was observed have a purple bruist On 3/8/16, at 2:54 p	ion, interview and record ailed to monitor bruising for 1) reviewed for non pressure ons. In addition, the facility d investigate a non-pressure ad provide interventions to 1 of 3 residents (R77) pressure related skin on 3/7/16, at 6:42 p.m. to e on top of his left hand. b.m., R27 was observed to be n his room. The purple			Regulation 483.25 Tag F309 Provide Care/Services for Highest Well-being Prairie Manor Care Center provides resident with the necessary care and services to attain or maintain the hig practicable physical, mental, and psychosocial well-being, in accordar with the comprehensive plan of care interdisciplinary care team assesses resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident's condition indicates. A plan care is developed, implemented, rou reevaluated, and revised as necessar	d ihest nce e. The s each n n of utinely	
	and another purple above R27's left elb R27's quarterly Min 12/17/15, identified polymyalgia rheuma R27's physician ord an order for prednis time a day (corticos the skin) and aspirin medication adminis identified R27 recei ordered. R27's incident repo	imum Data Set dated diagnoses of dementia, atic and atrial fibrillation. ers dated 1/19/16, identified cone 5 mg (milligrams) one teroids, side effect; thinning of n 81 mg one time a day. R27's tration record, dated 3/16 ved the medications daily as rts identified the following: ises on both upper arms,			based on continuing assessments. The policies and procedures for identifying, reporting, investigating, a monitoring bruises and other skin les were reviewed and found appropriat During the April 14 and 15 mandato nursing staff meetings, discussion w include the need to observe for skin lesions and the importance of appropriately reporting, documenting monitoring bruises/ lesions. Procedu related to the above will be reviewed well as developing care plans to monitor/treat/prevent bruises and oth skin lesions. Instruction will be provid the nursing assistants on the need to alert to bruising and other skin injuries/lesions and to immediately re	sions ie. ory <i>i</i> ll g and ures d as her ded to o be	

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	IPI I	E CONSTRUCTION	MB NO.	SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245482	B. WING _			03 /1	1/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	FER			20 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	Continued From pa	age 30	F 30	09			
		s on right elbow and two on			the findings to the licensed nurse.		
	bicep.				Observing and reporting skin proble		
		as a bruise on his right hand. Is a bruise on his left side			including bruises, will continue to b of the nursing assistant's bathing p		
		orted on top of left hand and			Resident number 27 – A registered	nurse	
		t known to be combative and			reassessed the resident's skin-rela		
		at times and is prone to			plan of care. The care plan has bee		
		EZ stand mechanical lift for			updated to address the resident's r		
		unable to verbalize how			bruising, options to prevent bruising		
	bruising may have	occurred.			implementation of interventions in t event of bruising.	ne	
	R27's care plan wa	s reviewed and did not include			event of bruising.		
		ated to R27's risk for bruising,			Resident number 77 – The lesions	on the	
		event bruising, nor interventions			top of the resident's right hand were	е	
	to implement if brui	ising was identified.			assessed by a nurse on March 9, 1		
					13. The plan of care included apply		
		1 p.m., registered nurse			antibiotic ointment to the affected a		
		risk of bruising had not been care plan. RN-A stated they try			twice a day. The resident was disch March 18, 2016 to another long ter		
		hat caused the bruising, but			facility closer to her family.		
		ot implemented interventions to					
	prevent bruising.	-			To monitor care plan compliance, the		
	0.04440.0				MDS Coordinator will audit the care		
		ector of nursing (DON)			for completeness and accuracy for		
	been added to R27	risk for bruising should have			residents who have open skin area contractures, or are receiving medi		
					such as aspirin, Coumadin or predi		
	A policy for non-pre	essure skin conditions was			or have other risk factors that incre		
	requested, but not	provided.			risk of bruising. To monitor complia	nce	
		RELATED SKIN CONDITION:			with identification of skin lesions, th Director of Nursing/designee will co	onduct	
		lesion on the back of right			random skin audits for two weeks.		
	hand without the fa				previously unreported bruises or ot		
		nvestigation of the lesion, and is to promote healing.			skin problems are observed, addition auditing and staff training/counselir		
		is to promote nearing.			be done. Compliance will be review		
	R77 was admitted t	to the facility on 2/15/16 with			during the April quarterly Quality		
		ded hemiplegia, hemiparesis,			Assurance and Assessment Comm	ittoo	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		E SURVEY PLETED
		245482	B. WING		03/	11/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	according to facility A body audit conduct indicated R77 had a left arm, bruise on I the right knee. The on back of right har During an observation dark brown crusted centimeter in size, y R77's right hand. T skin surrounding the During observations 3/9/16 at 11:20 a.m R77's hand remaine Document review o 2/26 to 3/8/16, reve 2/26/16-quarterly sk risk for skin breakde total assist with card lift, did not ambulate pink folds at times, hours sitting and lyi cares, weekly with the 2/29/16-shower this or skin tears. 3/7/16-had shower shift. No new skin i	wing cerebral infarction, admission record. cted for R77 dated 2/15/16, a rash in the groin area, on the eft shin, and an open area on ore was no indication of lesion nd. ions on 3/7/16 at 3:10 p.m., a lesion approximately one was noted on the back of There was no redness to the e area. s on 3/8/16 at 8:30 a.m., and ., the lesion to the back of ed unchanged. f facility progress notes from aled the following: kin risk assessment-at high own, required extensive to es, transferred by mechanical e, foley catheter in place, had reposition every one to two ng. Monitor skin daily with path, and as needed. and weekly skin check this issues at this time.	F 30			
		ncident report logs dated vealed no identification of				

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI	LE CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:			·		PLETED
		245482	B. WING			03/	11/2016
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	11/2010
	MANOR CARE CENT	-ED		2	220 THIRD STREET NORTHWEST		
FRAIRIE	MANON CARE CENT	En		E	BLOOMING PRAIRIE, MN 55917		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		DATE
					DEFICIENCY)		
F 309	Continued From pa	ao 20		00			
1 000	Continued From pa	ige 52	F 3	09	,		
		3/9/16 at 12:15 p.m., nursing					
		knowledged having first					
		ne lesion on R77's right hand nied knowing how the lesion					
		d. NA-D was also present					
	during the interview	and NA-D stated she'd					
		ne lesion that morning. NA-D					
		ion and would notify the nurse.					
		-					
		3/9/16 at 12:17 p.m.,					
		urse (LPN)-B stated she was sion. NA-D, who was also					
	present, stated whe						
		ed area, they are supposed to					
		mo book" and give the white					
		copy to the nurse. Document book at that time with NA-D,					
		had been identified on 3/5/16,					
		fright hand." There was no					
	carbon copy page II	ncluded. NA-D verified this.					
	R77's care plan prir	nted 3/9/16, indicated: skin					
	integrity will be mor	nitored weekly on bath day and					
		re plan also indicated staff					
	to nursing.	changes, problems or redness					
	0						
		ng assistant kardex printed					
		ed staff were to monitor skin bath day and as needed,					
		, problems, redness to					
	nursing.						
	Although nursing as	ssistant documentation					
		on 3/5/16, there was no					
	further evidence of	identification, assessment,					
	treatment or monito	pring until surveyor intervened					

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		AND HUMAN SERVICES				FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245482	B. WING			03 / [.]	11/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DRAIRIE	MANOR CARE CENT	FB		2:	20 THIRD STREET NORTHWEST		
		Lit		B	BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From pa on 3/9/16.	ıge 33	F 3	309			
	note dated 3/9/16 a "Staff reported sore areas were identifier right hand, one area 0.9 centimeter, the centimeter by 0.3 c noted to have no dr infection. Triple ant two times a day and	eyor's questions, this progress at 4:22 p.m. was documented: to resident's right hand. Two ed as dry patches on back of a measured 0.7 centimeter by other measured 0.2 entimeter. The areas were rainage and no signs of ibiotic ointment was initiated d leave open to air."					
	Audit policy dated 9 Page 1, Purpose: T and location on adr possible risk factors appropriate care to Page 2, #5 on resid day nursing assista skin check to ident may affect the resid The bath day skin of the licensed staff m resident on that shi concern can be che filled out if needed manager. The licen required to complet in the nurses notes #6. Daily skin check residents that are a and repositioning. N to report any skin c supervisor so that is documented and rep	ks are to be completed on all assisted with dressing, toileting, Nursing assistants are required oncerns to their immediate ssues can be checked, eported to the appropriate entions to be initiated to					

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		AND HUMAN SERVICES				FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245482	B. WING _			03/	11/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ĨER			20 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From pa	ige 34	F 30	09			
	During interview on registered nurse (R not aware of R77's and the wound nurs RN-A stated she ex concerns to the win then to complete ar emails to notify dire manager, wound nu administrator. RN-wing nurse to docur progress notes. RN monitored by the win assessment weekly looked at the area of treatment of triple a started the evening facility medication a verified the nursing part of carbon copy nurse and yellow pa in the memo book. During interview on director of nursing (nursing assistants t wing nurse and to c nursing assistant m stated she expected concern, complete to charge nurse, dir and social services During interview on was asked how she hand and she replie	a 3/10/16, at 7:38 a.m. RN)-A verified the facility was right hand lesion until 3/9/16, se assessed the area then. Appected staff to report skin ing nurse, the wing nurse was in incident report, and send ector of nursing, nurse urse, social services and A stated she also expected the ment skin concerns in the I-A stated skin concerns were ound nurse completing an y and by the wing nurse who daily. RN-A verified a antibiotic ointment had been of 3/9/16, as documented in administration record. RN-A assistant memo book-white y was to be given to the wing art of the carbon copy stayed a 3/10/16, at 9:50 a.m. the (DON) stated she expected to report skin concerns to the document the concern in the nemo book. The DON also d the wing nurse to assess the an incident report, and report rector of nursing, administrator					

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		AND HUMAN SERVICES		FORM	: 04/09/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3) DAT	E SURVEY IPLETED
		245482	B. WING	03	/11/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST	
PRAIRIE	MANOR CARE CENT	ER			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 309	plan of care for eve given per resident p included a care plan	ge 35 valed Purpose: To develop a ry resident to ensure care is preference. Procedure n would be developed for each the needs of each individual	F 309	9	
F 323 SS=D	HAZARDS/SUPER The facility must en environment remain as is possible; and		F 323	3	4/19/16
	by: Based on observat review, the facility fa were implemented residents (R27) rev Findings include: R27 was observed sitting in a wheelch was observed to be privacy curtain and On 3/8/16 at 2:54 p sitting in a recliner i was observed to be light was out of R27 On 3/8/16, at 3:05 p	NT is not met as evidenced tion, interview and record ailed to ensure interventions to prevent falling for 1 of 4 iewed for accidents. on 3/7/16, at 6:44 p.m. to be air in his room. The call light e clipped up high on the was out of R27's reach. , R27 was observed to be n his room and the call light e on top of R27's bed. The call 7's reach. , nursing assistant (NA)-A ght was not within reach for		 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 	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/09/2016 APPROVED 0938-0391
	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245482	B. WING		03/-	1/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER		20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	resident required as personal hygiene. I indicated R27 was a plan intervention ind reach and encourag assistance. On 3/10/16 at 12:41 verified R27's call li him to use. On 3/10/16 at 12:51 also stated she wou	nt date 3/11/16, indicated the esistance with toileting and in addition, the care plan at high risk for falls. The care cluded: Keep call light within ge resident to call for p.m., registered nurse-A ght should be within reach for p.m., the director of nursing and any resident who	F 323	admission and reassessed during th quarterly interdisciplinary care conferences and whenever there is significant change in the residents behavior, physical condition, and/or mental function. The facility's policie procedures instruct to provide a mea for the resident to call for assistance time. During the mandatory meetings Apri and 15, 2016, the nursing staff will b reminded to ensure that residents ha call light within reach before they lea room, including resident number 27. The Director of Nurses/designee wil conduct random observations of the resident rooms for two weeks to ens that each resident has a call light wi reach. If noncompliance is noted, additional monitoring and staff educ will be done. Compliance will be rev at the April Quality Assurance and Assessment Committee quarterly meeting.	a es and ans e at all il 14, be ave a ave the	
F 329 SS=E	483.25(I) DRUG RE UNNECESSARY D	EGIMEN IS FREE FROM RUGS	F 329	0		4/19/16
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequen	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of ices which indicate the dose or discontinued; or any e reasons above.				

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245482	B. WING _		03/11/20	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	MANOR CARE CENT	ED		220 THIRD STREET NORTHWEST		
FNAME	MANON CANE CENT	En		BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 37	F 32	29		
	resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and c record; and residen drugs receive gradu behavioral intervent contraindicated, in a drugs.	whensive assessment of a must ensure that residents antipsychotic drugs are not inless antipsychotic drug by to treat a specific condition documented in the clinical ts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these				
	by: Based upon intervi facility failed to iden and behavior symp non-pharmacologic pain and antianxiety analysis of sleep to and failed to ensure use of psychotropic residents (R75); fai mood and behavior an antianxiety medi (R34); and failed to symptoms to deterr antidepressant med (R45 and R35) who antidepressant med Findings include:	NT is not met as evidenced ew an document review, the http://resident.specific.mood toms for anxiety, to implement al interventions before use of y medicaiton, to ensure an warrant the use of a hypnotic e a physician's justification for medication for 1 of 5 led to identify and monitor symptoms to justify the use of cation for 1 of 5 residents identify and monitor mood nine effectiveness of and dication for for 2 of 5 residents o received daily dose of an dication.		483.25(I) Tag F329 Unnecessary Drugs Prairie Manor Care Center staff en that each resident's drug regime is from unnecessary drugs. The resi drug regime is reviewed by the interdisciplinary care team, physic consultant pharmacist to assure th medications are not used in excess doses, for excessive duration, with adequate monitoring, without adea indications, or in the presence of a consequences which indicate the should be reduced or the drug discontinued. An effort is made to the lowest effective dose of psych medications and to discontinue the psychotropic medications whenev possible.	s free dent's ian and nat sive nout quate adverse dose identify otropic e use of	

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u>OMB NO.</u>	APPROVEI 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
245482		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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETIO DATE	
F 329	in right leg. R75's 3 Assessment (MDS) was cognitively inta mood of feeling tire pain which had may frequency of pain d as needed (PRN) p received non-medic and had received a medications. R75's physician ord the following orders Lorazepam (antian) (milligrams) - one ta repeat one half tabl anxiety issues and Venlafaxine (antide once a day related disorder.	s of chronic pain, anxiety, pain 0 day Minimum Data 0 day Minimum Data 1 dated 2/16/16, identified R75 ict, had no behaviors, had of or having little energy, had de it hard to sleep at night, laily, received scheduled and pain medications, had not cation interventions for pain intidepressant and antianxiety ders dated 2/25/16, included s: xiety) tablet 0.5 mg ablet at HS (bedtime), may let in 30 minutes if still having not able to sleep. pressant) 75 mg - one capsule to generalized anxiety ic) 50 mg - two tablets every	F3	 Prairie Manor Care Center staff et that 1) residents who have not us psychotropic drugs are not given drugs unless psychotropic drug the necessary to treat a specific condiagnosed and documented in the record and 2) residents who use psychotropic drugs receive graduereductions with attempts to manabehaviors using nonpharmacolog interventions. Medications are reviewed by the consultant pharmacist monthly are attending physician/nurse practitied during their routine 30/60 day visi more often as indicated. Based or resident's comprehensive assess Prairie Manor Care Center staff reidentify target behaviors that justic use of psychotropic medications. At the time of the quarterly care conference and more often if needstarts. 	ed these herapy is lition as e clinical al dose ge ical ad by the oner ts and n the ment, putinely fy the		
	tablet every six hou Review of the Marc administration reco showed the followir R75 had received A time on 3/5/16, with non-pharmacologic	rd (MAR) and progress notes ng: Ativan as needed (PRN) one no documentation of cal interventions attempted		residents receiving psychotropic medications are reassessed by lia nurses and the social worker. The medication type/dose, behavior/m symptoms, and other related info are reviewed to assure that the re- continues to reflect adequate indi for use and that the dose tapering attempts are in compliance with r guidelines.	by licensed The or/mood information le record indications ering		
	•	ivan being administered. Dxycodone PRN six times from		The policies and procedures relat administration of psychotropic medications were reviewed and r			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245482 03/11/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST PRAIRIE MANOR CARE CENTER **BLOOMING PRAIRIE, MN 55917** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 329 Continued From page 39 F 329 3/1/16 to 3/10/16 with no documentation of Target behaviors justifying the use of antianxiety and antidepressant non-pharmacological interventions attempted prior to the PRN Oxycodone being administered. medications will be documented on the medication administration record and R75 had received Tramadol PRN four times from addressed in the care plan. Use of the 3/1/16 to 3/10/16 with no documentation of daily Mood and Behavior Tracking Log to non-pharmacological interventions attempted track target behaviors justifying the use of prior to the Tramadol being administered. antipsychotics and the effectiveness of listed interventions will continue. Review of the February 2016 MAR and progress The target behavior(s) will be identified in notes showed the following: the plan of care. For antipsychotic, antianxiety and hypnotic/sedative R75 had received Ativan PRN one time on medications prescribed on a PRN (as 2/11/16, with no documentation of needed) basis, guidelines/parameters are non-pharmacological interventions attempted developed for use and are documented prior to the PRN Ativan being administered. on the designated form. Nonpharmacological interventions are R75 had received Oxycodone PRN 34 times, with addressed. no documentation of non-pharmacological interventions attempted prior to the PRN Implementation of electronic tracking of Oxycodone being administered. target behaviors, nonpharmacological interventions for management of R75 had received Tramadol PRN one time on behaviors and pain control, and the effectiveness of the interventions is 2/29/16 with no documentation of non-pharmacological interventions attempted tentatively scheduled for May 2016. The prior to the Tramadol being administered. electronic system will provide automatic documentation prompts and reminders for Review of the January 2016 MAR, from the staff. admission on 1/19/16 to 1/31/16, and progress During the mandatory meetings on April notes showed the following: 14 and 15, 2016, the licensed nursing staff will be instructed on 1) the new R75 had received Ativan PRN eight times with no documentation procedures for target documentation of non-pharmacological behaviors and behavior related interventions attempted prior to the PRN Ativan interventions 2) the importance of being administered. attempting nonpharmacological interventions prior to administration of R75 had received Oxycodone PRN 27 times, with PRN psychotropic and analgesics 3) no documentation of non-pharmacological ensuring the care plan addresses target interventions attempted prior to the PRN behaviors and nonpharmacological

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
245482			03/11/2016	
IAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
TER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	_D BE COMPLETI	
administered. rint date 3/11/16, identified the d antianxiety medication use s of depression and anxiety of administer medication per etor's) order. Monitor for adverse reactions and report to ledication to be reviewed acist consultant, primary avior management nurse. es to be made as needed. avior and report to Nurse. w medication with certification teness and possible dose Psychotropic Drug Policy and for pain related to sacroiliac spinal stenosis and interventions of: administer s per MD orders and note the bort any unresolved pain to age resident to verbalize any report any noted non-verbal t, i.e., facial grimacing, agitation. Pain assessment However, the care plan had not armacological interventions for anxiety. te, dated 2/8/16, identified: ehavior note: Resident was 6 with complaints of right leg liagnosis of sacroiliacs. During	F 32	 interventions to manage mood sy anxiety and pain 4) the need to de the effectiveness of interventions the need for an assessment that the sleep monitoring data. The di staff will be reminded of the impobeing observant for behaviors an reporting target behaviors to the onurse. Resident number 75 – The nurse been reminded to document nonpharmacological interventions attempted prior to administration medications to treat anxiety and p care plan has been updated to aconopharmacological interventions target behaviors related to use of antianxiety medications as well as insomnia. The resident's sleep/we patterns are monitored on a routi and the effectiveness of the intervention to promote sleep will be assessed registered nurse. During the physinext visit, documentation address anxiety symptoms, insomnia, and justification of the order change fit to routine use of lorazepam will be contacted if the resident's medication management of depressed mood or insomnia is ineffective. 	bocument and 5) analyzes rect care rtance of d charge s have s have s that are of PRN bain. The ddress s and s ake ne basis ventions d by a ician's sing rom PRN e al , anxiety	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245482	IDENTIFICATION NUMBER: A. BUILDIN 245482 B. WING	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 245482 B. WING TER STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917 ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) age 40 F 329 administered. interventions to manage mood sy anxiety and pain 4) the need to of the staff will be reminded of the impo being observant for behaviors to the staff will be reminded of the impo being observant for behaviors to the auxiest and possible dose Psychotropic Drug Policy and interventions of: administer s per MD orders and note the age resident to verbalize any report any noted non-verbal t, i.e., facial grimacing, a egitation. Pain assessment However, the care plan had not armacological interventions for anxiety. Resident number 75 – The nurse been reminded to document nonpharmacological interventions attempted prior to administrar s per MD orders and note the age resident to verbalize any report any noted non-verbal t, i.e., facial grimacing, a egitation. Pain assessment However, the care plan had not armacological interventions for anxiety. The endiection address anxiety symptoms, insomnia, and justification of the order change for to routine use of lorazepam will be contacted if the resident smedica management of depressed mood or insomnia is ineffective. (add 2/8/16, identified: ehavior note: Resident was 16 with complaints of right leg tiagnosis of sacrolliacs. During Resident number 45 – A behavio sheet to monitor mood sy	

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STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
245482			B. WING			03/11/2016	
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PRAIRIE MANOR CARE CENTER					20 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 329	Insomnia, and Venl for Anxiety. Reside on 1/26/16. She ca continue scheduled as needed. No note medications. Prima pharmacist routinel continue with curre for medication char The behavior note, other documents pr identified resident s determine if the Ativ affective to relieve R75's physician ord Lorazepam (antian) (milligrams) one ta tablet in 30 minutes and not able to slee R75's record identifi dated 1/19/16 throu monitored hours of 9:00 a.m. daily. However, R75's me comprehensive sle the sleep monitorin addition, R75's care insomnia. R75's physician ord an order for Ativan PRN one time daily physician order on change the Ativan t	afaxine 75 mg capsule daily nt saw her primary physician me back with orders stating to d Ativan as is and PRN Ativan ed adverse reaction from ry physician and consulting y review medications. Will nt regimen and will contact MD nges as needed. physician orders, care plan, or rovided by facility had specific symptoms of anxiety to van and Venlafaxine was "anxiety." ders, dated 2/25/16, included xiety) tablet 0.5 mg ublet at HS may repeat one half s if still having anxiety issues	F 3	29	care conferences and more freque indicated. The physician will be corr if there is an increase in symptoms depressed mood. The social worke complete a depression screen questionnaire every 90 days and w significant change in condition. The plan will be reviewed and revised a necessary. Resident number 34 – The residen admitted July 21, 2015 with a prima diagnosis of schizoaffective disorde the physician noting that she is doi on her current psychotropic medica A behavior tracking sheet to monito symptoms and target behaviors to determine the effectiveness of the antipsychotic, antianxiety, antidepri and mood stabilizer medications ha implemented. Nonpharmacological interventions to be implemented pri administration of PRN (as needed) medications are addressed in the p care. The nursing staff has been in of the need to attempt nonpharmacological interventions to control and to document the interve attempted and the resident's respon During the consultant pharmacist's monthly medication audits and the quarterly care planning process, th residents' medication regimen will continue to be reviewed to assure the medications used to manage beha mood symptoms, insomnia and pa appropriately justified and monitore	tacted of of er will ith a e care is it was ary er with ng well ations. or mood essant as been ior to pain olan of for pain entions inse. e that the viors, in are	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE			0938-039 SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
	245482		B. WING			03/11/2016		
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE				
PRAIRIE MANOR CARE CENTER					20 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 329	Continued From pa	age 42	F 32	29				
	one capsule once a anxiety disorder, w since admission. R75's physician no R75 had Ativan at the be scheduled dose often forgets to ask and there is a little physician progress symptoms and inso physician justification medication dosage On 3/10/16, at 12:3 (RN)-A stated we do insomnia, but we h assessment for sle plan failed to incluo interventions for the medications. RN-A include documenta interventions being R75's record failed R75 had for the use medications. RN-A changed to schedu what the "family" re had taken the med in regards to how the monitoring moods a assistants report to documents the mod	81 p.m., registered nurse o sleep tracking for R75's ave not completed an ep. RN-A verified R75's care le non-pharmalogical e PRN pain and antianxiety verified R75's record failed to tion of non-pharmalogical offered prior to the PRN administered. RN-A verified to include specific symptoms e of the antianxiety stated R75's Ativan was led doses because that is equested and was how R75 ication at home. RN-A stated he facilities system for and behaviors, the nursing the nurse and then the nurse			the Director of Nurses/designee by audit of the records of residents re- antipsychotic, antianxiety, and antidepressant medications to ensi- the target behaviors/mood symptor identified, monitored, and related interventions are documented 2) and of the records of residents receivin pain medications and sedatives to that nonpharmacological interventia and monitoring of their effectivenes included in the plan of care and appropriately documented and 3) a audit of residents receiving hypnotics/sedatives to ensure slee assessments have been completed noncompliance is noted, additional auditing and staff training will be do Compliance will be reviewed at the quarterly Quality Assurance and Assessment Committee meeting a ongoing.	ceiving ure that ms are n audit g PRN ensure ons ss are a record p d. If one. April		

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		AND HUMAN SERVICES			FORM	04/09/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245482	B. WING _		03/	11/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PRAIRIE	MANOR CARE CENT	ER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 329	Continued From par sleep tracking shee sleep note. The DC non-pharmalogical plan and normally y giving the PRN med have not done spect antidepressant and before. The DON si R75's Ativan was of scheduled daily dos stated she would hat medication being of evidence and to be requesting the char enough reason for the ordered and the participation of the ordered. The facility Psychot includes psychoacti 3/28/14, indicated F Center (PMCC) ass regime is free from Resident's receiving monitored for: exce duration, adequate adverse side effects accordance with Fe policy of PMCC to r experiencing behave tacking psychotropi drugs outside of the management of mo	age 43 ets to be addressed in the DN stated normally the interventions are on the care you would try those before dications. The DON stated we cific resident symptoms for antianxiety medications tated she did not know why hanged to being given on a se vs. as needed. The DON ave expect the reason for the hanged is supported by clinical e documented and family nge would not be a strong the change. a.m., the DON stated she hysician to document use of any medications tropic Drug Use Policy which ive medication use, dated Purpose: Prairie Manor Care sures that each resident's drug unnecessary drugs. g psychotropic medication are essive doses, excessive indications, presence of s, and target behaviors in ederal Tag 329. Policy: it is the monitor all resident's vioral symptoms and that are ic medications (or any other eir intended use) for bod/behaviors. Procedure: 1. vior Management	F 32	DEFICIENCY)			
	Nurses/Nurse Mang medication changes	gers will track all psychotropic s, medication					

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		AND HUMAN SERVICES				FORM	04/09/2016 APPROVED 0938-0391	
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY COMPLETED		
		245482	B. WING			03 / [.]	11/2016	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
PRAIRIE	MANOR CARE CENT	ER			220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 329	initiations/discontinu reductions/increase psychotropic chrom 3. Resident's starte medication will be trigg or decreased or the charting will be trigg four weeks, then ch a RN Behavior Note disruption care plar residents with order medications (Ambie Non-pharmalogical included. Sleep trad routine certification A psychotropic care residents with order antianxiety medicat Celexa, Zoloft). interventions will be orders for PRN anti hypnotic will be ass Administration work medication and effer after given. The facility Pain Ma 4/9/14, indicated Pu PMCC to ensure re have a comprehens and will have estab Procedure: each re addressed on their include individualize well as non-pharma LACK OF MOOD/B	uations and dose es on resident's individual ological along with indications. ed on any psychotropic riggered under r daily charting times four shaviors, or if dose is increased e medication is discontinued, gered for daily charting times narting will be done quarterly in e and as needed. 9. A sleep n will be developed for rs for hypnotic/sedative	F	329				

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		AND HUMAN SERVICES				FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245482	B. WING			03 / [.]	11/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER			20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	ANTIDEPRESSAN	•	F:	329			
	major depressive d orders signed 2/23/	isorder. Current physician (16 included an order for essant)15 milligrams at					
	record, treatment a	edication administration dministration record, care notes failed to identify mood ession.					
	was interviewed for really anything we to thing is when she w would get moody. S	a.m. nursing assistant (NA)-D R45's mood symptoms, "Not rack for her [R45]. The only vas on a walking program she She will make facial really think she is moody."					
	SYMPTOMS TO DI IS AFFECTIVE; AL NON-PHARMACOI FOR CONTROL PA	YING MOOD/DEPRESSION ETERMINE IF MEDICATION SO LACK OF USE OF LOGICAL INTERVENTIONS AIN WERE USED BEFORE MEDICATION IS GIVEN:					
	included the orders (anti-anxiety medica Risperdal 4 mg (an tablets at bedtime, stabilizer) twice dail (anti-depressant me diagnosis of schizo Acetaminophen 500 for break through p	0 mg 2 tablets daily as needed ain and Tramadol 50 mg dication) 1 tablet as needed					

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARI				FORM	04/09/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245482	B. WING		03 / [.]	11/2016
NAME OF PROVIDER OR SUPPLIER	(⁻		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PRAIRIE MANOR CARE CEN	TER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329 Continued From p	age 46	F 329			
Review of R34's m record, treatment a plan, and progress symptoms or targe antipsychotic, anti- were affective. Als found or provided of non-pharmalogi use of as needed On 3/10/16 at 9:15 R34's mood symp "She doesn't like to She isn't on a walk would trigger her." nursing assistants She says stuff and kidding. She will sa feelings." On 3/10/16 10:42 week we were disc form of daily tracki is one of those tha behaviors]. I guess some staff. I am h [electronic medica how to do behavio anything in place f monitoring. If they changes the nurse would do it for four On 3/11/16 at 10:2 care plan has non- listed, but I don't th what they tried."	nedication administration administration record, care s notes failed to identify mood et behaviors to determine if the depressant and analgesics so there was no documentation by facility in regards to the use ical interventions prior to the				

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		AND HUMAN SERVICES				FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245482	B. WING	à		03/	11/2016
NAME OF I	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	FR			220 THIRD STREET NORTHWEST		
					BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	Continued From pa	ae 47	F	329			
		They should have identified		020			
		nd non-pharmacological					
		r to the administration of an					
	as needed pain me	dication.					
	A facility policy on n	nood monitoring, target					
		g was requested but was not					
F a a (provided.		-	~ ~ ^			
F 334	483.25(n) INFLUEN	VZA AND PNEUMOCOCCAL	F :	334	1		4/19/16
SS=E	INIMUMIZATIONS						
		evelop policies and procedures					
	that ensure that	a influenza immunization					
	each resident, or th	ne influenza immunization, le resident's legal					
	representative rece	ives education regarding the					
		ial side effects of the					
	immunization; (ii) Each resident is	offered an influenza					
		per 1 through March 31					
	annually, unless the	e immunization is medically					
		he resident has already been					
	immunized during t (iii) The resident or						
		the opportunity to refuse					
	immunization; and						
		medical record includes					
	following:	indicates, at a minimum, the					
		ent or resident's legal					
		provided education regarding					
	the benefits and po immunization; and	tential side effects of influenza					
		ent either received the					
	influenza immuniza	tion or did not receive the					
	influenza immuniza						
	contraindications or	reiusai.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		245482	B. WING			03/	11/2016
	PROVIDER OR SUPPLIER	ĒR		2	STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 334	that ensure that (i) Before offering the immunization, each legal representative the benefits and po- immunization; (ii) Each resident is immunization, unless medically contrained already been immu (iii) The resident or representative has immunization; and (iv) The resident's re documentation that following: (A) That the resider representative was the benefits and po- pneumococcal imm the pneumococcal imm the pneumococcal imm the pneumococcal imm years following the immunization, unless the resident or the the refuses the second	evelop policies and procedures ne pneumococcal resident, or the resident's e receives education regarding tential side effects of the offered a pneumococcal as the immunization is icated or the resident has nized; the resident's legal the opportunity to refuse medical record includes indicated, at a minimum, the ent or resident's legal provided education regarding tential side effects of unization; and ent either received the unization or did not receive immunization due to medical refusal. e, based on an assessment ommendation, a second unization may be given after 5 first pneumococcal as medically contraindicated or resident's legal representative immunization.	F	334			
	by:	NT is not met as evidenced and record review, the facility			Regulation 483.25(n) Tag F334		

Facility ID: 00650

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PRINTED: 04/09/2016

STATEMEN	OF DEFICIENCIES DF CORRECTION	KANNER STATE STREAM STREA	· · /			(X3) DATE	0938-039 SURVEY PLETED
		245482	B. WING _	WING			1/2016
NAME OF	PROVIDER OR SUPPLIER		·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	TER			0 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 334	failed to ensure resparties were educate the influenza vaccioner and the influenza vaccination status and the influenza vaccination status and the influenze and the influ	sidents and or their responsible thed prior to administration of one for 5 of 5 residents (R27, d R57) reviewed for influenza addition, the facility failed to ents (R57) pneumococcal and/or to offer the vaccine. to the facility on 4/4/12. R27's tion Record, indicated R27 last za vaccination on 10/21/15. to the facility on 8/7/12. R38's tion Record, indicated R38 last za vaccination on 10/22/15. to the facility on 5/20/13. R42's tion Record, indicated R42 last za vaccination on 10/21/15. to the facility on 8/28/14. R52's unization Record, indicated an influenza vaccination on to the facility on 4/1/15. R57's unization Record, indicated an influenza vaccination on	F 3:	34	Immunizations Prairie Manor Care Center has devery policies and procedures to ensure the each resident is offered an annual influenza immunization October 1 the March 31 and a pneumococcal immunization unless the immunization medically contraindicated or the resident's legal representative receined education regarding the benefits and potential side effects of the immunizations, each resident's legal representative has the opportunity the refuse immunization and 4) the resident's legal representative was provided educated regarding the benefits and potential effects of influenza and pneumococcil munizations; and •That the resident or resident's legal representative was provided educated regarding the benefits and potential effects of influenza and pneumococcil immunizations; and •That the resident either received influenza and pneumococcal immunizations or did not receive the immunizations or refusal. The immunization related policies and procedures were reviewed and revises signed consent to administer the influenzes and potential party has been informed of the benefits and party has been informed of the benefits and party has been informed of the benefits and Parts the resident received the informed of the benefits and potential parts has been informed of the benefits and potentials the informed of the benefits and potentials parts has been informed parts has been informe	hat 1) nrough ion is ident ore occal e ves d zations al o dent's tion side cal d the e nd sed. A luenza nsible	

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	-	AND HUMAN SERVICES	-			FORM	04/09/201 APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245482	B. WING			03 /1	1/2016
NAME OF I	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	FER			20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 334	stated information i influenza vaccine a documented in the vaccine would be g R42, R52 and R57 documented evider provided regarding effects of the influe or their responsible The facility Influenz dated 1/1/15, failed documented conse vaccination. R57 was admitted undated Test/Immu record, lacked docu R57 had received a to admission, or wh offered, received of admission. On 3/10/16, at 2:04 no documentation i whether the pneum offered to R57 since	P.m., registered nurse (RN)-B is sent out regarding the and unless a refusal was resident progress notes, the given. RN-B verified R27, R38, records failed to include face that education had been the benefits and potential side anza vaccine for the residents parties.	F 3	34	obtained. Currently residents/respo parties are sent a letter advising the the influenza vaccination will be administered unless contraindicate unless the resident/responsible par declines. An information sheet prov by the Center for Disease Control (outlining the benefits and risks and adverse of the vaccination is enclos with the letter. During the mandatory meetings Apr and 15, 2016, the nursing staff were reeducated on the regulatory requirements and the facility's policy/procedures addressing 1) the to administer/offer influenza and pneumococcal immunizations 2) the related resident/responsible party s notification, education, and consent 3) the resident/responsible party rig refuse the immunizations. Resident's number 27, 38, 42, 52, a have information in their record ver that the responsible parties receive information regarding the administr the influenza vaccine including the instructions for declining the immuni- as well as the CDC risk/benefit information.	em that d or ty rided CDC) sed ril 14 e e need e igned t and jht to and 57 ifying d the ation of	
	The facility's Pneur dated 1/1/15, indica of residents acquiri experiencing comp pneumococcal pne				Resident number 57 will be offered pneumococcal vaccination after his physician writes an order verifying t type of vaccine that is to be adminis (if not contraindicated). This will be addressed with the physician during upcoming visit.	: he stered	

Facility ID: 00650

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	MB NO.	E SURVEY
ND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:		G		PLETED
		245482	B. WING _		03/	11/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 334	receive, unless meer refuse or already in documentation in the the information/edu benefits and risks of administration or the contraindications to legal representative	nd has had the opportunity to dically contraindicated or munized. Assure he resident's medical record of cation provided regarding the of immunization and the e refusal of or medical o the vaccine. All resident's e will be provided educational to the benefits and potential	F 33	4 To monitor compliance, the infection control nurse/designee will 1) audi records of residents currently residents the facility and admitted to the faci during the 2016-2017 seasonal infivaccination season to assure that are signed consents and risk/bene education prior to administering the influenza vaccine and 2) identify re- who have not had the pneumococcover vaccination. If residents are identifivation the type of vaccination to administer compliance will be reviewed durin April Quality Assurance and Assess Committee quarterly meeting.	t the ling in lity luenza there fit e sidents cal ied, r advice nister. g the	
F 356 SS=C	INFORMATION The facility must po a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per sh - Registered nu - Licensed prac vocational nurses (a - Certified nurse o Resident census. The facility must po specified above on	rses. tical nurses or licensed as defined under State law). e aides. ost the nurse staffing data a daily basis at the beginning must be posted as follows:	F 35			4/19/16

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CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	FORM OMB NC	: 04/09/2016 APPROVED . 0938-0391
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:				MPLETED
		245482	B. WING		03	/11/2016
NAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE	
PRAIRIE	MANOR CARE CENT	ER			20 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	residents and visito The facility must, up make nurse staffing for review at a cost standard. The facility must ma staffing data for a m required by State la This REQUIREMEN by: Based on interview facility failed to ensu- was posted daily. T all 37 residents in th Findings include: Upon entrance to th p.m. the director of facility census was On 3/7/16 at 12:40 tour the Hours Rep the hallway next to a facility census of On 3/7/16 at 2:50 p guessing she just d person discharge to	ace readily accessible to rs. bon oral or written request, g data available to the public not to exceed the community aintain the posted daily nurse hinimum of 18 months, or as w, whichever is greater. NT is not met as evidenced and document review, the ure a correct resident census his had the potential to effect he facility. he facility on 3/7/15 at 12:30 nursing (DON) reported the 37. p.m. during the initial facility ort of Nursing Staff posted in the medication room revealed	F 3	856	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	
		m. licensed practical nurse but the sheets [census/staffing]			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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		AND HUMAN SERVICES				FORM	04/09/201 APPROVEI 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	E SURVEY PLETED
		245482	B. WING			03 / [.]	11/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ſER			20 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 356	it." On 3/10/16 at 11:46	age 53 Im the only one who updates 6 a.m. the DON stated the e census on Friday for the	F 3	56	scheduled staffing. The Administrator/designee will mon compliance by random audits of the accuracy of the posted information.	iitor	
F 428	weekend that inclus staff had not been the hours if a staff in reflect actual hours Facility stated they posting/census.	ded Saturday and Sunday. The updating the census to reflect member had called in sick to	F 4	20			4/19/16
SS=E	IRREGULAR, ACT			20			+/13/10
	the attending physi	ust report any irregularities to cian, and the director of reports must be acted upon.					
	by: Based upon intervi facility failed to ensibility failed to ensibility had identified the la and behavior symp medicaiton, to impli- interventions before medicaiton, to ensu- warrant the use of a	NT is not met as evidenced iew and document review the ure the consultant pharmacist ack of resident specific mood toms for use of an anxiety ement non-pharmacological e use of pain and antianxiety ure an analysis of sleep to a hypnotic and failed to ensure cation for use of psychotropic			Regulation 483.60(c) Tag F428 Drug Regimen Review The goal of Prairie Manor Care Cent 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		

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TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED	
			A. BUILDII	BUILDING				
		245482	B. WING _			03/11/2016		
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
PRAIRIE	MANOR CARE CENT	ſER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 428	identify and monito symptoms to justify medication for 1 of to identify and mon determine effective medication for for 2 who received daily medication. Findings include: R75's Admission R R75 had diagnoses in right leg. R75's 3 Assessment (MDS was cognitively inta mood of feeling tire pain which had ma frequency of pain d as needed (PRN) p received non-media and had received a medications. R75's physician ord the following orders Lorazepam (antian (milligrams) - one t repeat one half tab anxiety issues and Venlafaxine (antide	5 residents (R75); failed to r mood and behavior r the use of an antianxiety 5 residents (R34); and failed itor mood symptoms to mess of and antidepressant of 5 residents (R45 and R35) dose of an antidepressant ecord, dated 3/11/16, revealed s of chronic pain, anxiety, pain 0 day Minimum Data) dated 2/16/16, identified R75 act, had no behaviors, had ed or having little energy, had de it hard to sleep at night, laily, received scheduled and pain medications, had not cation interventions for pain intidepressant and antianxiety ders dated 2/25/16, included s: xiety) tablet 0.5 mg ablet at HS (bedtime), may let in 30 minutes if still having not able to sleep.	F 42	28	resident is reviewed at least once a by a licensed pharmacist. The phat reports irregularities to the attendin physician and the director of nursin these reports are acted upon. The Director of Nursing and Consu Pharmacist have reviewed the facil procedures for identifying and track target behaviors and mood sympto related to psychotropic medication documenting nonpharmacological interventions provided/offered to m pain and anxiety, completing sleep assessments and analyzing sleep monitoring data, and ensuring phys justification for use of psychotropic medications. The pharmacist will c to review records on a monthly bas routinely check for appropriate documentation related to the above issues. During the mandatory meetings on 14 and 15, 2016, the licensed nurs staff will be instructed on 1) the ne documentation procedures for targ behaviors and behavior related interventions 2) the importance of attempting nonpharmacological interventions prior to administration PRN psychotropic and analgesics a ensuring the care plan addresses t	rmacist g lg, and ltant lity's king ms use, anage sician ontinue is and e April ing w et n of 3) arget		
	once a day related disorder.	to generalized anxiety ic) 50 mg - two tablets every			behaviors and nonpharmacologica interventions to manage mood sym anxiety, and pain and 4) the need f assessment that analyzes the slee monitoring data. The direct care sta be reminded of the importance of b	l pptoms, or an p aff will		

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	IDI I			0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245482	B. WING _			03 /1	1/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	TER			20 THIRD STREET NORTHWEST SLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 428	Continued From pa	age 55	F 42	28			
	Oxycodone (narcot	ic pain reliever) 5 mg - one Irs as needed for pain			observant for behaviors/moods sym and reporting them to the charge nu		
	Review of the Marc administration reco showed the following	ord (MAR) and progress notes			Resident number 75 – The nurses I been reminded to document nonpharmacological interventions the attempted prior to administration of	hat are	
	time on 3/5/16, with non-pharmacologic	Ativan as needed (PRN) one n no documentation of cal interventions attempted ivan being administered.			medications to treat anxiety and pair care plan has been updated to add nonpharmacological interventions a target behaviors related to use of	in. The ress	
	3/1/16 to 3/10/16 w non-pharmacologic	Dxycodone PRN six times from with no documentation of cal interventions attempted xycodone being administered.			antianxiety medications as well as insomnia. The resident's sleep/wak patterns are monitored on a routine and the effectiveness of the interver to promote sleep will be assessed b	basis ntions by a	
	3/1/16 to 3/10/16 w non-pharmacologic	Tramadol PRN four times from with no documentation of cal interventions attempted lol being administered.			registered nurse. During the physici next visit, documentation addressin anxiety symptoms, insomnia, and justification of the order change from to routine use of lorazepam will be requested. The physician will be	g	
	notes showed the f	uary 2016 MAR and progress following: Ativan PRN one time on			contacted if the resident's medical management of depressed mood, a or insomnia is ineffective.	anxiety	
	2/11/16, with no do non-pharmacologic				Resident number 45 – A behavior to sheet to monitor mood symptoms re to the diagnoses of major depressiv disorder has been implemented. Th	elated /e	
	no documentation	Dxycodone PRN 34 times, with of non-pharmacological pted prior to the PRN administered.			results will be reviewed by the interdisciplinary team during the qua care conferences and more frequer indicated. The physician will be con	arterly ntly if tacted	
	2/29/16 with no doo non-pharmacologic	Framadol PRN one time on cumentation of cal interventions attempted lol being administered.			if there is an increase in symptoms depressed mood. The social worke complete a depression screen questionnaire every 90 days and wi significant change in condition. The	r will th a	

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		AND HUMAN SERVICES			0		APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	· · ·	E SURVEY PLETED
		245482	B. WING _			03/-	11/2016
NAME OF I	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PRAIRIE	MANOR CARE CENT	ſER			20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 428	Continued From pa	age 56	F 42	28			
		ary 2016 MAR, from 16 to 1/31/16, and progress			plan will be reviewed and revised a necessary.	IS	
	 additional intervention in a progress in the progress in the progress intervention 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 				Resident number 34 – The resident admitted July 21, 2015 with a prima diagnoses of schizoaffective disorc the physician noting that she is doi on her current psychotropic medica A behavior tracking sheet to monito symptoms and target behaviors to determine the effectiveness of the antipsychotic, antianxiety, antidepre and mood stabilizer medications ha implemented. Nonpharmacological interventions to be implemented pr administration of PRN (as needed) medications are addressed in the p care. The nursing staff has been in of the need to attempt nonpharmacological interventions to control and to document the intervent	5 with a primary fective disorder with hat she is doing well tropic medications. heet to monitor mood behaviors to eness of the ety, antidepressant edications has been irmacological blemented prior to (as needed) pain essed in the plan of f has been informed	
	nursing if noted. Me routinely by pharma physician and beha Appropriate change Monitor mood/beha Physician to review visits for appropriat changes. Refer to F Procedure. Resident is at risk f joint dysfunction, sp osteoarthritis with in pain medication as effectiveness. Repo physician. Encoura pain. Monitor and re	adverse reactions and report to edication to be reviewed acist consultant, primary avior management nurse. es to be made as needed. avior and report to Nurse. medication with certification reness and possible dose Psychotropic Drug Policy and for pain related to sacroiliac binal stenosis and nterventions of: administer per MD orders and note the port any unresolved pain to ge resident to verbalize any eport any noted non-verbal , i.e., facial grimacing,			attempted and the resident's respondent 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 the medications used to manage behat mood symptoms, insomnia and pa appropriately justified and monitored Compliance will be further monitored the Director of Nurses/designee by audit of the records of residents re- antipsychotic, antianxiety, and antidepressant medications to ensu- target behaviors/mood symptoms and identified, monitored, and related interventions are documented 2) and	e that viors, in are ed. ed by 7 1) an ceiving ure that are	

Facility ID: 00650

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED	
	of CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G	COM	FLETED	
		245482	B. WING			03/11/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PRAIRIE	MANOR CARE CENT	ſER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 428	quarterly and prn. H addressed non-pha either the pain or a R75's progress not registered nurse be admitted on 1/19/10 pain and primary di admission resident Ativan 0.5 mg ever additional 0.25 mg scheduled HS dose Insomnia, and Ven for Anxiety. Reside on 1/26/16. She ca continue scheduled as needed. No note medications. Prima pharmacist routinel continue with curre	agitation. Pain assessment However, the care plan had not armacological interventions for nxiety. e, dated 2/8/16, identified: ehavior note: Resident was 6 with complaints of right leg iagnosis of sacroiliacs. During noted to have orders for y hour of sleep (HS) with PRN 30 minutes after e if needed for Anxiety and lafaxine 75 mg capsule daily nt saw her primary physician me back with orders stating to d Ativan as is and PRN Ativan ed adverse reaction from ary physician and consulting ly review medications. Will nt regimen and will contact MD	F 42	of the records of residents rece pain medications and sedative nonpharmacological intervention monitoring of their effectiveness included in the plan of care and appropriately documented and audit of residents receiving hypnotics/sedatives to ensure a assessments have been comp noncompliance is noted, additi auditing and staff training will b Compliance will be reviewed at quarterly Quality Assurance an Assessment Committee meetin ongoing.	s to ensure ons and s is 3) a record sleep leted. If onal e done. the April d		
	other documents p identified resident s determine if the Ati affective to relieve R75's physician ord Lorazepam (antian (milligrams) one ta tablet in 30 minutes and not able to slee R75's record identii dated 1/19/16 throu	physician orders, care plan, or rovided by facility had specific symptoms of anxiety to van and Venlafaxine was "anxiety." ders, dated 2/25/16, included xiety) tablet 0.5 mg ablet at HS may repeat one half s if still having anxiety issues					

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		AND HUMAN SERVICES				FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY IPLETED
		245482	B. WING	i		03 / [.]	11/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER			220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	However, R75's me comprehensive slee the sleep monitoring addition, R75's care insomnia. R75's physician ord an order for Ativan of PRN one time daily physician order on change the Ativan to an extra one-half ta needed for sleep. In identified a physicia one capsule once a anxiety disorder, wh since admission. R75's physician not R75 had Ativan at b be scheduled dose often forgets to ask and there is a little I physician progress symptoms and inso physician justification medication dosages On 3/10/16, at 12:3 (RN)-A stated we do insomnia, but we ha assessment for slee plan failed to includ interventions for the medications. RN-A include documentat interventions being medications being	edical record lacked a ep assessment and analysis of g for the use of the Ativan. In e plan failed to address lers dated 1/19/16, identified 0.5 mg, take one to two tablets at HS for symptoms. A 1/26/16, identified an order to o 0.5 mg every HS, may give ablet PRN after 30 minutes if n addition, R75's record an order for Venlafaxine 75 mg a day related to generalized nich R75 had been receiving te, dated 1/26/16, indicated bedtime. They asked the Ativan vs. as needed due to her for it appropriately at bedtime language barrier. However, the note failed to address anxiety omnia needs and lacked on for the increased	F 4	428			

Facility ID: 00650

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		AND HUMAN SERVICES				FORM	: 04/09/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245482	B. WING	i		03/	11/2016
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER			20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	R75 had for the use medications. RN-A changed to schedu what the "family" re had taken the medi in regards to how th monitoring moods a assistants report to documents the moo On 3/10/16, at 1:00 (DON) stated they of sheets with the phy sleep tracking shee sleep note. The DC non-pharmalogical plan and normally y giving the PRN med have not done spec antidepressant and before. The DON st R75's Ativan was cl scheduled daily dos stated she would ha medication being cl evidence and to be requesting the char enough reason for the On 3/11/16, at 9:52 would expect the phy justification for the o ordered. The facility Psychot includes psychoact 3/28/14, indicated F Center (PMCC) ass	e of the antianxiety stated R75's Ativan was led doses because that is quested and was how R75 cation at home. RN-A stated he facilities system for and behaviors, the nursing the nurse and then the nurse od and behaviors. p.m., the director of nursing do review the sleep tracking sician. I would expect the ets to be addressed in the DN stated normally the interventions are on the care you would try those before dications. The DON stated we cific resident symptoms for antianxiety medications tated she did not know why hanged to being given on a se vs. as needed. The DON ave expect the reason for the hanged is supported by clinical e documented and family nge would not be a strong	F	428			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()	TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED		
		245482	B. WING		03	03/11/2016		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC				
PRAIRIE	MANOR CARE CENT	rer (220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETIC DATE		
F 428	Resident's receivin monitored for: exce duration, adequate adverse side effect accordance with Fe policy of PMCC to experiencing behave tacking psychotrop drugs outside of the management of mo Psychotropic Behave Nurses/Nurse Man medication change initiations/discontin reductions/increase psychotropic chron 3. Resident's starter medication will be t communications for weeks for target be or decreased or the charting will be trigg four weeks, then charter a RN Behavior Not disruption care plan residents with order medications (Ambie Non-pharmalogical included. Sleep trac- routine certification A psychotropic care residents with order antianxiety medication Celexa, Zoloft). interventions will be ass Administration worl	g psychotropic medication are essive doses, excessive indications, presence of s, and target behaviors in ederal Tag 329. Policy: it is the monitor all resident's vioral symptoms and that are ic medications (or any other eir intended use) for bod/behaviors. Procedure: 1. vior Management gers will track all psychotropic s, medication uations and dose es on resident's individual ological along with indications. ed on any psychotropic triggered under r daily charting times four ehaviors, or if dose is increased e medication is discontinued, gered for daily charting times narting will be done quarterly in e and as needed. 9. A sleep n will be developed for rs for hypnotic/sedative	F 4	428				

Facility ID: 00650

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		AND HUMAN SERVICES				FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245482	B. WING _			03/	11/2016
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER			20 THIRD STREET NORTHWEST LOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	Continued From pa after given.	.ge 61	F 42	28			
	4/9/14, indicated Pu PMCC to ensure re have a comprehens and will have establ Procedure: each re addressed on their include individualize well as non-pharma						
	major depressive d orders signed 2/23/	cord revealed a diagnosis of isorder. Current physician /16 included an order for essant)15 milligrams at					
	record, treatment a	edication administration dministration record, care notes failed to identify mood ession.					
	was interviewed for really anything we to thing is when she w would get moody. S	a.m. nursing assistant (NA)-D r R45's mood symptoms, "Not rack for her [R45]. The only vas on a walking program she She will make facial t really think she is moody."					
	SYMPTOMS TO DI IS AFFECTIVE; AL NON-PHARMACOL FOR CONTROL PA	YING MOOD/DEPRESSION ETERMINE IF MEDICATION SO LACK OF USE OF LOGICAL INTERVENTIONS AIN WERE USED BEFORE MEDICATION IS GIVEN:					

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		AND HUMAN SERVICES	FORM AP OMB NO. 09					
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245482	B. WING			03 /-	11/2016	
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
PRAIRIE	MANOR CARE CENT	FB			20 THIRD STREET NORTHWEST			
				В	LOOMING PRAIRIE, MN 55917			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 428	Continued From pa	ge 62	F 4	28				
	included the orders (anti-anxiety medica Risperdal 4 mg (anti- tablets at bedtime, stabilizer) twice dail (anti-depressant me diagnosis of schizoa Acetaminophen 500 for break through pa	0 mg 2 tablets daily as needed ain and Tramadol 50 mg dication) 1 tablet as needed						
	record, treatment ac plan, and progress symptoms or target antipsychotic, antide were affective. Also found or provided b of non-pharmalogic use of as needed pa On 3/10/16 at 9:15 R34's mood sympto "She doesn't like to She isn't on a walking	edication administration dministration record, care notes failed to identify mood behaviors to determine if the epressant and analgesics there was no documentation by facility in regards to the use al interventions prior to the ain medication. a.m. NA-D was interviewed for toms and target behaviors; walk, that kind of targets her. ng program now cause it the doesn't care for different						
	nursing assistants. She says stuff and t kidding. She will say feelings." On 3/10/16 10:42 a week we were discu form of daily trackin	She swears, she refuses stuff. then she will say she is just y stuff to try to hurt your 						

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PRINTED: 04/09/2016

		AND HUMAN SERVICES				FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245482	B. WING			03/	11/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER			20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428 F 441 SS=F	some staff. I am ha [electronic medical how to do behavior anything in place fo monitoring. If they s changes the nurses would do it for four On 3/11/16 at 10:21 care plan has non-p listed, but I don't thi what they tried." On 3/11/16 at 11:04 pharmacist stated, mood symptoms an should be tried prior as needed pain med A facility policy on m behavior monitoring provided. 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and c to help prevent the of disease and infect (a) Infection Contro The facility must es Program under white (1) Investigates, con in the facility; (2) Decides what pr should be applied to	ving someone from point click record] come in and show us tracking. We don't have in the anti-depressant mood start a new one or the dose is would chart on mood, they weeks, but nothing ongoing." I a.m. the DON added, "The oharmacological interventions ink they [nursing] document I a.m. the facility consultant They should have identified and non-pharmacological in to the administration of an dication. I CONTROL, PREVENT tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.	F 4				4/19/16

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	-	AND HUMAN SERVICES			INTED: 04/09/2016 FORM APPROVED IB NO. 0938-0391			
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X3) DATE SURVEY COMPLETED			
		245482	B. WING		03/11/2016			
NAME OF	PROVIDER OR SUPPLIER	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE				
PRAIRIE	MANOR CARE CENT	ER	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D 1 T T			
F 441	determines that a m prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di hand washing is ind professional practic (c) Linens Personnel must ha	rections. ead of Infection tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted	F 441					
	by: Based on interview failed to ensure sur infections and failed control education for the facility infection potential to affect a Findings include: SURVEILLANCE A INFECTIONS: The facility monthly Logs were obtained	NT is not met as evidenced y and record review, the facility veillance and analysis of d to ensure annual infection or all employees as outlined in control policy. This had the Il residents, staff and visitors. ND ANALYSIS OF y summary of Infection Control d from June 2015 through e logs identified for tracking the		Regulation 483.65 Tag F441 Infection Control Prairie Manor Care Center has established and maintains an infectio control program designed to provide safe, sanitary, and comfortable environment and to prevent the development of disease and infectio The facility has an infection control program that 1) investigates, control prevents infections in the facility 2) determines the appropriate procedur any, that will be implemented (such a	a n. s, and res, if			

Facility ID: 00650

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TATEMEN	OF DEFICIENCIES DF CORRECTION	KANNER CALCULAR AND CALCULAR		PLE CONSTRUCTION	OMB NO. (X3) DATE COMF	
		245482	B. WING		03/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PRAIRIE	MANOR CARE CEN	ſER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 441	resident name, site antibiotic/treatment house were areas of following informatic on the monthly logs 6/15, two urinary tra 7/15, four UTIs, on one cellulitis 8/15, four UTIs, two 9/15, three UTIs, of infection 10/15, five UTIs, two 11/15, two UTIs, or 12/15, five UTIs, or cellulitis, two respir 1/16, nine UTIs, on 2/16, four UTIs, on 2/16, four UTIs, on However the logs firesident room/s an that would enable t of infection, sympto identified, whether obtained (or rational performed) and dat In addition, the faci surveillance and ar information and infu- used to prevent the the infections. On 3/10/16, at 2:17 verified the logs fai resolution and wing stated she did not fine.	e, organism, t, date of onset and acquired in documented on the report. The on of infections were indicated s: act infections (UTIs) e pneumonia, one bronchitis, o cellulitis, one pneumonia ne pneumonia, one elbow to pneumonia ne pneumonia, one respiratory ne aspiration pneumonia, one atory, one ear infection te cellulitis recurrent e pneumonia, one cellulitis ailed to include specific d wing location racking and trending of spread oms culture of the organism was al if not te of resolution of the infection. lity failed to document halysis of the ection control precautions	F 44	isolation) for each resident with ar infectious disease and 3) maintain record of incidences of infections tracks any alternative actions take related to infection control. The facility's current monthly infect control log tracks the resident, infe- site, causative organism (if cultur antibiotic/treatment, date of onset whether the infection was acquire at the facility. To improve infection process and outcorme surveilland infection control log and related da identify the room/wing of the resid the infection, the symptoms identi whether a culture was obtained (or rationale if not), and the date of the resolution of the infection. Staff wi not participated in an infection con training session in the past year wi receive training on April 12 or 14, The infection control nurse has re the infection control regulations, wi focus on the requirements for infe surveillance and staff education. A comprehensive infection control re will attend a seminar presented by Pathway Health addressing systel improvements for preventing and controlling infections as well as re requirements and current standar practice.	ns a and en etion ection ed), , and d while d while e, the ata will ent with fied, or e ho have trol vill 2016. viewed vith a ection A esource On ol nurse / m gulatory ds of	

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		E & MEDICAID SERVICES					0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		245482	B. WING _		·····	03/-	11/2016	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PRAIRIE	MANOR CARE CENT	TER			20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 441	 441 Continued From page 66 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. 		F 4	41	surveillance program will be monitor the Director of Nursing/designee for next three months through a review the infection control tracking data a staff training records. If noncomplia noted, additional staff training and will be done. Process/outcome surveillance of infections, frequency/type of infecti and other infection control issues w continue to be routinely reviewed b Quality Assurance and Assessmen Committee.	or the v of 1) and 2) ance is auditing ons, vill be y the		
	documentation for education of infecti On 3/10/16, at 2:17	7 p.m., RN-B verified the lack ucation for infection control for						
	stated she would e	a.m., the director of nursing xpect infection control oyees to be done annually.						
	8/1/12, indicted it is Care Center to hav in place assure a s environment for res designed to help putransmission of dis	nfection Control Program dated s the policy of Prairie Manor ve an infection control program afe, sanitary and comfortable sidents and personnel. It is revent the development and ease and infection. Prairie r has established a program						

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	04/09/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245482	B. WING		03 / [.]	11/2016
NAME OF F	PROVIDER OR SUPPLIER	•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ſER		220 THIRD STREET NORTHWEST		
				BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	Continued From pa	-	F 441			
		estigates, controls and				
		in the facility, decides what sisolation, should be applied				
		ident and maintains a record of				
		ective actions related to				
		esponsibility, the infection				
		or designee, is responsible for				
		on control program. Maintain at document training in				
	infection control in e					
	The facility Infection	n Surveillance policy dated				
		fection prevention begins with				
		to identify infections that are				
		e potential to cause outbreak.				
		monitors all residents who				
		toms of infections through the and has a systemic method				
		lidating and analyzing data				
		quency an cause of a given				
		ollowed by dissemination of				
		those who can improve the				
		ent of the surveillance is to anges in prevalent organisms,				
		rate of infection in a timely				
		is should be used to plan				
		tivities, direct in-service				
		ntify individual resident				
		of interventions. Other sources slude laboratory cultures and				
		ility profiles. Reporting,				
		usions are reported to				
		assessment and assurance				
		gular basis and results of				
		ported back to nursing units as back. Data analysis, this data is				
		uarterly and included in the				
		lity improvement data. It is				
		eillance reports be shared with				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 04/09/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245482	B. WING	<u></u>		03/	/11/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PRAIRIE	MANOR CARE CENT	ſER			220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa	-	F,	441			
	appropriate individu to, the director of m addition, it is import practitioners receiv their practices to he of their care in infect based on analysis of implement action p education and/or of effectiveness of the provided, preventio Documentation, de provides the nursin observations relate cause of an infection underlying cause of The facility Infection indicated Prairie Ma wide infection contr measures to identifi infections acquired the community. Pol management of infe has been assigned The program exists maintaining records and any required for servicing on infection	uals including, but not limited ursing and medical director. In tant that he staff and re reports that are relevant to elp them recognize the impact ction rates and outcome. Plan, of data, develop and blan, corrective actions, ther strategies. Evaluate the re corrective actions, education on measure, etc. escriptive documentation og home summarized ed to the investigation of the on and/or identifies the					

Facility ID: 00650

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE COM	E SURVEY PLETED
		245482	B, WING		03/*	10/2016
IAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RAIRIE	MANOR CARE CENT	ER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
K 000	INITIAL COMMENT	ſS	K 00	0		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN 1TH YOUR VERIFICATION.				
	Minnesota Departn Fire Marshal Division dated 3/10/2016, P found not in substare quirements for particular Medicare/Medicaid 483.70(a), Life Safe edition of National	l at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),				
	PLEASE RETURN CORRECTION FC DEFICIENCIES (K-TAGS) TO: Health Care Fire Ir State Fire Marshal	OR THE FIRE SAFETY		EPOC		
	445 Minnesota St.,					

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/11/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		PLE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245482	B. WINC	÷		03/	10/2016
NAME OF F	PROVIDER OR SUPPLIER			10 - E	STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	TER		1	220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From par St Paul, MN 55101 By email to: Marian.Whitney@s Angela.Kappenmar THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pr 3. The name and/or responsible for com prevent a reoccurre This facility will be buildings. Prairie M building. The origin 1970 and was dete construction, with a addition was construction, with a addition was construction with a and spaces open to monitored for autor	age 1 -5145, or tate.mn.us and n@state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. oposed, completion date. or title of the person rection and monitoring to ence of the deficiency. surveyed as two separate lanor Care Center is a 1-story nal building was constructed in rmined to be of Type II(111) a partial basement. In 1984, ructed and was determined to	ĸ	000	DEFICIENCY)		
	census of 37 at the The requirement a	apacity of 52 beds and had a e time of the survey. t 42 CFR, Subpart 483.70(a) is					
K 025	NOT MET as evide NFPA 101 LIFE SA	enced by: NFETY CODE STANDARD	ĸ	02	5		4/5/16

Facility ID: 00650

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		AND HUMAN SERVICES				FORMA	04/11/2016 APPROVED 0938-0391
STATEMENT			(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	
		245482	B. WING			03/1	0/2016
NAME OF F	PROVIDER OR SUPPLIER	ü.			REET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER			LOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
K 025 SS=F	Continued From pa	ge 2	ĸ	025			
K 062 SS=D	least a one half hou constructed in acco barriers shall be per atrium wall. Window fire-rated glazing or steel frames. 8.3, 19.3.7.3, 19.3. This STANDARD in K25: Based on observath has failed to proper required 2-hour fire with NFPA 101 (200 19.1.1.4 and 19.1.2 deficient practice co of (52) residents, si FINDINGS INCLUE During the facility to AM and 11:30 PM or revealed: The smoke barrier Nurses area and the from the fire sprink NFPA 101 LIFE SA Required automatic condition and are in periodically. 19.7 9.7.5 This STANDARD Required automatic continuously maint condition and are in periodically. 19.7	s not met as evidenced by: ions and interview, the facility ty construct and maintain a e separation, in accordance 00), Chapter 19, Sections 2.1. In a fire emergency, this ould adversely affect the safety taff and visitors. DE: our between the hours of 09:00 on 3/10/2016, observation separation wall between the ne right wing has penetractions	K	062	Tag K025 The open penetrations in the smoke barrier wall between the nurses area the right wing has been sealed with mineral wool. All smoke barrier sep walls will be inspected for penetration the smoke barrier. The interim Maintenance Director is responsible for monitoring compliant The interim Maintenance Director is responsible for monitoring compliant The dates of completion of the quar fire sprinkler test will be tracked on the test is included on the list of rou scheduled maintenance tasks.	a and aration ons in ace.	4/5/16

Facility ID: 00650

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	STOR WEDICARE	& MEDICAID SERVICES			MB NO.	
D PLAN OF CORRECTION		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		B. WING		03/1	0/2016	
AME OF F	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
RAIRIE	MANOR CARE CENT	ER		20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 062	on 3/10/2016, a rev fire sprinkler test de facility failed to con	age 3 veen 9:00 AM and 11:30 PM view of the facility's available ocumentation revealed that the ducted the required quarterly	ity's available evealed that the			
K 064 SS=D	Portable fire exting inspected, and mai occupancies in acc 10. 18.3.5.6, 19.3.5.6 This STANDARD i Portable fire exting inspected, and mai	FETY CODE STANDARD uishers shall be installed, intained in all health care cordance with 9.7.4.1, NFPA is not met as evidenced by: guishers shall be installed, intained in all health care	K 064	The facility contracts with Austin F Safety Company to conduct the an	nual	4/5/16
K 154	10. 18.3.5.6, 19.3.5.6. Findings include: On facility tour betw on 3/10/2016, base extinguisher servic annualy inspected.	cordance with 9.7.4.1, NFPA ween 9:00 AM and 11:30 PM ed on observations the fire ing the Lanudry area was not	K 154	inspection of the fire extinguishers Although the fire extinguisher in th laundry area was on the list of extinguishers to inspect, the contra company failed to inspect it. The c was notified of omission and has s inspected the extinguisher. The interim Maintenance Director responsible for monitoring complia	e act ompany since is	4/5/16
K 154 SS=D	Where a required a out of service for m period, the authorit and the building is watch system is pr unprotected by the system has been m This STANDARD Where a required	automatic sprinkler system is hore than 4 hours in a 24-hour by having jurisdiction is notified, evacuated or an approved fire ovided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1 is not met as evidenced by: automatic sprinkler system is hore than 4 hours in a 24-hour	K 194	The facility has a plan to ensure s the building occupants in the even	safety of It the	

Event ID: JKSG21

Facility ID: 00650

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245482	B. WING		03/10/2016	
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CC 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
K 154	and the building is watch system is pr unprotected by the system has been r On facility tour betto on 03/10/2016, obs reviewed revealed	age 4 evacuated or an approved fire ovided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1 ween 09:00 AM and 11:30 PM servation and documentation that there was not a single service plan for the fire	K 154	service for more than four ho 24-hour period. The current reviewed and will be updated The interim Maintenance Dir responsible for monitoring co	rrent plan was dated. e Director is	
K 155 SS=D	Facility Maintenand discovery. NFPA 101 LIFE SA Where a required to service for more the the authority havin building is evacuate provided for all pare shutdown until the returned to service This STANDARD Where a required service for more the the authority havin building is evacuate provided for all pare shutdown until the returned to service On facility tour beto on 03/10/2016, ob reviewed revealed	is not met as evidenced by: fire alarm system is out of han 4 hours in a 24-hour period, g jurisdiction is notified, and the led or an approved fire watch is ties left unprotected by the fire alarm system has been	K 15	The facility has a plan to en the building occupants in the alarm system is out of servic than four hours in a 24-hour current plan was reviewed a updated. The interim Maintenance Di responsible for monitoring c	e event the fire ce for more period. The nd will be rector is	4/5/16

PRINTED: 04/11/2016

		AND HUMAN SERVICES				APPROVED
		& MEDICAID SERVICES	1			0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245482	B. WING			10/2016
NAME OF I	PROVIDER OR SUPPLIER		8	STREET ADDRESS, CITY, STATE, ZIP COD		
PRAIRIE	MANOR CARE CENT	ER		220 THIRD STREET NORTHWEST		
			E	BLOOMING PRAIRIE, MN 55917		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 155	Continued From pa	ge 5	K 155			
		ice was confirmed by the e Director (GS) at the time of				
				.*		0
					2	
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: JKSG2	21 Fa	acility ID: 00650 If c	ontinuation she	eet Page 6 of 6

		AND HUMAN SERVICES & MEDICAID SERVICES	F51	182025	FORM	: 04/11/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION ING 02 - CHAPEL		E SURVEY IPLETED
		245482	B, WING		03/	10/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER		220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
		TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORREC		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		ULD BE	COMPLETION DATE
K 000	INITIAL COMMENT	ſS	КO	00		
	FIRE SAFETY					
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Divisio dated 3/10/2016, P found not in substa requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National I	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY		EPO	C	
	Health Care Fire In State Fire Marshal 445 Minnesota St.,	Division				
	y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/11/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - CHAPEL			(X3) DATE SURVEY COMPLETED		
		245482	B. WING	_		03/	10/2016
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	ER			220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
	DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the defici 2. The actual, or pro 3. The name and/or responsible for corre prevent a reoccurre This facility will be s buildings. Prairie M building. The origin 1970 and was dete construction, with a addition was constr be of Type II(111) c The facility is fully s alarm system with f and spaces open to monitored for autor notification. The facility has a ca census of 37 at the	-5145, or tate.mn.us and n@state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. surveyed as two separate anor Care Center is a 1-story hal building was constructed in rmined to be of Type II(111) opartial basement. In 1984, ructed and was determined to onstruction. sprinkled. The facility has a fire full corridor smoke detection the corridors that is matic fire department apacity of 52 beds and had a time of the survey.	K	000			
K 154	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	K	154	4		4/5/16

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Event ID: JKSG21

Facility ID: 00650

If continuation sheet Page 2 of 4

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	BUILDING 02 - CHAPEL		OMPLETED	
	245482		B. WING		03/	10/2016	
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
PRAIRIE	MANOR CARE CEN	TER		20 THIRD STREET NORTHWEST			
			E	BLOOMING PRAIRIE, MN 55917			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
K 154 SS=D	Continued From pa	age 2	K 154				
	out of service for m period, the authorit and the building is watch system is pro- unprotected by the system has been m This STANDARD if Where a required out of service for m period, the authorit and the building is watch system is pro- unprotected by the system has been m On facility tour betw on 03/10/2016, obs reviewed revealed	automatic sprinkler system is nore than 4 hours in a 24-hour y having jurisdiction is notified, evacuated or an approved fire ovided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1 is not met as evidenced by: automatic sprinkler system is nore than 4 hours in a 24-hour y having jurisdiction is notified, evacuated or an approved fire ovided for all parties left shutdown until the sprinkler eturned to service. 9.7.6.1 ween 09:00 AM and 11:30 PM servation and documentation that there was not a single service plan for the fire		The facility has a plan to ensure the building occupants in the eve automatic sprinkler system is ou service for more than four hours 24-hour period. The current plan reviewed and will be updated. The interim Maintenance Director responsible for monitoring comp	ent the t of in a was or is		
K 155 SS=D	Facility Maintenance discovery. NFPA 101 LIFE SA Where a required f service for more th the authority having building is evacuate provided for all part shutdown until the returned to service. This STANDARD	tice was confirmed by the ce Director (GS) at the time of FETY CODE STANDARD ire alarm system is out of an 4 hours in a 24-hour period, g jurisdiction is notified, and the ed or an approved fire watch is ties left unprotected by the fire alarm system has been . 9.6.1.8 s not met as evidenced by: fire alarm system is out of	K 155	The facility has a plan to ensure	e safety of	4/5/16	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION (X A. BUILDING 02 - CHAPEL		TE SURVEY
		245482	B. WING		03	03/10/2016
	PROVIDER OR SUPPLIER		2:	TREET ADDRESS, CITY, STATE, ZIP CODE 20 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
K 155	building is evacual provided for all par shutdown until the returned to service On facility tour bet on 03/10/2016, ob reviewed revealed plan for the out of system. This deficient prace	ng jurisdiction is notified, and the ted or an approved fire watch is rties left unprotected by the fire alarm system has been	K 155	alarm system is out of service f than four hours in a 24-hour pe current plan was reviewed and updated. The interim Maintenance Direc responsible for monitoring com	riod. The will be tor is	

PRINTED: 04/11/2016



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 <u>only a suggestion</u> 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. Prairie Manor Care Center March 30, 2016 Page 2

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 <u>Email: gary.nederhoff@state.mn.us</u> 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,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697 Prairie Manor Care Center March 30, 2016 Page 3

PRINTED: 04/09/2016 FORM APPROVED

Minnesc	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00650	B. WING		03/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	FR	O STREET N G PRAIRIE,	ORTHWEST MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 04/09/16

STATE FORM

If continuation sheet 1 of 73

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00650	B. WING		03/	03/11/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
PRAIRIE	MANOR CARE CENT	reg .	RD STREET NO ING PRAIRIE, M	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 000	Department of Hea	Ith orders being submitted to	2 000				
	is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	Although no plan of correction ate Statutes/Rules, please rected" in the box available for n indicate in the electronic cess, under the heading le date your orders will be lectronically submitting to the nent of Health.					
	Department's staff, the following correct Please indicate in y correction that you	0, & 11, 2016 surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, e when they will be completed	t.				
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302			4/19/16	
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144						
	Alzheimer's disease or related of segregated or gene care staff	lity serves persons with disorders, whether in a eral unit, the facility's direct ors must be trained in dementia	a				
	related disorders; (2) assistance with	of Alzheimer's disease and activities of daily living; with challenging behaviors;					

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SURVEY COMPLETED	
		00650	B. WING		03/11/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL		STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	IFR	D STREET N NG PRAIRIE	NORTHWEST , MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	
2 302	written or electronic training program, th trained, the frequen topics covered.	age 2 I provide to consumers in c form a description of the ne categories of employees ncy of training, and the basic I document compliance with	2 302			
	by: Based on interview facility failed to provincluded all require employees hired be failed to provide wr facility dementia tra affect all 37 resider Findings include: Document review of	of the facility information		Minnesota State Statute 144.6503 ALZHEIMER'S DISEASE OR RELA DISORDER TRAINING Policies and procedures have been developed to provide direct care an supervisory staff additional training caring for residents with Alzheimer disease and related disorders. The training will include:	d on	
	Medicaid Services facility had 14 resid Alzheimer's diseas During interview on of nursing stated fa training to nursing a	n 3/7/16, at 3:20 p.m., director acility provided dementia assistants only. She verified ng was provided to licensed		 An explanation of Alzheimer's dis and related disorders Techniques for assisting resident cognitive impairments with their action of daily living, especially those who resistive to cares Techniques to solve/de-escalate challenging and problematic behavior 	s with ivities are	
	director of nursing residents with diag /dementia. Director nurses had not rec	n 3/10/16, at 10:15 a.m., verified facility had several nosis of Alzheimer's disease r of nursing verified licensed eived dementia training. She e new hired employees from		negatively impacting others and compromising high quality care, and 4) Techniques to effectively commu with residents with memory deficits improve the exchange of essential	nicate	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00650	B. WING		03/1	1/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	IFR	D STREET N NG PRAIRIE,	IORTHWEST , MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From pa	age 3	2 302			
	dementia training. facility did not prov residents/families, training. Director o responsible for the	had received all the required Director of nursing verified the vide information to consumers, regarding facility dementia of nursing stated she is dementia training program. cility had no policy related to		information. Information about the demo will be provided to consum and families. Methods for distribution being considere article in the facility newsle notice within the facility des dementia training, and add dementia training during th	nsumers, residents, ds for information isidered include an ewsletter, posting a ity describing the d addressing the ing the	
	The director of nurse educate staff on de provide consumers dementia training. in-service all direct supervisors on how dementia behavior include explanation related disorders, a daily living, problem behaviors, and com of nursing could ma and frequency of tr and facility social w required dementia	THOD OF CORRECTION: sing could develop policies to ementia training and policies to a with a description of facility The director of nursing could care staff and their v to work with persons with . This should, at a minimum, n of Alzheimer's disease and assistance with activities of n solving with challenging nmunication skills. The director aintain a list of staff attendance aining. The director of nursing vorkers could develop the training information to give to rector of nursing could monitor		family/resident council mee		
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			4/19/16
	comprehensive pla objectives and time	of plan of care. The in of care must list measurable stables to meet the resident's m goals for medical, nursing,				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00650	550 B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
		220 THIE		NORTHWEST		
PRAIRIE	MANOR CARE CEN	BLOOMI	NG PRAIRIE	, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 4	2 560			
	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:					
				Prairie Manor Care Center results of the comprehensito to develop, review and rev resident's comprehensive The individualized care pla measurable objectives an meet the resident's needs	sive assessment vise the plan of care. an 1) includes d timetables to	
	have missing teeth On 3/10/16, at 7:50 (LPN)-A observed	on 3/7/16 at 6:26 p.m., to on the lower gum line.) a.m. licensed practical nurse R75's teeth and verified R75 towards the front and on the um line.		the comprehensive asses describes the services tha furnished to attain or mair resident's highest practica mental, and psychosocial 3) recognizes the resident cares/services.	at are to be ntain the able physical, well-being and	
	dated 1/19/16, ider teeth, top partial ar bottom and partial R75's care plan pri	asion Assessment for R75, ntified oral/dental: missing nd noted: has own teeth on uppers. nted 3/11/16, identified a ed to dental status. "requires		The care plan related poli- and the staff responsibiliti- development and revision comprehensive plans of c reviewed and updated. At admission, a temporary ca implemented that address	es for of the are were the time of are plan is	
	Interventions includ "dentures are in me meals. Remove, cl bedtime. Last dent oral hygiene with a (evening) cares, ar	by b		need for assistance with a living; the interdisciplinary developed within seven da completion of the compre- assessment. As part of th conference process, the in team reviews the care pla completeness, accuracy,	activities of daily care plan is ays after hensive e quarterly care nterdisciplinary ns for	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00650	B. WING		03/1	1/2016
	ROVIDER OR SUPPLIER	ER 220 THIR		STATE, ZIP CODE IORTHWEST MN 55917	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 565	R75 had missing te On 3/10/16 at 12:3 (RN)-A verified R75 missing teeth. On 3/10/16 at 1:00 stated she would ex- identified on R75's The facility's policy, 8/13/13, indicated a developed for each of the individual res will address every s resident. SUGGESTED MET facility could review and revise if necess develop and preser regarding important the resident's care if develop and implen part of quality assu- ensure ongoing cor TIME PERIOD FOF (21) days. MN Rule 4658.0408 Plan of Care; Use Subp. 3. Use. A co	The care plan did not indicate eth. I p.m., registered nurse I's care plan failed to include p.m., the director of nursing cpect missing teeth to be care plan. Care Plan Policy dated a care plan would be resident identifying the needs ident. Each resident care plan specific area of care for each THOD OF CORRECTION: The care plan policies/procedures sary, the facility could then net education to staff members ce of fully developing/revising plan, the facility could then nent an auditing system as rance program that would npliance. R CORRECTION: Twenty-one 5 Subp. 3 Comprehensive personnel involved in the	2 560	During the mandatory meet and 15, 2016, the nursing s reminded 1) of the facility po plan reviews and updates 2 residents' care plans must k times and 3) that care plans to address the residents' de and any dental care needs. A registered nurse assesse cavity and dentition of resid The care plan was updated the resident has missing tee Compliance will be monitore Coordinator. For the next th dental problems identified d routine oral assessments on the minimum data set scree care plan will be reviewed to the resident's dental status/ appropriately addressed. If is noted, additional staff trai auditing will be done. Comp reviewed at the April quarter Assurance and Assessment meeting.	taff will be blicies for care) that the be current at all s must continue intal condition d the oral ent number 75. to reflect that eth. ed by the MDS ree months, if uring the triggered on ening tool, the be ensure that condition is noncompliance ning and liance will be rly Quality	4/19/16

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVE COMPLETED		
		00650			03/11/201	6	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
PRAIRIE	MANOR CARE CEN	IER		NORTHWEST MN 55917			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COM	X5) IPLE ATE	
2 565	Continued From pa	age 6	2 565				
	by: Based on observat review, the facility f interventions for re (R27) reviewed for monitor and report residents (R77) rev related skin concer Findings include: LACK OF REPOSI THE COMPREHEN R27's care plan, pr	TIONING ACCORDING TO NSIVE CARE PLAN: int date 3/11/16, identified the		Prairie Manor Care Center provide services that meet professional sta of quality and are delivered by appropriately qualified persons (e.f. licensed, certified) in accordance we each resident's written plan of care interdisciplinary care planning tear uses an assessment process to de an individualized care plan for eac resident that supports the highest practicable level of function and we 2) implements procedures and pra as outlined in the plan 3) reviews t at least quarterly and with significa	andards g., with e. The n 1) evelop h ell-being actices he plan unt		
	related to history of buttock and spong reposition when in R27 was observed 9:55 a.m. until 12:2 32 minutes), in whi repositioned. At 9:5 (NA)-B and NA-C w from the toilet back EZ stand mechanic have a red, shiny, o buttock. NA-C cont on his left buttock a	is at risk for skin breakdown f intragluteal ulcer right inner y heels. Intervention of chair every two hours. continuously on 3/9/16, from 27 p.m., (a total of 2 hours and ch R27 had not been 55 a.m., nursing assistant were observed to transfer R27 a into his wheelchair using an cal lift. R27 was observed to open area noted on his left firmed R27 had an open area and applied barrier cream to		 changes in condition and 4) makes modifications as necessary. The facility has policies and proceed for developing individualized plans and communicates the plan to the care givers by use of the nursing a care instruction Kardex. The care policies and procedures were revise and revised. During the April 14 and 15, 2016, mandatory meetings, the nursing s be reminded/instructed 1) that the residents' plans of care must be for 	dures of care direct issistant plan ewed staff will		
	sitting in his wheeld CREAM APPLIED w/c??? 10:12 a.m., R27 re wheelchair in his ro	0:03 a.m., R27 remained chair in his room. WAS after he transferred back to his mained sitting in his oom. At 10:25 a.m., NA-C shut off R27 television and		2) that repositioning residents according their plan of care is essential to prosolve their plan of care is essential to prosolve their plan of care is essential to prosolve the skin integrity and prevent/treat preducers and 3) that job performance expectations include being aware following the resident's plan of care including timely repositioning. The	eserve ssure of and		

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00650	B. WING		03/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	TFR		NORTHWEST , MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 7	2 565			
	asked R27 if he wo then assisted R27, wheelchair, to the o remained sitting in room. At 10:50 a.m wheelchair in the d remained sitting in room. NA-B was of the dining room tak eating. At 11:36 a.m wheelchair in the d assist R27 with eat observed to assist to R27's room. R27 wheelchair. NA-B p reach, turned on R R27 I will be right b 12:05 p.m., R27 re wheelchair in his ro entered R27's room which had a dressi sitting in his wheeld remained sitting in 12:18 p.m., R27 re wheelchair in his ro 12:25 p.m., R27 re wheelchair in the ro the contered R27' mechanical lift and wheelchair to the to area was purple in area looked dry. On 3/9/16, at 12:45 be repositioned events stated they had can resident cares. NA- and verified the can in chair every two h	build like to go to brunch. NA-C who remained sitting in his dining room. 10:40 a.m., R27 his wheelchair in the dining n., R27 remained sitting in his ining room. At 11:05 a.m., R27 his wheelchair in the dining oserved to sit next to R27 at ole and assisted R27 with n., R27 remained sitting in his ining room. NA-B continued to ting. At 11:50 a.m., NA-B was R27 from the dining room back 7 remained sitting in his olaced R27's call light within 27's television and stated to back, in just a few minutes. At mained sitting in his oom. Registered nurse (RN)-C n to look at R27's right arm, ng in place. R27 remained chair. At 12:09 p.m., R27 his wheelchair in his room, mained sitting in his		orientation for new employ continue to address the im following the resident's pla activities of daily living incl assistance with repositionia Resident number 27 – A m reviewed the resident's sk skin-related plan of care; e repositioning remains app nursing assistants have be the residents of the need f two-hour repositioning and referring to the care Karder resident's repositioning pla Resident number 77 – The top of the resident's right h assessed by a nurse on M 13. The plan of care include antibiotic ointment to the a The resident was discharg 2016 to another long term be closer to her family. Compliance with timely rep residents with mobility dep be monitored by the charg through observation of the staff. Resident care obsern assigned by the Director on Nurses/designee for two w noncompliance is noted, a auditing and staff training Compliance will be review April quarterly Quality Assi Assessment Committee m	aportance of an of care for uding ing. egistered nurse in condition and every two-hour ropriate. The een reminded of or every d the policy for ex for the an of care. e lesions on the hand were larch 9, 11, and ded applying affected area. Jed March 18, care facility to cositioning for bendencies will e nurses direct care vations will be f veeks. If idditional will be done. ed during the urance and	

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00650	B. WING		03/11/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE, ZIP CODE				
PRAIRIE	MANOR CARE CEN	IFR	ND STREET NO NG PRAIRIE, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	R27 was to be report On 3/10/16, at 12:4 (RN)-A stated sheet be followed for report because R27's skin to reposition R27 er R27 is healed in re- buttock at this time On 3/10/16, at 12:5 (DON) stated sheet repositioned every planned for R27, or vicinity of two hours NON-PRESSURE R77 was observed revealed a lesion of hand, approximate lesion was covered red skin surroundin 3/8/16, at 8:30 a.m revealed the lesion right hand. R77 wa 2/15/16 with diagnon hemiparesis, and of infarction, accordin The facility identifie 2/15/16, with rash if on left shin, and op was no indication of Facility care plan p staff a focus of req	positioned every two hours. 41 p.m., registered nurse would expect the care plan to ositioning every two hours, n is so fragile. We will continue every two hours even though ference to an open area on left for p.m., the director of nursing would expect R27 to be two hours if that was care r somewhere in the close	t		51)		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00650	B. WING		03/	03/11/2016	
JAME OF F	PROVIDER OR SUPPLIER			DRESS, CITY, STATE, ZIP CODE		11/2010	
PRAIRIE	MANOR CARE CEN	220 THIR	ND STREET NO NG PRAIRIE, N	RTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 9	2 565				
	printed 3/9/16, dire monitored weekly of	of nursing assistant kardex, cted staff skin integrity will be on bath day and as needed, s, problems, redness to					
	identified the lesior	ssistant documentation n on 3/5/16, there was no n monitoring and reporting the					
		of facility progress notes dated revealed the following:					
	risk for skin break total assist with car lift, did not ambulat pink folds at times, hours sitting and ly	kin risk assessment-at high lown, required extensive to res, transferred by mechanical te, foley catheter in place, had reposition every one to two ing. Monitor skin daily with bath, and as needed.					
	2/29/16-shower thi or skin tears.	s morning with no new bruising					
		and weekly skin check this issues at this time.					
		of facility incident report log /16, revealed no identification ח.					
	nursing assistant (aware of R77's ha stated she did not During interview at aware of the lesion	n 3/9/16, at 12:15 p.m., NA)-G stated she had became nd lesion on 3/7/16. NA-G know how the lesion occurred. that time, NA-D stated was today, 3/9/16. NA-D stated n the lesion and notify the					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00650	B. WING		03/	03/11/2016	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		11/2010	
PRAIRIE	MANOR CARE CEN	IFR	RD STREET NO ING PRAIRIE, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 10	2 565				
	nurse.						
	licensed practical r aware of the lesion NA-D stated when related area, staff book and give the to the nurse. Docu at that time with N	n 3/9/16, at 12:17 p.m., nurse (LPN)-B stated was not n. During interview at that time staff discover a non-pressure are to document in the memo white page of the carbon copy ment review of the memo bool A-D, revealed the lesion was S, as "sore on top of right					
	3/9/16, at 4:22 p.m resident's right har as dry patches on measured 0.7 cent other measured 0. The areas were no no signs of infection	revealed progress note dated a., "Staff reported sore to nd." Two areas were identified back of right hand, one area timeter by 0.9 centimeter, the 2 centimeter by 0.3 centimeter ofted to have no drainage and on. Triple antibiotic ointment mes a day and leave open to					
	registered nurse (F aware of R77's right the wound nurse a RN-A stated she e concerns to the win complete an incide notify director of nu nurse, social servic stated she expected skin concerns in pu skin concerns were nurse completing a the wing nurse who	n 3/10/16, at 7:38 a.m., RN)-A verified facility was not ht hand lesion until 3/9/16, and ssessed the area at that time. xpected staff to report skin ng nurse, wing nurse to ent report, and send emails to ursing, nurse manager, wound ces and administrator. RN-A ed the wing nurse to document rogress notes. RN-A stated e monitored by the wound an assessment weekly and by b looked at the area daily. s treatment of triple antibiotic					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00650	B. WING		03/11/2016		
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
PRAIRIE	MANOR CARE CEN	IFR					
(X4) ID			NG PRAIRIE, N	IN 55917 PROVIDER'S PLAN OF		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	COMPLET DATE	
2 565	Continued From pa	age 11	2 565				
	record. RN-A verifie book-white part of the wing nurse and stayed in the memory During interview or of nursing stated st to report skin conce document the conce memo book. Direct expected the wing	a 3/10/16, at 9:50 a.m., director he expected nursing assistants erns to the wing nurse and to sern in the nursing assistant tor of nursing stated she nurse to assess the concern,					
	nurse, director of n social services. The facility Care Pl indicated purpose, every resident to en resident preference	nt report, and report to charge ursing, administrator and an Policy, dated 8/13/13, to develop a plan of care for nsure care is given per e. Procedure, each resident ess every specific area of care resident.					
	The director of nurs and/or revise polici the facility followed residents individua nursing could educ policies and proces	THOD OF CORRECTION: sing could develop, review, es and procedures to ensure care plans according to the lized needs. The director of rate all appropriate staff on the dures. The director of nursing itoring systems to ensure e.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			4/19/16	

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :	(X3) DATE COMP	SURVEY LETED
	00070	B. WING			
	00650			03/1	1/2016
IAME OF PROVIDER OR SUPPLIE			STATE, ZIP CODE		
PRAIRIE MANOR CARE CEN	ITER	NG PRAIRIE	NORTHWEST , MN 55917		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 570 Continued From p	page 12	2 570			
care must be revie interdisciplinary te physician, a regist for the resident, a disciplines as dete and, to the extent participation of the guardian or chose quarterly and with the comprehensiv	n. A comprehensive plan of ewed and revised by an earn that includes the attending tered nurse with responsibility nd other appropriate staff in ermined by the resident's needs practicable, with the e resident, the resident's legal en representative at least in seven days of the revision of re resident assessment required 0, subpart 3, item B.				
by: Based on observa review, the facility include skin interv prevent breakdow (R27) reviewed fo revise the care pla 1 of 3 residents (F conditions; failed resident (R38) rev failed to revise the (R39) who demon and who made fre about other reside	nent is not met as evidenced ation, interview and record failed to revise the care plan to rentions to promote healing and rn of skin for 1 of 1 resident r pressure ulcers; failed to an to include risk for bruising for R27) reviewed for skin to revise a care plan for 1 of 1 riewed for contractures; and e plan of care for 1 of 1 resident istrated delusional behaviors equent inaccurate allegations ents being abused.		Tag F282 Services by Qualifi per Care Plan Prairie Manor Care Center pr services that meet profession of quality and are delivered b appropriately qualified person licensed, certified) in accorda each resident's written plan of interdisciplinary care planning uses an assessment process an individualized care plan for resident that supports the hig practicable level of function a 2) implements procedures ar as outlined in the plan 3) revi	rovides nal standards y ns (e.g., ince with of care. The g team 1) to develop r each hest ind well-being nd practices ews the plan	
HEELS:" R27's care plan p following: Resider related to history of	/ENTION/S FOR "SPONGY rinted 3/11/16, identified the at is at risk for skin breakdown of intragluteal ulcer right inner gy heels. Interventions included: to dry skin areas with cares AM		at least quarterly and with sig changes in condition and 4) r modifications as necessary. The facility has policies and p for developing individualized and communicates the plan t	nificant nakes procedures plans of care	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY _ETED	
		00650	B. WING		03/11/2016		
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
		220 THIF	ND STREET I	NORTHWEST			
'KAIRIE	MANOR CARE CEN	BLOOMI	NG PRAIRIE	, MN 55917			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLE DATE	
2 570	Continued From pa	age 13	2 570				
	Continued From page 13 (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.			care instruction Kardex. The car policies and procedures were re- and revised. During the April 14 and 15, 2016 mandatory meetings, the nursin be reminded/instructed 1) that the residents' plans of care must be 2) that repositioning residents at their plan of care is essential to skin integrity and prevent/treat p ulcers and 3) that job performant expectations include being away following the resident's plan of c including timely repositioning. The orientation for new employees we continue to address the important following the resident's plan of c activities of daily living including assistance with repositioning.	s, g staff will followed ccording to preserve oressure ice re of and are ne vill nce of are for		
	(NA)-B and nursing observed to transfe EZ stand mechanic feet in the recliner, reach and walked removing R27's sh On 3/9/16, at 12:45 shoes had been le recliner. NA-C and aware R27's shoes R27 was sitting in thad care sheets th NA-C and NA-B re verified the care sh	5 p.m. NA-C confirmed R27's ft on while R27 sat in the NA-B stated they were not s were to be removed when the recliner. NA-C stated they ey followed for resident care. viewed R27's care sheet and neet failed to indicate R27's emoved during the day while		Resident number 27 – A register reviewed the resident's skin com skin-related plan of care; every repositioning remains appropria nursing assistants have been re- the residents of the need for ever- two-hour repositioning and the preferring to the care Kardex for resident's repositioning plan of com- Resident number 77 – The lesion top of the resident's right hand we assessed by a nurse on March 9 13. The plan of care included appendix antibiotic ointment to the affecter The resident was discharged Ma 2016 to another long term care be closer to her family.	ered nurse ndition and two-hour ate. The eminded of ery policy for the care. ons on the were 9, 11, and pplying ed area. larch 18,		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		00650	B. WING		03/1	03/11/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE			
PRAIRIE	MANOR CARE CENT	IFR	NG PRAIRIE	NORTHWEST . MN 55917			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 570	Continued From pa	age 14	2 570				
	stated removing R2 had been implement stated the nursing a aware R27's shoes sat in the recliner h R27's care plan sho been revised to inc shoes during the da stated she did not h not been added to should have caugh			Compliance with timely re- residents with mobility de- be monitored by the char through observation of th staff. Resident care obse assigned by the Director Nurses/designee for two noncompliance is noted, auditing and staff training Compliance will be review April quarterly Quality Ass Assessment Committee to	pendencies will ge nurses e direct care ervations will be of weeks. If additional g will be done. wed during the surance and		
	(DON) stated she w care plan to be revi shoes during the da	1 p.m., the director of nursing would have expected R27's ised to include removal of his ay when in the recliner, and ed the nursing assistant ed.					
		YING RISK OF BRUISING ONS IF OBSERVED:					
		on 3/7/16, at 6:42 p.m. to se on top of his left hand.					
	sitting in a recliner bruised area was o	p.m., R27 was observed to be in his room. The purple observed on R27's left hand, colored bruise was noted bow.					
	12/17/15 identified	nimum Data Set dated diagnoses of dementia, atic and atrial fibrillation.					
	an order for predni	ders dated 1/19/16, identified sone 5 mg (milligrams) one steroids, side effect; thinning of	F				

	ta Department of H				T	APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00650	B. WING		03/11/2016	
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	IFR	D STREET NO NG PRAIRIE, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 15	2 570			
	medication admini	in 81 mg one time a day. R27's stration record, dated 3/16 vived the medications daily as				
	1/2/16, multiple bru many areas identif 1/6/16, new bruise bicep. 2/12/16 resident ha 2/20/16 resident ha upper lip. 3/3/16, bruises rep left elbow. Resider resistive with careas bruising. Does use	orts identified the following: uises on both upper arms, ied as blue in color. s on right elbow and two on as a bruise on his right hand. as a bruise on his left side ported on top of left hand and at known to be combative and s at times and is prone to e EZ stand mechanical lift for t unable to verbalize how occurred.				
	a problem area rel interventions to pre	as reviewed and did not include ated to R27's risk for bruising, event bruising, nor interventions ising was identified.				
	(RN)-A verified the included on R27's to find the source t	1 p.m., registered nurse risk of bruising had not been care plan. RN-A stated they try hat caused the bruising, but ot implemented interventions to				
		ector of nursing (DON) risk for bruising should have 7's care plan.				
		NT STATUS FOR RIGHT TURE INTERVENTIONS:				
	R38's care plan da	ted 1/30/16, included diagnosis	•			
ATE FORI			6899	KSG11	If continuati	on sheet 16 c

	ta Department of Heart	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI F	CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED
		00650	B. WING		03/11/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	IFR	ND STREET NO			
		BLOOMI	NG PRAIRIE, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 16	2 570			
	diagnosis included wash cloth in resid	zed osteoarthritis. ed to the osteoarthritis , "Staff will place rolled up ent's right hand r/t [related to] d with decreasing pain as				
	indicated the reside with trailing of hand hand. The note ind	ng Progress Note dated 7/8/15 ent had been non-compliant d splint/palm roll to the right dicated the resident's non do with R38 routinely holding ed fist position.				
	(LPN)-B stated, "S hand, it's contracte applying a brace a but she did not tole	a.m., licensed practical nurse he [R38] can't open her right ed. We tried doing exercises, nd using a rolled washcloth erate it. We tried doing the can get easily combative."				
	(DON) stated, "I do anywhere in the ca experiencing pain washcloth." The Do not been updated t	a.m. the director of nursing on't see the issue identified are plan except for her with the use of a rolled ON verified the care plan had to reflect R38's current with her right hand and refusal				
	LACK OF CARE P INTERVENTIONS	LANNED BEHAVIORAL :				
	the resident had di	ecord dated 5/12/15, indicated agnoses including anxiety ecified dementia without ance.				
	indicated R39 had	ata Set (MDS) dated 12/30/15, a Brief Interview for Mental				
nesota De	epartment of Health VI		⁶⁸⁹⁹ JK	(SG11	If continuati	on sheet 17

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00650	B. WING		03/	03/11/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	•		
PRAIRIE	MANOR CARE CEN	IFR	ND STREET NO NG PRAIRIE, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 570	Continued From pa	age 17	2 570				
	was cognitively inta R39 had experience (a patient health que monitor the severit score of 11, which depression. Accord had stated on the f	re of 14, which indicated he act. In addition, the MDS noted ced no behaviors. R39's PHQ-9 uestionnaire used as a tool to y of depression) identified a indicated the resident had mild ding to the documentation, R39 PHQ-9 that he felt down, eless; and that he felt bad abour					
	suffered a chronic/ intellectual function deficit, judgment, c processes related dementia. The car confusion increase assess and evalua signs or symptoms medical problems. resident at being a abused. Intervention encouraged to report abuse/neglect to se appropriate outside plan did not address of making accusation	o date), indicated he had progressive decline in hing characterized by memory decision making and thought to short term memory loss and e plan indicated that if R39's ed suddenly, staff were to te whether there were any s of infection, or any other R39's care plan identified the low to medium risk of being ons indicated R39 was ort any concerns related to ocial services, nursing and/or e agency. However, the care as the resident's regular habit ions about other residents taff which occurred over the hich had been					
	10:22 a.m., R39 was seen any other res stated, "There is of had this one girl, I stated the "guy" res then stated the girl	terview with R39 on 3/8/16 at as asked whether he'd ever ident abused by staff. R39 ne guy that stayed here and he think he got her pregnant." R39 sided at the facility [R18]. R39 worked at the facility, "He was is here for a short time. He is)				

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00650	B. WING		03/11/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
PRAIRIE	MANOR CARE CEN	IFR	ND STREET NO NG PRAIRIE, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 570	here. She still work about it. Well, she somewhere else. Well she still goes dowr When interviewed director of nursing the employee who interview was his of explained that R39 having an affair wit stated the last time been diagnosed wit (UTI) and that once behaviors had stop happened twice in the employee in qu nursing assistant the girlfriend. The DON a male nursing assistant the girlfriend. The DON a male nursing assistant the assistants talking, stated social service and the female nur had spoken with the they'd been unable allegations. When interviewed stated that one day watching television	He got an employee pregnant is here. I told a nurse's aide moved him down the hallway Well, that didn't help any and in to him." on 3/8/16 at 11:00 a.m., the (DON) stated R39 had thought is he had referred to during own girlfriend. The DON thought the employee was th another staff member. She is R39 had acted this way he'd ith a urinary tract infection is it had been treated, the oped. The DON stated this had the past. The DON also stated uestion was an evening shift hat R39 had picked as his N explained that there was also sistant working at the facility, 9 saw those two nursing R39 would get upset. The DON be staff had spoken with R39 rsing assistant, and the DON be male nursing assistant, and a to substantiate any of R39's on 3/9/16 at 12:11 p.m., R39 y he was in the dayroom in the carpeted area. He ing as dark with no lights on.	2 570	DEFICIENC	Y)		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00650	B. WING		- 03/11/2016	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	TER	RD STREET NO NG PRAIRIE, M	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE
2 570	Continued From pa	age 19	2 570			
	services (SS)-A sta back in October (2 appeared to correl tract infection and	on 3/8/16 at 3:25 p.m., Social ated R39's behaviors began 015). She stated the behaviors ate with the advent of a urinary that nursing was notified when d, and they tracked for any				
	licensed practical n had a urinary tract at that time though a staff member. LF R39's behaviors has stated the nursing been experiencing	on 3/8/16 at 3:59 p.m., nurse (LPN)-C confirmed R39 infection in January 2016 and t he was in a relationship with PN-C stated she'd thought ad ended. In addition, LPN-C staff thought perhaps R39 had delusions. LPN-C stated R39 ary tract infections.				
	administrator state have been care pla	on 3/9/16 at 9:18 a.m., the d that R39's behaviors should anned. He stated that there R39's behaviors which should pated more.				
	stated a problem r making allegations sexually abused sh She stated that sh	on 3/9/16 at 11:00 a.m., SS-A elated to R39's behaviors of about other residents being hould have been care planned. e would initiate training for the d reporting abuse allegations.				
	registered nurse (F services had been also stated R39 we conference meetin the nursing assista when R39 was exp	on 3/9/16 at 2:34 p.m., RN)-A stated that social aware of R39's behaviors. She ould usually wait for a care g to bring up any issues, that ints would normally report beriencing behaviors. RN-A are of one episode the DON	2			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION		E SURVEY PLETED
		00650	B. WING		03/	11/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	I F B	D STREET NO NG PRAIRIE, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	ige 20	2 570			
	8/13/13, included: " developed for each of each individual re plan will address eve each resident. The updated from the n annually, and with a plan will be updated any changes in res SUGGESTED MET The director of nurs develop and impler related to care plan designee, could pro staff related to the f	Care Plan Policy dated A care plan will be resident identifying the needs esident. Each resident care very specific area of care for care plan will be reviewed and urse manager quarterly, a significant change. The care d from a registered nurse with ident care as needed" THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures nevisions. The DON or byide training for all nursing timeliness of care plan ity assessment and assurance erform random audits to				
2 820	(21) days.	R CORRECTION: Twenty-one	2 920			4/10/16
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident				4/19/16

Minnesc	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00650	B. WING		03/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	FR	D STREET N IG PRAIRIE,	IORTHWEST MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 21	2 830			
	by: Based on observati review, the facility fa of 3 residents (R27 related skin condition failed to identify and related skin area ar promote healing for reviewed with non-pr concerns. Also faile light to prevent falls was observed to no when unattended b Findings include: R27 was observed have a purple bruis On 3/8/16, at 2:54 p sitting in a recliner i bruised area was of and another purple above R27's left elt R27's quarterly Min 12/17/15, identified polymyalgia rheuma R27's physician ord an order for prednis time a day (corticos the skin) and aspirit medication adminis	on 3/7/16, at 6:42 p.m. to e on top of his left hand. o.m., R27 was observed to be n his room. The purple oserved on R27's left hand, colored bruise was noted		Prairie Manor Care Center provide resident with the necessary care a services to attain or maintain the h practicable physical, mental, and psychosocial well-being, in accord with the comprehensive plan of ca- interdisciplinary care team assess resident at the time of admission, quarterly, with significant changes condition, and more often as the re- condition indicates. A plan of care developed, implemented, routinely reevaluated, and revised as necess based on continuing assessments The policies and procedures for identifying, reporting, investigating monitoring bruises and other skin were reviewed and found appropri During the April 14 and 15 manda nursing staff meetings, discussion include the need to observe for sk lesions and the importance of appropriately reporting, documenti monitoring bruises/ lesions. Proce- related to the above will be review well as developing care plans to monitor/treat/prevent bruises and o skin lesions. Instruction will be pro the nursing assistants on the need alert to bruising and other skin injuries/lesions and to immediately the findings to the licensed nurse. Observing and reporting skin prob	nd ighest ance re. The es each in esident's is sary , and lesions ate. tory will in ng and dures ed as other vided to I to be report	

220 THIE	B. WING		03/11/2016
220 THIE			00/11/2010
220 THIF	DDRESS, CITY,	STATE, ZIP CODE	
CENTER		NORTHWEST AMN 55917	
RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPL
reports identified the following: e bruises on both upper arms, entified as blue in color. uises on right elbow and two on ent has a bruise on his right hand. ent has a bruise on his left side s reported on top of left hand and sident known to be combative and cares at times and is prone to a use EZ stand mechanical lift for ident unable to verbalize how have occurred. un was reviewed and did not include a related to R27's risk for bruising, o prevent bruising, nor interventions f bruising was identified. 12:41 p.m., registered nurse d the risk of bruising had not been 27's care plan. RN-A stated they try rce that caused the bruising, but ad not implemented interventions to ng. e director of nursing (DON) I the risk for bruising should have o R27's care plan. n-pressure skin conditions was t not provided.	5	 including bruises, will continue to b of the nursing assistant's bathing p Resident number 27 – A registered reassessed the resident's skin-rela plan of care. The care plan has be- updated to address the resident's r bruising, options to prevent bruising implementation of interventions in event of bruising. Resident number 77 – The lesions top of the resident's right hand wer assessed by a nurse on March 9, 13. The plan of care included apply antibiotic ointment to the affected a twice a day. The resident was disc. March 18, 2016 to another long ter facility closer to her family. To monitor care plan compliance, t Coordinator will audit the care plan completeness and accuracy for the residents who have open skin area contractures, or are receiving med such as aspirin, Coumadin or pred or have other risk factors that incre- risk of bruising. To monitor complia with identification of skin lesions, th Director of Nursing/designee will co- random skin audits for two weeks. previously unreported bruises or ot problems are observed, additional and staff training/counseling will be Compliance will be reviewed during April quarterly Quality Assurance a 	orotocol. d nurse tted en risk of g, and the on the re 11, and ving area harged m care he MDS is for ose as, ications nisone, ease the ance he conduct If ther skin auditing e done. g the
	a related to R27's risk for bruising, to prevent bruising, nor interventions if bruising was identified. 12:41 p.m., registered nurse d the risk of bruising had not been 27's care plan. RN-A stated they try ince that caused the bruising, but ad not implemented interventions to ng. the director of nursing (DON) d the risk for bruising should have the pressure skin conditions was t not provided.	treports identified the following: le bruises on both upper arms, lentified as blue in color. ruises on right elbow and two on ent has a bruise on his right hand. ent has a bruise on his left side s reported on top of left hand and sident known to be combative and cares at times and is prone to s use EZ stand mechanical lift for sident unable to verbalize how have occurred. an was reviewed and did not include a related to R27's risk for bruising, to prevent bruising, nor interventions if bruising was identified. 12:41 p.m., registered nurse d the risk of bruising had not been 27's care plan. RN-A stated they try tree that caused the bruising, but ad not implemented interventions to ng. the director of nursing (DON) d the risk for bruising should have to R27's care plan. m-pressure skin conditions was t not provided. URE RELATED SKIN CONDITION: usted lesion on the back of right	2 830ar reports identified the following: le bruises on both upper arms, lentified as blue in color. ruises on right elbow and two on urises on right elbow and two on unt has a bruise on his right hand. ent has a bruise on his right hand. ent has a bruise on his left sideResident number 27 – A registered plan of care. The care plan has be updated to address the resident's skin-red plan of care. The care plan has be updated to address the resident's skin-red plan of care. The care plan has be updated to address the resident's skin-red plan of care care plan has be updated to address the resident's skin-red plan of care care plan has be updated to address the resident's skin-red plan of care included appl antibiotic ontment to the affected a twice a day. The resident was disc March 18, 2016 to another long ter facility closer to her family.12:41 p.m., registered nurse d the risk of bruising had not been 27's care plan. n.pressure skin conditions was t not provided.To monitor care plan compliance, t Coordinator will audit the care plan completeness and accuracy for the residents who have open skin area contractures, or are receiving med such as aspirin, Coumadin or pred such as aspirin, Coumadin or previously unreported bruises or or have other risk factors that increa risk of bruising. To monitor complia and staft training/counseling will be Compliance will be reviewed during April quarterly Quality Assurance a Assessment Committee meeting.

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00650	B. WING		03/11/2016	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	TER	RD STREET NO NG PRAIRIE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 23	2 830			
	without interventior	ns to promote healing.				
	diagnosis that inclu	to the facility on 2/15/16 with ided hemiplegia, hemiparesis, owing cerebral infarction, admission record.				
	indicated R77 had left arm, bruise on	icted for R77 dated 2/15/16, a rash in the groin area, on the left shin, and an open area on ere was no indication of lesion nd.				
	dark brown crusted centimeter in size,	tions on 3/7/16 at 3:10 p.m., a d lesion approximately one was noted on the back of There was no redness to the ne area.				
		is on 3/8/16 at 8:30 a.m., and n., the lesion to the back of led unchanged.				
	Document review of 2/26 to 3/8/16, reve	of facility progress notes from ealed the following:				
	risk for skin breakc total assist with car lift, did not ambulat pink folds at times, hours sitting and ly	kin risk assessment-at high down, required extensive to res, transferred by mechanical te, foley catheter in place, had reposition every one to two ing. Monitor skin daily with bath, and as needed.				
	2/29/16-shower this or skin tears.	s morning with no new bruising]			
	3/7/16-had shower shift. No new skin	and weekly skin check this issues at this time.				

STATEMEN	ta Department of Herric II of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
		00650	B. WING		03/11/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	IFR	ND STREET NO NG PRAIRIE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 24	2 830			
		incident report logs dated evealed no identification of				
	assistant (NA)-G a become aware of t on 3/7/16. NA-G de might have occurre during the interview become aware of t also stated she'd d	n 3/9/16 at 12:15 p.m., nursing cknowledged having first he lesion on R77's right hand enied knowing how the lesion ed. NA-D was also present w and NA-D stated she'd he lesion that morning. NA-D locument a note about the sion and would notify the nurse.				
	licensed practical r not aware of the le present, stated wh non-pressure relate document in a "me page of the carbon review of the mem revealed the lesion as a "sore on top of	n 3/9/16 at 12:17 p.m., nurse (LPN)-B stated she was sion. NA-D, who was also en staff discover a ed area, they are supposed to emo book" and give the white a copy to the nurse. Document o book at that time with NA-D, had been identified on 3/5/16, of right hand." There was no included. NA-D verified this.				
	integrity will be mo as needed. The ca	inted 3/9/16, indicated: skin nitored weekly on bath day and are plan also indicated staff changes, problems or redness				
	3/9/16, also indicat integrity weekly on	ing assistant kardex printed ted staff were to monitor skin bath day and as needed, s, problems, redness to				
		ssistant documentation n on 3/5/16, there was no				

STATEMEN	ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00650	B. WING		0.27	03/11/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		03/	11/2010	
		220 THIE	DRESS, CHT, ST				
PRAIRIE	MANOR CARE CEN	BLOOM	NG PRAIRIE, N	MN 55917			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 25	2 830				
		identification, assessment, oring until surveyor intervened					
	note dated 3/9/16 a "Staff reported sord areas were identified right hand, one are 0.9 centimeter, the centimeter by 0.3 c noted to have no d infection. Triple and	eyor's questions, this progress at 4:22 p.m. was documented: e to resident's right hand. Two ed as dry patches on back of ea measured 0.7 centimeter by other measured 0.2 centimeter. The areas were rainage and no signs of tibiotic ointment was initiated id leave open to air."					
	Audit policy dated 9 Page 1, Purpose: 7 and location on ad possible risk factor appropriate care to Page 2, #5 on resid day nursing assista skin check to iden may affect the resi The bath day skin the licensed staff n resident on that sh concern can be ch filled out if needed manager. The licen required to comple in the nurses notes #6. Daily skin cheo residents that are a and repositioning. to report any skin o	ks are to be completed on all assisted with dressing, toileting Nursing assistants are required concerns to their immediate					
	documented and re	issues can be checked, eported to the appropriate entions to be initiated to					

	ta Department of Here T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00050	B. WING		00/11/0010	
		00650			03/	11/2016
		220 THIE	DDRESS, CITY, S ⁻ D STREET NO			
PRAIRIE	MANOR CARE CEN	IFR	NG PRAIRIE, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC [\]	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 26	2 830			
	prevent further skin	n breakdown.				
	registered nurse (F not aware of R77's and the wound nur RN-A stated she ex- concerns to the win then to complete a emails to notify dire manager, wound n administrator. RN- wing nurse to docu progress notes. RN- monitored by the w assessment weekl looked at the area treatment of triple a started the evening facility medication verified the nursing part of carbon copy nurse and yellow p in the memo book.					
	director of nursing nursing assistants wing nurse and to nursing assistant n stated she expected concern, complete to charge nurse, di and social services During interview or was asked how sh	n 3/11/16, at 8:55 a.m., R77 e got the sores on her right				
	·	ed very softly, "I don't know." of facility Care Plan Policy				
nocota Dr	epartment of Health		<u> </u>			<u> </u>

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00650	B. WING		03/11/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
PRAIRIE	MANOR CARE CENT		ND STREET NO NG PRAIRIE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 27	2 830			
	plan of care for eve given per resident p included a care pla	ealed Purpose: To develop a ery resident to ensure care is preference. Procedure n would be developed for each the needs of each individual	I.			
	LACK OF CALL LI PREVENT ACCIDE	GHT IN REACH TO ENTS:				
	sitting in a wheelch was observed to be	on 3/7/16, at 6:44 p.m. to be air in his room. The call light e clipped up high on the was out of R27's reach.				
	sitting in a recliner	o.m., R27 was observed to be in his room and the call light e on top of R27's bed. The cal 7's reach.				
		p.m., nursing assistant (NA)-A ight was not within reach for				
	resident required a personal hygiene. indicated R27 was plan intervention in	int date 3/11/16, indicated the ssistance with toileting and In addition, the care plan at high risk for falls. The care cluded: Keep call light within ge resident to call for				
		1 p.m., registered nurse-A ight should be within reach for				
	also stated she wo	1 p.m., the director of nursing uld expect the call light to be 7 and any resident who Il light.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY
		A. BUILDING:		COMP	LETED
	00650	B. WING		03/1	1/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PRAIRIE MANOR CARE CENT	FR	D STREET N IG PRAIRIE,			
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETE DATE
director of nursing (develop, review, an procedures to ensu as assessed. The I educate all appropr procedures. The Do monitoring systems compliance.	HOD OF CORRECTION: The DON) or designee could d/or revise policies and re resident cares are provided DON or designee could iate staff on the policies and DN or designee could develop	2 830			
have a continuous management to red unnecessary use of comprehensive res home must ensure A. a resident w without an indwellin unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac much normal bladd	nce. A nursing home must program of bowel and bladder luce incontinence and the f catheters. Based on the ident assessment, a nursing	2 910			4/19/16
	ent is not met as evidenced				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00650	B. WING		03/11	/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY,	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	I F R		NORTHWEST , MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
2 910	Continued From pa	ige 29	2 910			
	failed to identify syr infection/s (UTIs) b and/or ensure mon and symptoms, org resolution for urinar of 4 residents (R3, received antibiotic n Findings include: R3's Admission Re- diagnoses of fractur of falling. R3's physician order an order for Bactrin mg (milligrams) one days. R3's medicat (MAR), dated 10/15 the Bactrim DS as of R3's progress note: 10/20/15, identified 9/29/15, admitted to of urinary tract infect symptoms of curren 9/29/15, call receive sterile UA (urine an order to be collected	s dated from 9/29/15 to the following: o facility, denied having history ctions (UTIs) and no signs or nt UTI. ed from physician office, ok for alysis) to be collected. Will of on lab day.		Prairie Manor Care Center has established and maintains an infe control program designed to provi safe, sanitary, and comfortable environment and to prevent the development of disease and infect facility has an infection control pro- that 1) investigates, controls, and infections in the facility 2) determin appropriate procedures, if any, that implemented (such as isolation) for resident with an infectious disease maintains a record of incidences of infections and tracks any alternati actions taken related to infection of The facility's current monthly infect control log tracks the resident, infe- site, causative organism (if cultur antibiotic/treatment, date of onset whether the infection was acquire at the facility. To improve infection and outcorme surveillance, the inf control log and related data will id room/wing of the resident with the infection, the symptoms identified a culture was obtained (or rationa and the date of the resolution of th infection. Staff who have not partie in an infection control training ses the past year will receive training of 12 or 14, 2016.	de a tion. The ogram prevents nes the at will be or each e and 3) of ve control. tion ection ed), , and d while process fection entify the , whether le if not), ne cipated sion in on April	
	resident was positiv	ed from physician office stating ve for UTI. Orders included, 0 mg one tablet BID (twice per		The infection control nurse has re the infection control regulations, w focus on the requirements for infe surveillance and staff education. A comprehensive infection control re manual is available for reference. 10, 2016, the infection control nur	vith a oction A esource On June	

JKSG11

If continuation sheet 30 of 73

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00650	B. WING		03/1	1/2016
AME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
RAIRIE	MANOR CARE CENT	IFR	RD STREET I NG PRAIRIE	NORTHWEST MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 910	Continued From pa	age 30	2 910			
	no signs or sympto	tic for UTI, temp is stable and ms of confusion. tic, temperature was 98.0		attend a seminar present Health addressing system for preventing and contro well as regulatory require current standards of prace	n improvements Iling infections as ments and	
10 no 10 as sy 10 or 10 ter R3 thu ad ide re: no Or sta no rei fai	10/9/15, on antibiot no signs or sympto 10/10/15, quarterly assessment, reside symptoms of UTI.	tic therapy continues for UTI, ims of infection noted. bowel and bladder ent denies any signs or on antibiotic for UTI, no signs ntinued UTI.		Compliance with regulate and facility policies for an surveillance program will the Director of Nursing/de next three months throug the infection control track staff training records. If n noted, additional staff train will be done.	bry requirements infection control be monitored by esignee for the h a review of 1) ing data and 2) oncompliance is	
	three signs and syr addition, R3's recond identification of the	o include evidence of at least nptoms of symptomatic UTI. Ir		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.		
	stated R3 was adm not know who orde record failed to incl and symptoms of L	7 p.m., registered nurse (RN)-E nitted on 9/29/15, and she did ored the UA. RN-B verified R3's lude documented three signs JTI and confirmed R3's record entification of the organism and is of the UA.	;			
	R36's Admission R diagnosis of retenti	ecord, dated 3/11/16, identified ion of urine.	ł			
	an order for UA wit	ders, dated 1/6/16, identified h culture if indicated. May n [catheter] if needed for				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00650			03/11/2016	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S		03/	11/2010
PRAIRIE	MANOR CARE CEN	220 THI	RD STREET NO	DRTHWEST		
		BLOOM	ING PRAIRIE, I		000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 31	2 910			
	identified an order BID [two times dail dated 1/16, reveale medication as orde	sion and dated 1/8/16, for Cipro [antibiotic] 250 mg y] for three days. R36's MAR, ed R36 had received the ered.				
	1/12/16, identified					
	1/6/16, resident is weakness and leth	confused, had increased argic.				
	1/7/16, UA obtaine amber in color and	d via mini cath, urine is dark no odor.				
	1/8/16, order for Ci	pro 250 mg BID for three days	5.			
	organism and if Cy organism. In additi- include documenta symptoms of the U	to include identification of the pro was affective to treat the on, R36's record failed to tion of resolution of signs and TI, which included confusion, c and dark amber urine.				
	confirmed R57's re- identification of the results of the UA a resolution of signs Surveyor had require and culture results	7 p.m., registered nurse (RN)-l cord failed to include organism and susceptibility nd lacked documentation of and symptoms of the UTI. ested identification of organisr . RN-B provided a report, faxed to the facility or	n			
		ecord, dated 3/11/16, identifie tion of urine and history of	d			
	R39's physician or epartment of Health	ders, dated 2/21/16, identified				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00650	B. WING	B. WING		03/11/2016	
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		11/2010	
RAIRIE	MANOR CARE CEN	TER	RD STREET NO NG PRAIRIE, M	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
2 910	Continued From pa	age 32	2 910				
		g BID for 10 days. R39's MAR, 6, revealed R39 had received ordered.					
	R39's progress not 3/3/16, identified th	tes dated from 2/19/16 to ne following:					
		oided cloudy odorous urine. had been up an hour ago to					
	weakness, lethargy has a history of UT Temperature 99.2.	as been having increased y and incontinence. Resident Is that become septic. Physician office contacted for Iture, will await physician					
		direction to send to ED tment) for evaluation.					
		rom ED with diagnoses of UTI, d dehydration. Resident is on e given at the ED.					
	use urinal twice an	Cipro for UTI. Has been up to d has had no incontinence. and symptoms of adverse					
		on antibiotic for UTI. Resident , offering no complaints. No ted.					
	organism and susc addition, R39's rec documentation of r	I to include identification of the ceptibility results of the UA. In ord failed to include resolution of signs and ITI, which included increased					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00650	B. WING	B. WING		11/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		11/2010
PRAIRIE I		IFR	ND STREET NO NG PRAIRIE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 910	Continued From pa	age 33	2 910			
	confirmed R39's re identification of the results of the UA and resolution of signs Surveyor had reque and culture results. documentation of a 3/10/16, which ider Enterococcus faec. A physician order, of treat with doxycycli daily for seven day previous UTI was r R57's Admission R diagnoses of chron and retention of uri R57's physician order an order for obtain for diagnoses of chron an order for obtain for diagnoses of co identified an order times daily) and 10 14 days. R57's me (MAR), dated 10/13 the medication as of R57's progress not 10/16/15, identified 10/1/15, call placed the resident's recent continuous need for	a report, faxed to the facility on ntified the organism of alis and was resistant to Cipro. dated 3/10/16, identified will ne (antibiotic) 1000 mg twice s, as it is presumed that the not treated. eccord, dated 3/11/16, identified nic kidney disease stage three ne. ders, dated 10/1/15, identified a UA and culture if indicated onfusion and dated 10/3/15, for Keflex 500 mg TID (three /6/15, clarification Keflex times edication administration record 5, revealed R57 had received ordered.				
	order to obtain UA.	nurse practitioner for possible ed form nurse practitioner with				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY PLETED	
		00650	B. WING		03/	03/11/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	1		
PRAIRIE	MANOR CARE CEN	IFR	D STREET NO NG PRAIRIE, I				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
2 910	Continued From pa	age 34	2 910				
	orders to obtain UA and culture if indicated due to diagnoses of confusion.						
		eturned from the ED with the ex 500 mg TID times 14 days.					
	three signs and syn with an antibiotic, ic and susceptibility r record failed to inc resolution of signs	to include evidence of at least mptoms of UTI before treating dentification of the organism esults. In addition, R57's lude documentation of and symptoms of UTI, and increase in request to be					
	stated the three sig were confusion, inc cathed and history request to be straig is not included as a medication for sym R57's record failed three signs and syn RN-B confirmed R identification of the results of the UA. identification of org	7 p.m., registered nurse (RN)-B gns and symptoms R57 had crease of request to be straight of UTI however, increased ght cathed and history of UTIs a reason to use antibiotic uptomatic UTI. RN-B verified to include documentation of mptoms for obtaining a UA. 57's record failed to include organism and susceptibility Surveyor had requested panism and culture results. cumentation of a report, faxed 10/16.					
	(DON) stated we d looking for sympton we would get an or stated she would e the resident record expect documenta	5 a.m., the director of nursing o have a protocol UTI tracking, ms and documenting before der for an antibiotic. The DON xpect culture results to be in I. The DON stated she did not tion on resolution, but would tion of three signs and					

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		00650	B. WING		03/11/2016	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		03/	11/2010
		220 THIR	D STREET NO			
PRAIRIE	MANOR CARE CEN	BLOOMI	NG PRAIRIE, I	MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 35	2 910			
	Procedure, dated 1 of Prairie Manor Ca unnecessary usage urinary tract infection UTI is suspected, r following steps: initi for suspected UTI. needs assessment assessment sheets (activities, nursing, directions on the sl indwelling catheter are not met and re- three symptoms. If the physician. If re- criteria, continue to shift. If resident con- symptoms, notify p	Tract Infection Policy and 1/20/16, indicated it is the policy are Center to try to prevent the e of antibiotics for treatment of on symptoms. Procedure, if a nursing staff are to initiate the tiate 72 hour monitoring packet This packet includes fluid t calculation, fluid intake s for each department and dietary). Follow the heet, note that residents with s need two symptoms if criteria sidents without catheters need criteria are met initially, notify sident does not meet the o monitor for symptoms each ntinues to have noted hysician direction. Charting will pint Click (computer program) g symptoms noted.	L			
	indicated Prairie M wide infection cont measures to identii infections acquired the community. Po management of inf has been assigned The program exists maintaining record and any required for	n Control Policy, dated 8/1/12, anor Care Center has a facility rol program with effective fy, control and prevent or brought to the facility from licy, responsibility for the fection control and prevention to the Infection Preventionist. s for reporting, evaluating and s of infections among residents billow up. Antibiotic use is				
	monitored for pertinusage. The Quality discusses infection	ed by the infection he medical director and nent aspects of antibiotic Assurance Committee a control issues. However, the ers for medicare/medicaid				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED
		00650	B. WING	03/	11/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
PRAIRIE	MANOR CARE CENT	IFR	D STREET N IG PRAIRIE,	IORTHWEST MN 55917	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 910	services (CMS) del	age 36 finition of symptomatic UTI that being treated with antibiotics.	2 910		
	The director of nurs staff on the need to needed to treat with obtaining the result and culture results infections. The dire all employees resp tract infections on t	THOD OF CORRECTION: sing could in-service licensed o identify three symptoms are h an antibiotic therapy, as of identification of organisms and documenting resolution of ector of nursing could Inservice onsible for preventing urinary he need to assess and ns to prevent urinary tract			
21375	(21) days.	R CORRECTION: Twenty-one 0 Subp. 1 Infection Control;	21375		4/19/16
	Subpart 1. Infection	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.			
	by: Based on interview failed to ensure sur infections and faile control education for the facility infection	ent is not met as evidenced and record review, the facility rveillance and analysis of d to ensure annual infection or all employees as outlined in control policy. This had the Il residents, staff and visitors.		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	

STATE FORM

6899

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00650	B. WING		03/11/2016	
AME OF F	ROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	00/1	1/2010
	MANOR CARE CENT	220 THIRI	D STREET N	ORTHWEST		
		BLOOMIN	IG PRAIRIE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
21375	Continued From pa	ge 37	21375			
	SURVEILLANCE A INFECTIONS: The facility monthly Logs were obtained February 2016. The resident name, site antibiotic/treatment house were areas of following informatio on the monthly logs 6/15, two urinary tra 7/15, four UTIs, on one cellulitis 8/15, four UTIs, two 9/15, three UTIs, or infection 10/15, five UTIs, two 11/15, five UTIs, or cellulitis, two respire 1/16, nine UTIs, on 2/16, four UTIs, on that would enable to of infection, sympto identified, whether of obtained (or rational performed) and dat	ND ANALYSIS OF summary of Infection Control d from June 2015 through e logs identified for tracking the , organism, , date of onset and acquired in documented on the report. The on of infections were indicated act infections (UTIs) e pneumonia, one bronchitis, o cellulitis, one pneumonia ne pneumonia, one elbow ro pneumonia ne pneumonia, one respiratory ne aspiration pneumonia, one atory, one ear infection e cellulitis recurrent e pneumonia, one cellulitis ailed to include specific d wing location racking and trending of spread oms culture of the organism was al if not te of resolution of the infection.		appropriate procedures, if implemented (such as isolar resident with an infectious maintains a record of incid infections and tracks any a actions taken related to inf The facility's current month control log tracks the resid site, causative organism (antibiotic/treatment, date o whether the infection was a at the facility. To improve in and outcorme surveillance control log and related data room/wing of the resident v infection, the symptoms ide a culture was obtained (or and the date of the resoluti infection. Staff who have n in an infection control train the past year will receive tr 12 or 14, 2016. The infection control nurse the infection control regula focus on the requirements surveillance and staff educ comprehensive infection con attend a seminar presenter Health addressing system for preventing and controlling	ation) for each disease and 3) ences of alternative ection control. hy infection ent, infection if cultured), for onset, and acquired while nfection process , the infection a will identify the with the entified, whether rationale if not), ion of the ot participated ing session in raining on April e has reviewed tions, with a for infection cation. A ontrol resource erence. On June trol nurse will d by Pathway improvements	
	information and infe used to prevent the the infections.	ection control precautions spread of		well as regulatory requirem current standards of practi		
	On 3/10/16, at 2:17	p.m., registered nurse (RN)-B ed to include date of		Compliance with regulatory and facility policies for an i surveillance program will b	nfection control	

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE 21375 Continued From page 38 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. 21375 LACK OF INFECTION EDUCATION: The facility provide documentation of a list of current employees, which totaled 121 employees. The facility provide docuation 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 courented to have attended for 8/18/15, 9/15/15 and October 2015 was 65 employees. Process/outcome surveillance of infection control. 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 Ithe stream of the stream	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
PRARIE MANOR CARE CENTER 220 THIRD STREET NORTHWEST BLOOMING PRARIE, NN 55917 INTED SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECED BY FULL (EACH OF NUTS IN STREET PRECED BY FULL (EACH OF MUST BY FULL (EACH OF INFECTION EDUCATION: (EACH OF INFECTION EDUCATION: (The facility provide documentation of a list of (Current employees, which totaled 121 employees. The facility failed to provide any further documentation for employee attendance for education of infection control. PRECENCES (EACH OF MUST BY FULL (EACH OF MUST B			00650	B. WING		03/1	1/2016
PHAILIE MANOR CAPE CENTEF BLOOMING PRAIRIE, MN 55917 (X4) ID PREE/X TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREI/X PRECIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OWNED THE APPROPRIATE DEFICIENCY) 21375 Continued From page 38 21375 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 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: Process/outcome surveillance of infection control issues will be continue to be routinely reviewed by the Quality Assurance and Assessment Committee. The facility provide documentation of a list of current employees, which totaled 121 employees. The facility provide docuber attendance sheets, which the facility identified were for infection control, dated 818/15, 9/15/15 and October 2015. The sheet for October 2015 failed to include the year and the total number of employees. Committee. The facility failed to provide any further documentation for employee attendance for education of infection control. NB- Serified the lack of documented education for infection control for	NAME OF I	PROVIDER OR SUPPLIER	STREET AD				1/2010
PHÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENT DATE 21375 Continued From page 38 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. ILACK OF INFECTION EDUCATION: The facility provide documentation of a list of current employees, which totaled 121 employees. The facility provide documentation of a list of current employees, which totaled 121 employees. The facility failed to provide and the total number of employees. Process/outcome surveillance of infection control. The facility failed to provide and the total number of employees. The total number of employees. Provide documented for 8/18/15, 9/15/15 and October 2015 may 65 employees. The facility failed to provide and thered for education of infection control. The facility failed to provide and further documentation for employee attendance for education of infection control. He lack of documented education for infection control for	PRAIRIE	MANOR CARE CEN	TFR	-			
 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 provide documentation of a list of continue to be routinely reviewed by the Quality Assurance and Assessment Committee. The facility provide docuber 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 mas 65 employees. The facility failed to provide any further documentation of infection control. On 3/10/16, at 2:17 p.m., RN-B verified the lack of documented education for infection control for 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	COMPLET
 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 provide document 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 failed to include the year and the total number of employees. The facility failed to provide any further documentation of infection control. On 3/10/16, at 2:17 p.m., RN-B verified the lack of documented education for infection control for 	21375	Continued From pa	age 38	21375			
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 nnesota Department of Health		stated she did not l and analysis of the identified the facility she or the charge r ensuring the nursir proper peri-cares. documentation of r effectiveness of en LACK OF INFECT The facility provide current employees The facility provide sheets, which the f infection control, da October 2015. The to include the year employees docume 8/18/15, 9/15/15 ar employees. The facility failed to documentation for education of infecti On 3/10/16, at 2:17 of documented edu all of the facility em On 3/11/16, at 9:55 stated she would e education for empl The facility policy In 8/1/12, indicted it is Care Center to hav in place assure a s environment for res	have documented surveillance infections. RN-B stated had y was having a lot of UTIs and hurse had been down the halls ing assistants were doing RN-B confirmed there was no nonitoring or analysis of suring proper peri-cares. ION EDUCATION: documentation of a list of , which totaled 121 employees. d education attendance acility identified were for ated 8/18/15, 9/15/15 and sheet for October 2015 failed and the total number of ented to have attended for nd October 2015 was 65 o provide any further employee attendance for on control. 7 p.m., RN-B verified the lack ucation for infection control for uployees. 6 a.m., the director of nursing xpect infection control oyees to be done annually.		next three months through a r the infection control tracking of staff training records. If nonco noted, additional staff training will be done. Process/outcome surveillance infections, frequency/type of in and other infection control iss continue to be routinely review Quality Assurance and Assess	review of 1) data and 2) ompliance is and auditing e of nfections, ues will be ved by the	

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00650	B. WING		03/	11/2016
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		03/	11/2010
	MANOR CARE CEN	220 THIE	D STREET NO			
		BLOOMI	NG PRAIRIE, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	age 39	21375			
	transmission of dis Manor Care Cente under which it: inve prevents infections procedures such a to an individual res incidents and corre infections. Basic R Preventionist (IP), directing the infecti	revent the development and ease and infection. Prairie r has established a program estigates, controls and in the facility, decides what s isolation, should be applied ident and maintains a record o ective actions related to esponsibility, the infection or designee, is responsible for on control program. Maintain at document training in employee files.	f			
	8/1/12, indicated in ongoing surveilland causing, or have the The facility closely exhibit signs/sympton ongoing surveilland of collecting, const concerning the free disease or event, fit that information to outcomes. The inter- identify clusters, chor increases in the manner. The result infection control ac- education, and idee problems in need of of relevant data increant antibiotic susceptible analysis and conclu- appropriate quality committee on a reg	n Surveillance policy dated fection prevention begins with ce to identify infections that are ne potential to cause outbreak. monitors all residents who toms of infections through ce and has a systemic method plidating and analyzing data quency an cause of a given ollowed by dissemination of those who can improve the ent of the surveillance is to nanges in prevalent organisms, rate of infection in a timely ts should be used to plan tivities, direct in-service ntify individual resident of interventions. Other sources clude laboratory cultures and pility profiles. Reporting, usions are reported to assessment and assurance gular basis and results of ported back to nursing units as				

	ta Department of H	ealth				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00650	B. WING		03/	11/2016
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	IFR	RD STREET NO			
		BLOOMI	NG PRAIRIE, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 40	21375			
	important that surv appropriate individ to, the director of n addition, it is impor practitioners receiv their practices to h of their care in infe based on analysis implement action p education and/or o effectiveness of the provided, prevention Documentation, de provides the nursin observations related	escriptive documentation ng home summarized ed to the investigation of the on and/or identifies the				
	indicated Prairie M wide infection cont measures to identi infections acquired the community. Po management of inf has been assigned The program exist maintaining record and any required for servicing on infecti provided to all dep Quality Assurance control issues.	n Control Policy, dated 8/1/12, anor Care Center has a facility rol program with effective fy, control and prevent l or brought to the facility from licy, responsibility for the rection control and prevention I to the Infection Preventionist. s for reporting, evaluating and s of infections among residents pllow up. Required employee ir on control prevention are artments at least annually. The Committee discusses infection	5			
	director of nursing need to follow the a functioning infect spread of infection	THOD OF CORRECTION: The could in-service staff on the facility policy and procedure for tion program to prevent the s.				
inesota De	epartment of Health					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (>	(3) DATE SURVEY COMPLETED	
		00650	B. WING		03/11/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	IFR	D STREET N IG PRAIRIE,	ORTHWEST MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPL	
21375	Continued From pa	age 41	21375			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control		21426		4/19/1	
	maintain a compre- infection control pro- current tuberculosi issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Mort This program must infection control pla unpaid employees, residents, and volu Health shall provid regarding impleme	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance entation of the guidelines. ance with this subdivision must he nursing home.				
	by: Based on interview facility failed to ens Tuberculosis (TB) develop a written in includes procedure active TB disease	tent is not met as evidenced y and document review, the sure a policy and procedure for infection control program, infection control plan that es for handling persons with and failed to ensure TB e facility employees. This had		Minnesota State Statute 144A.04 Su Tuberculosis Prevention and Contro Prairie Manor Care Center has established and maintains a comprehensive tuberculosis infectio control program according to the mo	n	

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Innesota Department of He ATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00650	B. WING		03/1	1/2016
AME OF PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE		
RAIRIE MANOR CARE CENT	IFR	ID STREET I NG PRAIRIE	NORTHWEST . MN 55917		
REFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426 Continued From pa	age 42	21426			
 the potential to affervisitors. Findings include: LACK OF TB INFEPROGRAM: On 3/11/16, at 8:47 stated she had no pinfection control procedures for handisease. LACK OF STAFF EThe facility provide current employees, The facility provide sheets, which the fainfection control and content, dated 8/18 sheet for October f the total number of have attended for temployees. The facility failed to documentation for education content. On 3/11/16, at 8:47 employees had not On 3/11/16, at 9:55 (DON) stated sheet 	CTION CONTROL a.m., registered nurse (RN)-B policy and procedure for a TB ogram. CTION CONTROL PLAN: a.m., RN-B stated she had no ntrol plan that includes dling persons with active TB		current tuberculosis infect guidelines issued by the L Centers for Disease Cont Prevention (CDC) and the Tuberculosis Control in M Care Settings published b Department of Health. The includes a tuberculosis im plan that covers all paid a employees, contractors, s residents, and volunteers addresses the procedures persons with active TB dis All employees are trained detection and prevention hire and annually. The tra the following topics: • TB pathogenesis and tra • Signs and symptoms of disease, and • The facility's infection co early recognition, isolation procedures). The employees who have training within the past tw be trained on the above to mandatory infection contri- will be scheduled in the new	United States rol and e Regulations for innesota Health by the Minnesota e program fection control ind unpaid students, . The policy s for handling sease. on tuberculosis at the time of ining includes ansmission, active TB ontrol plan (i.e., n, and referral e not had TB elve months will opics during the ol meetings that	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00650	B. WING	VING		11/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	FER	D STREET NO NG PRAIRIE, N	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426	for TB infection corr infection control pla would have to look The facility Tubercu Employees policy, o policy of Prairie Ma educate employees to TB. Record of err the infection contro address training on plan for TB. SUGGESTED MET The director of nurs policies and proceo The director of nurs employees regardin facility infection corr	ity had a policy and procedure and a written an for TB. The DON stated she for it. ulosis, Annual Education for dated 8/1/12, indicated it is the nor Care Center to annually s on the potential for exposure nployee training will be kept in I office. The policy failed to the facility infection control THOD OF CORRECTION: sing could review tuberculosis dures to ensure compliance. sing could educate all ng TB education and the	21426			
21530	A. The drug regim reviewed at least m currently licensed b This review must b Appendix N of the S Surveyor Procedure Requirements in Lo the Department of Health Care Financ This standard is in available through th system. It is not su	0 A.B.C Drug Regimen Review en of each resident must be nonthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan ubject to frequent change. acist must report any	21530			4/19/16

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL				
		00650	B. WING		03/11/2016				
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE					
PRAIRIE MANOR CARE CENTER 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917									
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	ON	(X5)			
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLET DATE			
21530	Continued From pa	age 44	21530						
	and the attending p must be acted upo physician visit, or s pharmacist. For pu upon" means the a report and the sign of nursing services C. If the attend with the pharmacis not provide adequa pharmacist believe being adversely aff refer the matter to if the medical direct physician. If the m the attending physi justification for the physician does not must be referred for assessment and as by part 4658.0070. the medical direct must refer the matter	director of nursing services obysician, and these reports n by the time of the next sooner, if indicated by the urposes of this part, "acted acceptance or rejection of the ing or initialing by the director and the attending physician. ding physician does not concur it's recommendation, or does ate justification, and the es the resident's quality of life is fected, the pharmacist must the medical director for review etor is not the attending edical director determines that ician does not have adequate order and if the attending change the order, the matter or review to the quality ssurance committee required If the attending physician is or, the consulting pharmacist ter directly to the quality ssurance committee.							
	by: Based upon intervi facility failed to ens	ew and document review the sure the consultant pharmacist ack of resident specific mood		The goal of Prairie Manor Care Ce to maintain the resident's highest practicable level of functioning and					
	and behavior symp medicaiton, to impl interventions befor medicaiton, to ensu- warrant the use of	ack of resident specific mood otoms for use of an anxiety lement non-pharmacological e use of pain and antianxiety ure an analysis of sleep to a hypnotic and failed to ensure cation for use of psychotropic		prevent or minimize adverse consequences related to medication therapy. The drug regimen of each resident is reviewed at least once by a licensed pharmacist. The pha reports irregularities to the attending	on 1 a month 1rmacist				
pposota D	medication for 1 of	5 residents (R75); failed to r mood and behavior		physician and the director of nursing these reports are acted upon.					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00650	B. WING		03/11/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
PRAIRIE		IFR	D STREET N NG PRAIRIE	NORTHWEST . MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 45	21530			
	symptoms to justify medication for 1 of to identify and mon determine effective medication for for 2 who received daily medication. Findings include: R75's Admission R R75 had diagnoses in right leg. R75's 3 Assessment (MDS was cognitively inta mood of feeling tire pain which had ma frequency of pain d as needed (PRN) p received non-media and had received a medications. R75's physician ord the following orders Lorazepam (antian (milligrams) - one t repeat one half tab anxiety issues and Venlafaxine (antide once a day related disorder. Tramadol (analges six hours as needed	v the use of an antianxiety 5 residents (R34); and failed intor mood symptoms to eness of and antidepressant 2 of 5 residents (R45 and R35) dose of an antidepressant 2 of 5 residents (R45 and R35) dose of an antidepressant 2 of a antidepressant 2 of a antidepressant 3 day Minimum Data 3 dated 2/16/16, identified R75 act, had no behaviors, had ed or having little energy, had de it hard to sleep at night, laily, received scheduled and bain medications, had not cation interventions for pain antidepressant and antianxiety ders dated 2/25/16, included s: xiety) tablet 0.5 mg ablet at HS (bedtime), may let in 30 minutes if still having not able to sleep. epressant) 75 mg - one capsule to generalized anxiety ic) 50 mg - two tablets every		The Director of Nursing an Pharmacist have reviewed procedures for identifying target behaviors and moor related to psychotropic med documenting nonpharmace interventions provided/offe pain and anxiety, complet assessments and analyzin monitoring data, and ensu- justification for use of psyc medications. The pharma to review records on a mo- routinely check for approp- documentation related to issues. During the mandatory me 14 and 15, 2016, the licen- will be instructed on 1) th documentation procedure behaviors and behavior re- interventions 2) the impor- attempting nonpharmacol interventions prior to adm PRN psychotropic and an ensuring the care plan ad behaviors and nonpharma- interventions to manage re- anxiety, and pain and 4) th assessment that analyzes monitoring data. The direct be reminded of the import observant for behaviors/m and reporting them to the Resident number 75 – Th been reminded to docume nonpharmacological interventions	d the facility's and tracking d symptoms edication use, cological ered to manage ing sleep ng sleep uring physician chotropic cist will continue onthly basis and oriate the above etings on April ased nursing staff e new s for target elated tance of ogical inistration of algesics 3) dresses target acological mood symptoms, he need for an a the sleep ct care staff will tance of being moods symptoms charge nurse. e nurses have ent	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00650	B. WING		03/1	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	FR	D STREET I	NORTHWEST . MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	ge 46	21530			
21000	Review of the Marc administration reco showed the followin R75 had received A time on 3/5/16, with non-pharmacologic prior to the PRN Ati R75 had received C 3/1/16 to 3/10/16 w non-pharmacologic prior to the PRN Ox R75 had received T 3/1/16 to 3/10/16 w non-pharmacologic prior to the Tramad Review of the Febru notes showed the febru notes showed the febru	h 2016 medication rd (MAR) and progress notes ng: Ativan as needed (PRN) one in o documentation of al interventions attempted van being administered. Dxycodone PRN six times from ith no documentation of al interventions attempted kycodone being administered. Tramadol PRN four times from ith no documentation of al interventions attempted ol being administered. uary 2016 MAR and progress ollowing:		attempted prior to administ medications to treat anxiety care plan has been updated nonpharmacological interve- target behaviors related to antianxiety medications as insomnia. The resident's slip patterns are monitored on a and the effectiveness of the to promote sleep will be ass registered nurse. During the next visit, documentation ad anxiety symptoms, insomni justification of the order cha to routine use of lorazepam requested. The physician we contacted if the resident's r management of depressed or insomnia is ineffective. Resident number 45 – A be sheet to monitor mood sym to the diagnoses of major of disorder has been implement results will be reviewed by t interdisciplinary team during	y and pain. The d to address entions and use of well as eep/wake a routine basis e interventions sessed by a e physician's ddressing ia, and ange from PRN n will be will be nedical mood, anxiety ehavior tracking optoms related lepressive ented. The the	
	R75 had received C no documentation of interventions attem Oxycodone being a R75 had received T 2/29/16 with no doc non-pharmacologic	Dxycodone PRN 34 times, with of non-pharmacological pted prior to the PRN dministered. Tramadol PRN one time on		care conferences and more indicated. The physician wi if there is an increase in syn depressed mood. The social complete a depression scree questionnaire every 90 day significant change in condit plan will be reviewed and re- necessary.	e frequently if Il be contacted mptoms of al worker will een s and with a ion. The care	
	Review of the Janu	ary 2016 MAR, from 16 to 1/31/16, and progress		Resident number 34 – The admitted July 21, 2015 with diagnoses of schizoaffectiv the physician noting that sh	a primary e disorder with	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		00650	B. WING		03/1	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
		220 THIRE	STREET N	NORTHWEST		
PRAIRIE	MANOR CARE CENT	BLOOMIN	G PRAIRIE	, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLET DATE
01500			01500	DEFICIENCY)		
21530	Continued From pa	ige 47	21530			
	documentation of n interventions attem being administered R75 had received C no documentation of interventions attem Oxycodone being a R75's care plan, pri following: Antidepressant and related to diagnosis with interventions o MD's (medical doct effectiveness and a nursing if noted. Ma routinely by pharma physician and beha Appropriate change Monitor mood/beha Physician to review visits for appropriat changes. Refer to F Procedure. Resident is at risk f	Dxycodone PRN 27 times, with of non-pharmacological pted prior to the PRN administered. int date 3/11/16, identified the d antianxiety medication use s of depression and anxiety of administer medication per cor's) order. Monitor for adverse reactions and report to edication to be reviewed acist consultant, primary twoir management nurse. es to be made as needed. avior and report to Nurse. medication with certification eness and possible dose Psychotropic Drug Policy and for pain related to sacroiliac		on her current psychotropic behavior tracking sheet to m symptoms and target behav determine the effectiveness antipsychotic, antianxiety, an and mood stabilizer medicati implemented. Nonpharmacc interventions to be implement administration of PRN (as m medications are addressed care. The nursing staff has h of the need to attempt nonpharmacological interven control and to document the attempted and the resident's During the consultant pharm monthly medication audits a quarterly care planning proc residents' medication regime continue to be reviewed to a medications used to manag mood symptoms, insomnia a appropriately justified and m Compliance will be further m the Director of Nurses/desig audit of the records of reside antipsychotic, antianxiety, an	nonitor mood iors to of the ntidepressant tions has been blogical nted prior to eeded) pain in the plan of been informed ntions for pain interventions a response. nacist's nd the ess, the en will assure that e behaviors, and pain are ionitored by nee by 1) an ents receiving nd	
	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.			antidepressant medications target behaviors/mood symp identified, monitored, and re interventions are documented of the records of residents re pain medications and sedati nonpharmacological interven monitoring of their effectiver included in the plan of care a appropriately documented a audit of residents receiving hypnotics/sedatives to ensur	to ensure that otoms are lated ed 2) an audit ecciving PRN ves to ensure ntions and ness is and nd 3) a record	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00650	B. WING		03/	11/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	IFR	D STREET N NG PRAIRIE,	IORTHWEST , MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	ige 48	21530			
	registered nurse be admitted on 1/19/10 pain and primary di admission resident Ativan 0.5 mg every additional 0.25 mg scheduled HS dose Insomnia, and Venl for Anxiety. Resider on 1/26/16. She ca continue scheduled as needed. No note medications. Prima pharmacist routinel continue with curre for medication char The behavior note, other documents pri identified resident s	a note, dated 2/8/16, identified: se behavior note: Resident was 19/16 with complaints of right leg rry diagnosis of sacroiliacs. During dent noted to have orders for every hour of sleep (HS) with mg PRN 30 minutes after dose if needed for Anxiety and Venlafaxine 75 mg capsule daily sident saw her primary physician e came back with orders stating to duled Ativan as is and PRN Ativan noted adverse reaction from rimary physician and consulting tinely review medications. Will current regimen and will contact MD changes as needed.		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.		
	affective to relieve ' R75's physician orc Lorazepam (antian: (milligrams) one ta tablet in 30 minutes and not able to slee	"anxiety." ders, dated 2/25/16, included xiety) tablet 0.5 mg blet at HS may repeat one half s if still having anxiety issues				
	dated 1/19/16 throu monitored hours of 9:00 a.m. daily.	ugh 3/9/16. The sleep tracking sleep from 6:00 p.m. through edical record lacked a				
	comprehensive sleet the sleep monitorin	ep assessment and analysis of g for the use of the Ativan. In e plan failed to address	:			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00650	B. WING		03/11/2016		
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
PRAIRIE	MANOR CARE CEN	IFR	ND STREET NO NG PRAIRIE, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21530	Continued From pa	age 49	21530				
	PRN one time daily physician order on change the Ativan an extra one-half ta needed for sleep. I identified a physicia one capsule once anxiety disorder, w since admission. R75's physician no R75 had Ativan at be scheduled dose often forgets to asl and there is a little physician progress symptoms and inse	0.5 mg, take one to two tablets y at HS for symptoms. A 1/26/16, identified an order to to 0.5 mg every HS, may give ablet PRN after 30 minutes if n addition, R75's record an order for Venlafaxine 75 mg a day related to generalized hich R75 had been receiving te, dated 1/26/16, indicated bedtime. They asked the Ativar e vs. as needed due to her s note failed to address anxiety omnia needs and lacked on for the increased es.					
	(RN)-A stated we c insomnia, but we h assessment for sle plan failed to include interventions for th medications. RN-A include documenta interventions being R75's record failed R75 had for the us medications. RN-A changed to schedu what the "family" re had taken the med in regards to how t	B1 p.m., registered nurse do sleep tracking for R75's have not completed an eep. RN-A verified R75's care de non-pharmalogical e PRN pain and antianxiety a verified R75's record failed to ation of non-pharmalogical offered prior to the PRN administered. RN-A verified to include specific symptoms e of the antianxiety a stated R75's Ativan was alled doses because that is equested and was how R75 lication at home. RN-A stated he facilities system for and behaviors, the nursing					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00650	B. WING		03/	11/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	IFR	D STREET NO			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
21530 Continued From page 50		age 50	21530			
	assistants report to the nurse and then the nurse documents the mood and behaviors.					
	(DON) stated they sheets with the phy sleep tracking shee sleep note. The DO non-pharmalogical plan and normally y giving the PRN me have not done spea antidepressant and before. The DON s R75's Ativan was c scheduled daily do stated she would h medication being c evidence and to be requesting the cha enough reason for	, i i i i i i i i i i i i i i i i i i i				
	would expect the p	2 a.m., the DON stated she hysician to document use of any medications				
	includes psychoad 3/28/14, indicated I Center (PMCC) as regime is free from Resident's receivin monitored for: exce duration, adequate	tropic Drug Use Policy which tive medication use, dated Purpose: Prairie Manor Care sures that each resident's drug unnecessary drugs. Ig psychotropic medication are essive doses, excessive indications, presence of				
	accordance with Fe policy of PMCC to experiencing behavior	ts, and target behaviors in ederal Tag 329. Policy: it is the monitor all resident's vioral symptoms and that are ic medications (or any other				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		03/	11/2016
		220 THIE	RD STREET NO			
PRAIRIE	MANOR CARE CEN	IFR	NG PRAIRIE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 51	21530			
	management of me Psychotropic Beha Nurses/Nurse Man medication change initiations/discontin reductions/increase psychotropic chron 3. Resident's starte medication will be to communications fo weeks for target be or decreased or the charting will be trig four weeks, then cl a RN Behavior Not disruption care plan residents with orde medications (Ambi Non-pharmalogical included. Sleep tra routine certification A psychotropic care residents with orde antianxiety medica Celexa, Zoloft). interventions will be orders for PRN ant hypnotic will be ass Administration wor medication and effe after given.	gers will track all psychotropic es, medication nuations and dose es on resident's individual nological along with indications. ed on any psychotropic	l I I			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00650	B. WING		03/	11/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	IFR	RD STREET NO ING PRAIRIE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 52	21530			
		ed interventions for pain as alogical interventions for pain.				
		BEHAVIOR MONITORING TO GOING USE OF AN T:				
	major depressive d orders signed 2/23	ecord revealed a diagnosis of lisorder. Current physician /16 included an order for essant)15 milligrams at				
	record, treatment a	edication administration Idministration record, care notes failed to identify mood ession.				
	was interviewed for really anything we thing is when she w would get moody.	a.m. nursing assistant (NA)-D r R45's mood symptoms, "Not track for her [R45]. The only vas on a walking program she She will make facial t really think she is moody."				
	SYMPTOMS TO D IS AFFECTIVE; AL NON-PHARMACO FOR CONTROL PA	YING MOOD/DEPRESSION ETERMINE IF MEDICATION SO LACK OF USE OF LOGICAL INTERVENTIONS AIN WERE USED BEFORE MEDICATION IS GIVEN:				
	included the orders (anti-anxiety medic Risperdal 4 mg (an tablets at bedtime, stabilizer) twice dat	ician orders signed 2/9/16 s; buspirone tablet 30 mg ation) 1 tablet twice daily, ti-psychotic medication) 2 Topamax 50 mg (mood ly, and fluoxetine 60 mg edication) daily for a primary				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	IFR	D STREET NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
21530	Continued From pa	age 53	21530			
	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.					
	record, treatment a plan, and progress symptoms or targe antipsychotic, antic were affective. Also found or provided b	edication administration administration record, care notes failed to identify mood t behaviors to determine if the depressant and analgesics to there was no documentation by facility in regards to the use cal interventions prior to the bain medication.				
	R34's mood sympt "She doesn't like to She isn't on a walk would trigger her. S nursing assistants. She says stuff and	a.m. NA-D was interviewed for oms and target behaviors; walk, that kind of targets her. ing program now cause it She doesn't care for different She swears, she refuses stuff. then she will say she is just ay stuff to try to hurt your				
	week we were disc form of daily trackin is one of those that behaviors]. I guess some staff. I am ha [electronic medical how to do behavior anything in place for monitoring. If they changes the nurse	a.m. the DON stated, "Last sussing how we don't have a ng [for mood/behavior]. [R34] t doesn't really have any [target s sometimes she doesn't like aving someone from point click record] come in and show us r tracking. We don't have or the anti-depressant mood start a new one or the dose s would chart on mood, they				
	On 3/11/16 at 10:2 care plan has non-	weeks, but nothing ongoing." 1 a.m. the DON added, "The pharmacological interventions ink they [nursing] document				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00650	B. WING		03/	11/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	I F B	ND STREET NO NG PRAIRIE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 54	21530			
	what they tried."					
	pharmacist stated, mood symptoms and should be tried price as needed pain me					
		nood monitoring, target g was requested but was not				
	The Director of Nur develop, review, ar procedures to ensu- monitors and repor medications. The E could educate all a and procedures. The	THOD OF CORRECTION: rsing or designee could ad/or revise policies and ure the consultant pharmacist ts irregularities in resident's Director of Nursing or designee ppropriate staff on the policies ne Director of Nursing or velop monitoring systems to mpliance.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Gene	Subp.1 ABCD Unnecessary ral	21535			4/19/16
	must be free from a unnecessary drug i A. in excessive therapy; B. for excessive C. without ade D. in the prese	al. A resident's drug regimen unnecessary drugs. An s any drug when used: e dose, including duplicate drug re duration; quate indications for its use; or nce of adverse consequences dose should be reduced or				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		00650	B. WING		03/11/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	FR	D STREET N IG PRAIRIE,	IORTHWEST MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
21535	part 4658.1310, th with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Finand This standard is ind available through th system and the Sta subject to frequent This MN Requirem by: Based upon intervit facility failed to ider and behavior symp non-pharmacologic pain and antianxiet analysis of sleep to and failed to ensure use of psychotropic residents (R75); fai mood and behavior an antianxiety med	rug regimen review required in e nursing home must comply ne Interpretive Guidelines for egulations, title 42, section Appendix P of the State , Guidance to Surveyors for acilities, published by the Ith and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan te Law Library. It is not		The goal of Prairie Manor Care C to maintain the resident's highest practicable level of functioning ar prevent or minimize adverse consequences related to medicat therapy. The drug regimen of eac resident is reviewed at least once by a licensed pharmacist. The ph reports irregularities to the attend physician and the director of nurs these reports are acted upon.	ion ch a month armacist ing	
	symptoms to detern antidepressant med	mine effectiveness of and dication for for 2 of 5 residents preceived daily dose of an		The Director of Nursing and Cons Pharmacist have reviewed the fa procedures for identifying and tra target behaviors and mood symp related to psychotropic medicatio	cility's cking toms	
	R75 had diagnoses in right leg. R75's 3	ecord, dated 3/11/16, revealed of chronic pain, anxiety, pain 0 day Minimum Data) dated 2/16/16, identified R75		documenting nonpharmacologica interventions provided/offered to pain and anxiety, completing slee assessments and analyzing slee monitoring data, and ensuring ph justification for use of psychotrop	ll manage p o ysician	

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00650	B. WING		03/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	FR		NORTHWEST , MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLET DATE
21535	Continued From pa	ge 56	21535			
	was cognitively inta mood of feeling tire pain which had mad frequency of pain d as needed (PRN) p received non-medic and had received a medications. R75's physician ord the following orders Lorazepam (antians (milligrams) - one ta repeat one half tabl anxiety issues and Venlafaxine (antide once a day related disorder. Tramadol (analgesi six hours as needed	ct, had no behaviors, had d or having little energy, had de it hard to sleep at night, aily, received scheduled and ain medications, had not cation interventions for pain ntidepressant and antianxiety lers dated 2/25/16, included s: xiety) tablet 0.5 mg ablet at HS (bedtime), may et in 30 minutes if still having not able to sleep. pressant) 75 mg - one capsule to generalized anxiety c) 50 mg - two tablets every d for pain.		medications. The pharmacist wito review records on a monthly routinely check for appropriate documentation related to the abissues. During the mandatory meetings 14 and 15, 2016, the licensed n will be instructed on 1) the new documentation procedures for t behaviors and behavior related interventions 2) the importance attempting nonpharmacological interventions prior to administra PRN psychotropic and analgesi ensuring the care plan addresse behaviors and nonpharmacolog interventions to manage mood s anxiety, and pain and 4) the new assessment that analyzes the s monitoring data. The direct care observant for behaviors/moods	basis and ove on April ursing staff arget of tion of cs 3) es target ical symptoms, ed for an leep e staff will of being symptoms	
	 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 Ativan being administered. 			and reporting them to the charg Resident number 75 – The nurs been reminded to document nonpharmacological intervention attempted prior to administration medications to treat anxiety and care plan has been updated to a nonpharmacological intervention target behaviors related to use of antianxiety medications as well insomnia. The resident's sleep/ patterns are monitored on a rou and the effectiveness of the inter to promote sleep will be assess registered nurse. During the phy next visit, documentation addres	tes have ns that are n of PRN I pain. The address ns and of as wake tine basis erventions ed by a ysician's	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP		
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NAME OF F	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE			
PRAIRIE	MANOR CARE CENT	IFR	ND STREET N	NORTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLE DATE	
21535	Continued From pa	ige 57	21535				
	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:			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.			
	2/11/16, with no do non-pharmacologic	Ativan PRN one time on cumentation of al interventions attempted ivan being administered.		Resident number 45 – A beha sheet to monitor mood sympto to the diagnoses of major dep disorder has been implemente results will be reviewed by the	ms related essive		
	no documentation of	Dxycodone PRN 34 times, with of non-pharmacological pted prior to the PRN administered.		interdisciplinary team during the care conferences and more free indicated. The physician will be if there is an increase in symptotic depressed mood. The social w	equently if contacted coms of		
	R75 had received Tramadol PRN one tin 2/29/16 with no documentation of non-pharmacological interventions attem prior to the Tramadol being administered	cumentation of al interventions attempted		complete a depression screen questionnaire every 90 days a significant change in condition plan will be reviewed and revis necessary.	nd with a . The care		
	Review of the January 2016 MAR, from admission on 1/19/16 to 1/31/16, and progress notes showed the following:Resident num admitted July		Resident number 34 – The res admitted July 21, 2015 with a p diagnoses of schizoaffective d	orimary isorder with			
	documentation of n	Ativan PRN eight times with no ion-pharmacological pted prior to the PRN Ativan		the physician noting that she is on her current psychotropic me behavior tracking sheet to mor symptoms and target behavior determine the effectiveness of	edications. A hitor mood s to		
	no documentation of	Dxycodone PRN 27 times, with of non-pharmacological pted prior to the PRN administered.		antipsychotic, antianxiety, antia and mood stabilizer medication implemented. Nonpharmacolo interventions to be implemented administration of PRN (as nee	depressant ns has been gical ed prior to		
	following:	int date 3/11/16, identified the I antianxiety medication use		medications are addressed in care. The nursing staff has be of the need to attempt	the plan of		

Iinnesota Depar TATEMENT OF DEFIN ND PLAN OF CORRE	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00650	B. WING		03/1	1/2016
AME OF PROVIDER	OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
RAIRIE MANOR	CARE CEN	IFR	RD STREET N NG PRAIRIE,	IORTHWEST MN 55917		
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21535 Continu	ed From pa	age 58	21535			
related with international MD's (n effective nursing routinel physicia Approprise Monitor Physicia visits fo change Procedu Resider joint dys osteoar pain me effective physicia pain. M signs of guardin quarterl address either th R75's p register admitte pain an admissi Ativan 0 addition schedul Insomn for Anxi on 1/26	to diagnosis erventions of nedical doci- eness and a if noted. May y by pharma in and beha- iate change mood/beha an to review r appropriat s. Refer to l ure. It is at risk f function, sp thritis with i edication as eness. Rep- thritis with i discomfort g, increase y and prn. H and prn. H and primary d on resident 0.5 mg ever al 0.25 mg ed HS dose ia, and Ven ety. Reside (16. She ca	s of depression and anxiety of administer medication per tor's) order. Monitor for adverse reactions and report to edication to be reviewed acist consultant, primary avior management nurse. es to be made as needed. avior and report to Nurse. w medication with certification teness and possible dose Psychotropic Drug Policy and for pain related to sacroiliac pinal stenosis and nterventions of: administer per MD orders and note the ort any unresolved pain to uge resident to verbalize any eport any noted non-verbal t, i.e., facial grimacing, agitation. Pain assessment However, the care plan had not armacological interventions for	t	nonpharmacological inter control and to document to attempted and the resider During the consultant pha monthly medication audits quarterly care planning pr residents' medication reg continue to be reviewed to medications used to man mood symptoms, insomn appropriately justified and Compliance will be furthe the Director of Nurses/de audit of the records of resi antipsychotic, antianxiety, antidepressant medication target behaviors/mood sy identified, monitored, and interventions are docume of the records of residents pain medications and sec nonpharmacological inter monitoring of their effective included in the plan of car appropriately documented audit of residents receiving hypnotics/sedatives to en assessments have been of noncompliance will be review quarterly Quality Assurant Assessment Committee r ongoing.	the interventions nt's response. Armacist's s and the rocess, the imen will o assure that age behaviors, ia and pain are f monitored by signee by 1) an sidents receiving , and ns to ensure that mptoms are related nted 2) an audit s receiving PRN latives to ensure ventions and veness is re and d and 3) a record ig sure sleep completed. If additional will be done. ved at the April ce and	

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	IFR	D STREET NO NG PRAIRIE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE ⁻ DATE
21535	Continued From pa	age 59	21535			
		ly review medications. Will ent regimen and will contact MD nges as needed.				
	other documents p identified resident s determine if the Ati affective to relieve R75's physician or Lorazepam (antian (milligrams) one ta	ders, dated 2/25/16, included xiety) tablet 0.5 mg ablet at HS may repeat one hal s if still having anxiety issues				
	dated 1/19/16 throu	fied sleep tracking sheets ugh 3/9/16. The sleep tracking sleep from 6:00 p.m. through				
	comprehensive sle the sleep monitorin	edical record lacked a ep assessment and analysis o ng for the use of the Ativan. In e plan failed to address	f			
	an order for Ativan PRN one time daily physician order on change the Ativan an extra one-half ta needed for sleep. I identified a physicia one capsule once a	ders dated 1/19/16, identified 0.5 mg, take one to two tablets y at HS for symptoms. A 1/26/16, identified an order to to 0.5 mg every HS, may give ablet PRN after 30 minutes if n addition, R75's record an order for Venlafaxine 75 mg a day related to generalized hich R75 had been receiving				
		te, dated 1/26/16, indicated bedtime. They asked the Ativar				

-	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	IFR	ID STREET NO NG PRAIRIE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 60	21535			
	often forgets to ask and there is a little physician progress symptoms and inso	e vs. as needed due to her k for it appropriately at bedtime language barrier. However, the note failed to address anxiety omnia needs and lacked on for the increased es.				
	(RN)-A stated we consort insomnia, but we hassessment for sleeplan failed to include interventions for the medications. RN-A include documentar interventions being R75's record failed R75 had for the us medications. RN-A changed to schedu what the "family" rehad taken the medi in regards to how to monitoring moods	31 p.m., registered nurse do sleep tracking for R75's have not completed an eep. RN-A verified R75's care de non-pharmalogical e PRN pain and antianxiety a verified R75's record failed to ation of non-pharmalogical g offered prior to the PRN administered. RN-A verified to include specific symptoms e of the antianxiety a stated R75's Ativan was uled doses because that is equested and was how R75 lication at home. RN-A stated he facilities system for and behaviors, the nursing o the nurse and then the nurse ood and behaviors.				
	(DON) stated they sheets with the phy sleep tracking shee sleep note. The DC non-pharmalogical	D p.m., the director of nursing do review the sleep tracking ysician. I would expect the ets to be addressed in the DN stated normally the interventions are on the care you would try those before				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	OF CONTLETION	IDENTIFICATION NOWIDEN.	A. BUILDING: _		COM	
		00650	B. WING		03/	11/2016
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
PRAIRIE	MANOR CARE CEN	IEB	ND STREET NO NG PRAIRIE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 61	21535			
	scheduled daily do stated she would h medication being o evidence and to b requesting the cha enough reason for On 3/11/16, at 9:52 would expect the p justification for the ordered. The facility Psychoo includes psychoac 3/28/14, indicated	2 a.m., the DON stated she hysician to document use of any medications tropic Drug Use Policy which tive medication use, dated Purpose: Prairie Manor Care				
	regime is free from Resident's receivin monitored for: exce duration, adequate adverse side effect accordance with For policy of PMCC to experiencing behat tacking psychotrop drugs outside of th	sures that each resident's drug a unnecessary drugs. Ing psychotropic medication are essive doses, excessive a indications, presence of ts, and target behaviors in ederal Tag 329. Policy: it is the monitor all resident's vioral symptoms and that are pic medications (or any other eir intended use) for				
	Psychotropic Beha Nurses/Nurse Man medication change initiations/discontin reductions/increase psychotropic chron 3. Resident's starte	ngers will track all psychotropic es, medication nuations and dose es on resident's individual nological along with indications. ed on any psychotropic				
nnesota D	weeks for target be or decreased or the	riggered under or daily charting times four ehaviors, or if dose is increased e medication is discontinued, gered for daily charting times	8			

STATEMEN AND PLAN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY
NAME OF					COMPLETED
NAME OF		00650	B. WING		03/11/2016
	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
PRAIRIE	MANOR CARE CEN	IFR	D STREET N IG PRAIRIE,	ORTHWEST MN 55917	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
21535		-	21535		
	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.				
	after given. The facility Pain Management Policy, date 4/9/14, indicated Purpose: it is the policy PMCC to ensure residents experiencing p have a comprehensive assessment of the and will have established plan to treat tha Procedure: each resident will have pain addressed on their care plan. Care plans include individualized interventions for pa well as non-pharmalogical interventions for	urpose: it is the policy of esidents experiencing pain will sive assessment of that pain olished plan to treat that pain. esident will have pain care plan. Care plans will ed interventions for pain as alogical interventions for pain.			
		BEHAVIOR MONITORING TO GOING USE OF AN IT:			
	major depressive of orders signed 2/23	ecord revealed a diagnosis of disorder. Current physician /16 included an order for ressant)15 milligrams at			
lippessts D		edication administration			
TATE FOR	epartment of Health M		⁶⁸⁹⁹ J	KSG11	If continuation sheet 63 of 7

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00650			03/11/2016	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	IFR	D STREET NO NG PRAIRIE, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	age 63	21535			
		administration record, care notes failed to identify mood ression.				
	was interviewed fo really anything we thing is when she would get moody.	a.m. nursing assistant (NA)-D r R45's mood symptoms, "Not track for her [R45]. The only was on a walking program she She will make facial 't really think she is moody."				
	SYMPTOMS TO D IS AFFECTIVE; AL NON-PHARMACO FOR CONTROL P	FYING MOOD/DEPRESSION DETERMINE IF MEDICATION SO LACK OF USE OF DLOGICAL INTERVENTIONS AIN WERE USED BEFORE I MEDICATION IS GIVEN:				
	included the orders (anti-anxiety medic Risperdal 4 mg (ar tablets at bedtime, stabilizer) twice da (anti-depressant m diagnosis of schize Acetaminophen 50 for break through p	00 mg 2 tablets daily as needed pain and Tramadol 50 mg edication) 1 tablet as needed				
	record, treatment a plan, and progress symptoms or targe antipsychotic, antic were affective. Also found or provided I	edication administration administration record, care notes failed to identify mood to behaviors to determine if the depressant and analgesics to there was no documentation by facility in regards to the use cal interventions prior to the bain medication.				

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	00650	B. WING		03/	11/2016
AME OF PROVIDER OR SUPPLIE	R STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
RAIRIE MANOR CARE CEI		ND STREET NO			
	BLOOMI	NG PRAIRIE, N			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL I LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535 Continued From p	bage 64	21535			
R34's mood symp "She doesn't like She isn't on a wal would trigger her. nursing assistants She says stuff and	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."				
week we were dis form of daily track is one of those the behaviors]. I gues some staff. I am h [electronic medica how to do behavio anything in place monitoring. If they changes the nurs would do it for fou On 3/11/16 at 10:: care plan has nor	a.m. the DON stated, "Last acussing how we don't have a king [for mood/behavior]. [R34] at doesn't really have any [target as sometimes she doesn't like having someone from point click al record] come in and show us for tracking. We don't have for the anti-depressant mood v start a new one or the dose es would chart on mood, they in weeks, but nothing ongoing." 21 a.m. the DON added, "The n-pharmacological interventions hink they [nursing] document				
pharmacist stated mood symptoms	04 a.m. the facility consultant I, They should have identified and non-pharmacological ior to the administration of an nedication.				
	mood monitoring, target ng was requested but was not				
SUGGESTED ME	ETHOD OF CORRECTION: The				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED
		00650	B. WING	03/	11/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
PRAIRIE	MANOR CARE CEN	IFR	ID STREET I NG PRAIRIE	NORTHWEST , MN 55917	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
21535	Continued From pa	age 65	21535		
		e for medication use on the equirements as written under			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One			
21665	MN Rule 4658.140	0 Physical Environment	21665		4/19/16
	functional, comforta environment, allow	ust provide a safe, clean, able, and homelike physical ing the resident to use is to the extent possible.			
	by: Based on observat review the facility fa within reach for 1 of during stage one. Findings include: R27 was observed sitting in a wheelch was clipped up high R27's room, out of On 3/8/16 at 2:54 p sitting in a recliner laid on top of R27's for R27 use. On 3/8/16, at 3:05	ent is not met as evidenced ion, interview and record ailed to ensure a call light was of 30 residents (R27), observed on 3/7/16, at 6:44 p.m. to be lair in his room. R27's call light h on the privacy curtain in reach for R27. o.m., R27 was observed to be in his room R27's call light was s bed, again fully out of reach p.m., nursing assistant (NA)-A ight was on R27's bed and not		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	
		7. int date 3/11/16, identified the requires assistance with		significant change in the residents behavior, physical condition, and/or mental function. The facility's policies and procedures instruct to provide a means for	r

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00650	B. WING		03/1 ⁻	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT			NORTHWEST , MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLET DATE
21665		21665	the resident to call for assistance a time. During the mandatory meetings Ap and 15, 2016, the nursing staff will reminded to ensure that residents I call light within reach before they le room, including resident number 27 The Director of Nurses/designee w conduct random observations of th resident rooms for two weeks to en that each resident has a call light w reach. If noncompliance is noted, additional monitoring and staff educ will be done. Compliance will be re- at the April Quality Assurance and Assessment Committee quarterly r	ril 14, be nave a ave the 7. ill e isure <i>r</i> ithin cation viewed		
within reach light. SUGGESTI Administrat in-service s provide call TIME PERI (21) days. 21850 MN St. Stat Residents c Subd. 14. Residents s defined in tl "Maltreatme section 626	SUGGESTED MET Administrator or Di in-service staff resp provide call light for TIME PERIOD FOI (21) days. MN St. Statute 144 Residents of HC Fa Subd. 14. Freed Residents shall be defined in the Vulne "Maltreatment" mea section 626.5572, s	THOD OF CORRECTION: rector of Nursing could consible for cares to always r resident use if needed. R CORRECTION: Twenty-one .651 Subd. 14 Patients & ac.Bill of Rights om from maltreatment. free from maltreatment as erable Adults Protection Act. ans conduct described in subdivision 15, or the -therapeutic infliction of	21850			4/19/16

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00650	B. WING		03/11/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
		220 THIR		ORTHWEST		
PRAIRIE	MANOR CARE CENT	BLOOMI	NG PRAIRIE	, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21850	Continued From pa	ge 67	21850			
	conduct intended to distress. Every res non-therapeutic che except in fully docu authorized in writing resident's physician period of time, and	ary, or any persistent course of p produce mental or emotional ident shall also be free from emical and physical restraints, mented emergencies, or as g after examination by a n for a specified and limited only when necessary to t from self-injury or injury to				
	by: Based on interview facility failed to con	ent is not met as evidenced and document review, the duct an investigation of an atment/abuse for 1 of 17 iewed for abuse.		Prairie Manor Care Center knowingly employ individua been found guilty of abusir or mistreating residents. A actions against an employ indicate unfitness for servi	als who have ng, neglecting, ny knowledge of ee which would ce in a resident	
	10:22 a.m., R39 wa	erview with R39 on 3/8/16 at as asked whether he'd ever dent abused by staff. R39		care position is investigate to the State nurse aid regis authorities.		
	stated, "There is or had this one girl, I t stated the "guy" res then stated the girl an outsider. He way still residing here. H here. She still work about it. Well, she n somewhere else. V she still goes down A social services (S	he guy that stayed here and he hink he got her pregnant." R39 sided at the facility [R18]. R39 worked at the facility, "He was s here for a short time. He is the got an employee pregnant s here. I told a nurse's aide moved him down the hallway Vell, that didn't help any and to him."		The facility's policies and p investigation/reporting of ir reviewed and found approp Manor Care Center policy alleged violations involving mistreatment, neglect, abu unknown source and misa property be 1) reported imp administrator and appropri agencies and 2) thoroughly a timely manner with the ir results reported to the adm	ncidents were priate. Prairie requires that all resident use, injuries of ppropriation of mediately to the ate state y investigated in nvestigative ninistrative staff	
	the group [at a care an incident that hap He said that [R18]	s reported by R39; "[R39] told conference meeting] about open [sic] out in the day room. was out there and there was 2 Is walked over and sat on his		and state officials as require alleged violation is verified corrective action will be tak intervenes to prevent furth abuse while the investigati	, appropriate ken. The facility er potential	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00650	B. WING		03/1	1/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	IFR		NORTHWEST , MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE
21850	Continued From pa	age 68	21850			
	He said the other g girl ran off and that chuckled when he said he was sure h on him because he [R39] had brought Can [sic] tell this in has before accuse having sex. [R39] h [care conference]. invite [R39] and his they will attend and SS-A was interview SS-A stated she ha about the allegation SS-A stated she regarding the episc 1/7/16 except for th documented in the whether she had re administrator, Offic (OHFC), or whethe investigation, SS-A The director of nurs 3/8/16 at 4:06 p.m. whether or not the R39 (regarding R18 accordance with fa they hadn't determine	verified she hadn't. sing (DON) was interviewed on , and questioned about allegation reported 1/7/16 by 8) had been reported in cility policy. The DON stated ined R39's report from 1/7/16		On April 12 and 14, 2016 all Pra Care Center staff will be instruct following: 1) the definition of a via adult 2) who is a mandated report actual or suspected resident abuse/neglect/misappropriation property 3) the types of incidents be reported to the common entri- and/or the Minnesota Departme Health 4) the requirements of im- reporting of alleged abuse/negled misappropriation of funds to the supervisory/administrative staff appropriate governmental agence forms and procedures for appro- timely reporting. The staff is edu- vulnerable adult issues at least e- twelve months; vulnerable adult investigation and reporting are a during new employee orientation At the time Resident Number 39 that there were girls sitting on th Resident Number 18 in the day common area frequently occupied other residents and visitors), the worker assessed the situation and determined there was no abuse Resident Number 18. Resident I 39 had previously accused the si- other residents of sexual behavi- since there was no additional ev- that this incident had occurred a	ed on the ulnerable rter of of s that must y point nt of mediate ct and cated on every ddressed n. alleged e lap of room (a ed by social nd to Number taff and ors, and idence s	
	whether or not the R39 (regarding R18 accordance with fa they hadn't determine to be a reportable of report now. When interviewed of services (SS)-A sta	allegation reported 1/7/16 by 8) had been reported in cility policy. The DON stated		39 had previously accused the s other residents of sexual behavi since there was no additional ev	taff and ors, and idence s allegation to the nts le state the	

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00650	B. WING		03/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		220 THIR	D STREET N	IORTHWEST		
FNAINIL		BLOOMIN	IG PRAIRIE	, MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
21850	Continued From pa	age 69	21850			
	never seen them be When interviewed of administrator, DON administrator states decisions and state girls were, they cou- have been his gran know?" When interviewed of administrator states sexual abuse for R thoroughly investig- there was nothing i regarding R39's all inappropriate beha administrator states	on 3/8/16 at 6:13 p.m. the I, SS-A were present when the d that R18 could make his own ed, "Who knows who those ild have been anyoneit could iddaughters, how do we on 3/9/16 at 9:18 a.m., the d the allegation of potential 18 should have been more ated. However, he reiterated n the SS progress note 1/7/16 egation that indicated any vior had taken place. The d since there was nothing or, they hadn't thought the		abuse. The federal auditor did the state surveyor's request to vulnerable adult report and ins lead state surveyor to "take thi your team for another review." 9, 2016 OHFC response indica further action was needed by t During the Social Worker's Ma interview with Resident Number regarding possible sexual mist he denied being mistreated by others. He stated that he "has treated find here and is very sa The care plan for Resident Nu- was updated to address the re regular habit of making unsubs allegations about other resider abused by the staff. Allegations Resident Number 39 will contin- investigated to ensure that no being mistreated.	file a tructed the s back to The March ated that no heir office. urch 9, 2016 er 18 reatment, the staff or been atisfied here. mber 39 sident's stantiated tts being s by nue to be	
	that the facility did i the abuse allegatio on 1/7/16. The 3/9/ denied any sexual The Facility Abuse Policy/Procedure (* reports of suspected immediately accord Administrator is immediately accord Administrator			Compliance with the facility's v adult policies and procedures a regulatory requirements will be by both social workers for the r months. The social workers wi collaborate in the investigation alleged incidents that have a p of sexually-related resident abu incidents of alleged sexually inappropriateness will also be with the Administrator and/or D Nurses and an interdisciplinary will be made whether the incide reportable to the Office of Hea Complaints. Compliance will be during the April Quality Assurate Assessment Committee quarter and ongoing.	and related e monitored next three II of all ossible risk use. All discussed Director of <i>t</i> decision ent is Ith Facility e reviewed nce and	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY	
		00650	B. WING	0	03/11/2016	
AME OF F	PROVIDER OR SUPPLIER		DDRESS. CITY. S	TATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	
	MANOR CARE CEN	220 THIE	RD STREET N			
nainiL	MANON CANE CEN	BLOOMI	NG PRAIRIE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE ⁻ DATE	
21850	Continued From pa	age 70	21850			
	is true or false or no disprove through in involved partiesA or suspicion of sus immediately"	nplaint, determining whether it ot possible to substantiate or iterviews and examination with ny person with the knowledge pected violations shall report				
	administrator could requirements for re allegations of abus	in-service all staff on the porting and investigating e.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21855	MN St. Statute 144 Residents of HC Fa	.651 Subd. 15 Patients & ac.Bill of Rights	21855		4/19/16	
	residents shall have and privacy as it re personal care prog consultation, exam confidential and sh Privacy shall be residential bathing, and other	nent privacy. Patients and e the right to respectfulness lates to their medical and ram. Case discussion, ination, and treatment are all be conducted discreetly. spected during toileting, activities of personal hygiene, for patient or resident safety or				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and document ailed to provide privacy during esident's room to the shower dent (R79).		Prairie Manor Care Center staff respects the resident's right to personal privacy including accommodations, medical treatment, written and telephone communications, personal care, visits, a meetings with family and resident groups	nd	

Minnesota Department of Health STATE FORM

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00650	B. WING		03/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CENT	FR	D STREET I NG PRAIRIE	NORTHWEST , MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21855	Continued From pa	ige 71	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." 			The facility has policies and appropriately addressing the right to privacy and confident the April 14 and 15, 2015 m meeting, all staff were remines state and federal regulation policies addressing resident rights. The nurses and nurses were counseled regarding be to care delivery practices the compromise resident dignity supervisory nursing staff has instructed to be observant of privacy during cares/transport counsel with the direct care rights are compromised.	e residents' ntiality. During andatory nded of the s and facility ts' privacy sing assistants being sensitive at could y. The live been of resident ort and to staff if privacy	
	was interviewed via have bath blankets they are covered up [transporting R79] v are trying to order a it [bath blanket] tuck get as much covered	a.m. nursing assistant (NA)-F a telephone and stated, "We and we do have to make sure o as much as possible. That was a little more difficult, we a new shower chair. I can't get ked into the sides and I try to ed up as I can. I guess I could nd her top half around her		Procedures to assure respe- residents' privacy during pe- were reinforced (e.g., closin pulling divider curtains, cove- when in view from common knocking before entering, p personal cares/treatments of others). The residents' right confidentiality, and dignified included in the orientation the employees and is addressed annual mandatory in-service	rsonal cares ag doors, ering residents areas, roviding but of view of t to privacy, I treatment is raining for new d during the	
	(DON) stated, "You covered up. I would showing." The DON	B a.m. the director of nursing want them [residents] to be In't expect areas to be I verified R79's exposed sides In should have been covered		Compliance will be monitor Director of Nurses or her de Weekly tours of the nursing be made for six weeks, if privacy/confidentiality proble additional monitoring and si	ed by the esignee. care unit will ems are noted,	
		Bath, Shower dated 6/4/09, resident in shower chair and ate drape."		will be done. Compliance w monitored by the social serv through direct observation a interview. If noncompliance	vice staff and resident	

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00650	B. WING		03/11/2016	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE		
PRAIRIE	MANOR CARE CEN	IFR	NG PRAIRIE,	IORTHWEST MN 55917		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21855	Continued From pa	age 72	21855			
	director of nursing review and revise p to ensuring resider respect. The direct could develop a sy develop a monitori providing care in a manner.	THOD OF CORRECTION: The (DON) or designee could policies and procedures related its are treated with dignity and stor of nursing or designee istem to educate staff and ing system to ensure staff are dignified and respectful R CORRECTION: Twenty-one		additional staff counseling Compliance will be review April quarterly Quality Ass Assessment meeting.	ed during the	
			1	1		1