DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 21, 2022

Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, MN 55917

RE: CCN: 245482
Cycle Start Date: March 3, 2022

Dear Administrator:

On March 22, 2022, we notified you a remedy was imposed. On April 9, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 4, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 21, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 22, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 21, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 4, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

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Electronically delivered
April 21, 2022

CMS Certification Number (CCN): 245482

Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, MN 55917

Dear Administrator:

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 April 4, 2022 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
March 22, 2022

Administrator
Prairie Manor Care Center
220 Third Street Northwest
Blooming Prairie, MN 55917

RE: CCN: 245482
Cycle Start Date: March 3, 2022

Dear Administrator:

On March 3, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 21, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 21, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 21, 2022.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by April 21, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Prairie Manor Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 21, 2022. You will receive further information regarding this from the State agency. 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.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 3, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to

file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING _____ B. WING _____	C 03/03/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 02/28/22 through 03/03/22, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a communication plan, which included a method for sharing appropriate information from the emergency plan that the	E 035	The facility had Emergency preparedness plans printed off in labeled file holders all over on facility walls in public areas. In addition the facility floor plans are posted	3/25/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/25/2022

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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E 035	Continued From page 1 facility had determined was appropriate with residents, families or representatives. This had the potential to affect 30 residents currently residing in the facility, as well as staff and visitors. Findings include: On 3/2/22, at 2:00 p.m. the facility emergency policies and procedures were reviewed with the administrator and the head of maintenance. During the review it was revealed and verified the facility did not develop a communication plan, which included a method for sharing appropriate information from the emergency plan that the facility had determined was appropriate with residents, their families or representatives.	E 035	publicly, which shows all exits, fire extinguishers, and pull stations. The facility will add one more packet of our preparedness policy and procedures to the labeled file holder at the entrance. This file holder is used to communicate other required things to the public such as our smoking policy, and past survey results. To further communicate that this is here, other than having it publicly labeled by the front door, social services has added a paragraph to the resident admission packet referencing this file folder and the fact it contains our emergency procedures. Maintenance director will be responsible for updating the emergency plan and making sure all file folders have the most current one available. Administrator will check by the POC due date that the above has been done and will report this out at the next quarterly QAPI to the interdisciplinary team. Activities Director will let all current residents know at next resident council meeting that the resident agreement was altered to reference the file folder by the front door, and let all the residents know a copy of our emergency procedures is available to them at all times. Resident council minutes will be brought to the next quarterly QAPI meeting to be discussed by the interdisciplinary team.	
F 000	INITIAL COMMENTS	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 2 On 2/28/22 through 3/3/22, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5482041C/MN70235 H5482042C/MN78009 H5482043C/MN79148 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		3/25/22

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F 695	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, facility failed to follow their policy to maintain clean and sanitary oxygen tubing for 1 of 1 resident (R28) reviewed for respiratory care. Findings include: R28's admission Minimum Data Set (MDS) dated 2/15/22, included cognitively intact with diagnoses including cardiorespiratory debility and respiratory failure. R28 required extensive assistance with most activities of daily living (ADL's) and received oxygen therapy. R28's physician orders indicated R28 was to receive oxygen continuously at 3 lpm (liters per minute), and oxygen tubing should be changed every Friday by the night shift. R28's medication and treatment administration record (MAR/TAR) indicated nurses had signed R28's oxygen tubing had been changed by them on 2/11/22, 2/18/22 and 2/25/22. During observation on 2/28/22, at 1:54 p.m. R28's oxygen tubing had a label on it dated, "2/11." When interviewed on 3/1/22, at 2:09 p.m. nursing assistant (NA)-F looked at R28's oxygen tubing and stated the tubing had last been changed on 2/11/22. NA-F stated the nurses were responsible for changing the oxygen tubing, but she was aware it should be changed every week. When interviewed on 3/1/22, at 2:13 p.m. a licensed practical nurse (LPN)-D stated the oxygen tubing was changed by the night shift	F 695	Policies and procedures related to Oxygen use are to be reviewed and revised by DON or designee. If changes in the policy are made, a new copy will be given to all applicable nursing staff. If so, signatures will be obtained stating that applicable staff received the new policy and were given instructions on the facilities procedures for oxygen tubing. Regardless if the policy needs altered, DON or designee will ensure this does not happen to another resident by instructing all staff who are eligible to sign off on oxygen tasks within the MAR/TAR, that the date must be checked and accurate before signing off. Clarification will be given that any eligible staff member can put new tubing on and that no certain person or shift is solely responsible for our oxygen tubing cares. Immediate corrective action will be given to those that falsify a MAR/TAR treatment. DON or designee will audit the MAR/TAR and physical oxygen tubing's, weekly for 5 weeks. Results will be brought to the next quarterly QAPI meeting to be discussed with the interdisciplinary team.	

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F 695	Continued From page 4 nurses, and LPN-D was unsure of when it should be changed; however, LPN-D said the tubing had not been changed as indicated in the MAR/TAR. When interviewed on 3/1/22, at 2:19 p.m. LPN-A stated oxygen tubing should be changed weekly by the night shift and should have a date applied to the tubing indicating when it was last changed. When interviewed on 3/1/22, at 2:23 p.m. LPN-E stated oxygen tubing was changed every Friday and directions for this would be found on the MAR. LPN-E stated any nurse working on the day shift noting tubing had not been changed should change it. When interviewed on 3/1/22, at 2:50 p.m. the director of nursing (DON) stated the facility had an, "order set" that would flow to the MAR/TAR for oxygen tubing to be changed every Friday on night shift. DON stated an expectation for nurses to place a date on the tubing when it was changed, and to sign the MAR/TAR after this had been completed. DON stated both the extension tubing and the nasal cannula should be changed weekly, and stated a concern for the possibility of bacterial growth in the tubing that might cause resident infection. The facility provided a policy titled Oxygen Therapy dated 3/26/20 indicated, "Oxygen Supplies: DME providers recommend changing standard nasal cannula's and masks every week and oxygen tubing every month."	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information.	F 732		3/25/22

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F 732	Continued From page 5 §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to update the staff posting when	F 732	The public staffing sheet that we have been putting out, that was found to not	

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F 732	Continued From page 6 staffing changed. This had the potential to affect all 30 residents residing at the facility as well as family/visitors. Findings Include: Staff postings and schedules were reviewed from 1/1/22 to 3/3/22; no staff postings were updated when staffing changes occurred on the actual staffing. The Staffing posted 2/22/22, indicated for the night shift for registered nursing assistants (NA) 24 hours. The daily nursing attendance report indicated for the night shift, one NA called in and was not replaced. No changes had been made to reflect the actual hours worked on the Staff posting. The Staffing posted 2/28/22, indicated for the day shift nurse manger 8 hours and for registered nursing assistants (RNA) 32 hours. The daily nursing attendance report indicated for the day shift, one nurse manger called in and was not replaced. For the evening shift a RNA called in and the facility was able to cover all but four hours of the shift. No changes had been made to reflect the actual hours worked on the Staff posting. The Staffing posted 3/2/22, indicated for the evening shift RNA's 30 hours. The daily nursing attendance report indicated for the evening shift, three RNAs called in and the facility was able to replace 14 hours. No changes had been made to reflect the actual hours worked on the Staff posting. During an interview on 3/02/22, at 1:37 p.m.	F 732	have all staffing changes on it, will be overseen by the following. In order... Scheduler>DON>ADON>Nurse Managers>Charge nurse. At a minimum the facility will have a charge nurse 24 hours a day. This means there will always be someone held accountable for knowing about staffing changes and making the changes on the public staffing sheet. The person responsible for putting out the initial sheet and storing old copies is the DON or designee. DON or designee will monitor the sheet daily and indefinitely. If the DON while changing the sheet notices no changes were made in the last 24 hours, the scheduler will verify the sheet is accurate before its stored. DON will report out on 5 weeks of prior sheets during the next quarterly QAPI meeting.	

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F 732	Continued From page 7 licensed practical nurse (LPN)-C stated she was responsible for updating the staff posting and stated she only updated the census. LPN-C stated she did not update the staff posting when there were changes to the staff schedule. During an interview on 3/02/22, at 1:58 p.m. registered nurse (RN)-A verified the above information and indicated per the facility policy the staff posting should be updated to reflect the changes made to the hours worked with every staffing change. The Daily Census Sheet policy and procedure updated 3/28/2020 indicated, "Purpose: To maintain public access to posted information on current resident census and number of staff to providing care on each shift. The hours worked will be updated from the license nurse on duty with every staffing change. "	F 732		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		4/4/22

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F 880	Continued From page 8 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880		

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F 880	Continued From page 9 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the Center for Disease Control (CDC) guidance during a COVID-19 outbreak in the facility for 3 of 4 residents (R4, R9, And R23) who were positive for COVID-19 and doors to their rooms were left open, for 2 of 10 staff (NA-A and LA-A)observed to not wear an N95 respirator when entering COVID-19 positive resident rooms and 1 staff (LA)-A who did not remove gloves and wash hands while collecting dirty laundry between resident rooms. Findings include: CDC guidance titled Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection included: -Healthcare personnel (HCP) caring for residents with suspected or confirmed SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator). -Ideally, a resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending.	F 880	Facility Covid-19 policy has been altered by DON to remove left wing being the designated quarantine wing. it now states that... "the hall which positive residents are first noted on will be the quarantine wing. Wing doors will be kept shut and consistently staffed as able to minimize transmission to other halls. If positive residents are able to be transferred to another room and isolated from the rest of the hall/residents, this may be done to further mitigate risk of spread. Resident rooms door are to be kept shut unless residents safety is a concern due to cognition, frequent falls, etc. In this case the QAPI team will determine an alternate option." This updated policy will be given to and discussed with all department managers as it would be the facility leadership that sets in motion, and follows through on what the policy states. Nursing department staff will be reeducated on need to keep doors with droplet and modified droplet precautions shut unless	

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F 880	Continued From page 10 -In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2. This is especially important for residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care unit. However, in some circumstances (e.g., memory care units), keeping the door closed may pose resident safety risks and the door might need to remain open. If doors must remain open, work with facility engineers to implement strategies to minimize airflow into the hallway. COVID-19 is a respiratory disease caused by SARS-CoV-2, a coronavirus discovered in 2019. The virus spreads mainly from person to person through respiratory droplets produced when an infected person coughs, sneezes, or talks. Some people who are infected may not have symptoms. During the entrance conference on 2/28/22, at 12:51 p.m. the director of nursing (DON) stated there were three residents in isolation in the building for COVID-19 positive status, R4, R9, and R23. These individuals tested positive for COVID-19 on 2/21/22. R28 tested positive for COVID-19 on 3/1/22. A facility document titled Positive Residents - COVID19-Line List was initiated on October 2020 and indicated R4, R9, and R23 had tested positive for COVID-19 on 2/21/22. A facility document titled Positive Workers-COVID19-Line List beginning October 2020, indicated there were two positive staff in December 2021, 23 positive staff in January 2022, and 24 positive staff in February 2022.	F 880	there is a safety concern which must then be brought to the attention of IDT. Additionally, N95 masks will be required for direct care staff working with Covid positive and Covid rule out patients. No residents in the building currently have Covid-19 as of writing this on 03/25/22. Infection control policies and procedures regarding standard precautions do not need to be updated nor does additional training need to be done as requirements have been met. Rather Administrator will reinforce that all managers must hold employees accountable. 1 on 1 education will be given by the ADON or designee to those seen not abiding by proper infection control procedures, followed by corrective action for subsequent infractions. ADON or designee will do random weekly audits for 5 weeks on donning/doffing of ppe, quarantine room status, handwashing, and other applicable infection control things. These reports will come to the next quarterly QAPI meeting to be reviewed by the team.	

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A facility document titled Data from December 2021 for January QAPI Meeting indicated facility had one positive COVID-19 residents and two positive staff.

A facility document titled Data from January 2022 for February QAPI Meeting indicated facility had 20 COVID-19 positive staff.

A facility document titled Data from February 2022 for March QA Reporting indicated facility had 14 COVID-19 positive residents and 24 positive staff.

During observation on 2/28/22, at 3:09 p.m. R4, R9, and R23's rooms were located on center hall which was not an isolation unit. COVID-19 positive resident rooms were located next to and across from COVID-19 negative resident rooms.

During observation on 2/28/22, at 3:09 p.m. R4's room was wide open despite an isolation cart, and a posted sign indicating respiratory precautions and the door was to be closed. At 3:09 p.m. nursing assistant (NA)-A stated R4 had COVID-19 symptoms and was in isolation with results pending, but he was unsure when R4 had been tested. NA-A stated the door was open because the nurse forgot to shut it. NA-A was observed to enter R4's room wearing black surgical mask but did not gown or glove. NA-A informed R4 he was going to shut door due to COVID-19 positive status. NA-A exited room without performing hand hygiene or changing black surgical mask. At 3:15 p.m. the door to R4's room was observed open again and R4 was observed coughing next to open doorway.

During observation on 2/28/22, at 3:13 p.m. R23's

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room had an isolation cart, with a sign indicating respiratory precautions and the door should be shut. Another sign on the door included, "leave door open" and the door was several inches ajar.

During observation on 2/28/22, at 3:15 p.m. R9's room had an isolation cart outside the door with the door fully open. The sign on the door indicated enhanced respiratory precautions and door should be closed. NA-A stated they kept R9's door open "at times", stated it was "up to her as long as she stays in her room." NA-A stated R9 was not able to get up by herself and was a two person assist.

When interviewed on 2/28/22, at 3:23 p.m. DON stated her expectations for a resident in COVID-19 isolation was for staff to wear a gown, gloves and mask, "we strongly recommend a N95 and goggles or face shield." DON stated expectation for the resident's door to remain closed at all times, unless it was, "stuffy." DON stated they made recommendations based on Minnesota Department of Health and CDC guidelines.

When interviewed on 2/28/22, at 3:46 p.m. the administrator stated all staff should be wearing N-95 masks and isolation gowns in COVID-19 positive rooms.

During observation on 2/28/22, at 4:12 p.m. doors to the following residents in respiratory isolation were left open: R4, R9, R23.

During observation on 2/28/22, at 4:22 p.m. R4 was heard to be audibly coughing while seated in open doorway.

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When interviewed on 2/28/22, at 4:47 p.m. LPN-A stated full PPE should be worn in COVID-19 positive rooms which included gown, gloves, N95 mask, eyewear, and bins located inside resident rooms to doff PPE.

When interviewed on 2/28/22, at 4:54 p.m. LPN-B stated gown, gloves, eyewear, and N95 mask were to be worn for any COVID-19 positive rooms. Facility uses N95 mask up to 5 uses and that PPE is not interchangeable from one resident to the next.

When interviewed on 2/28/22, at 5:45 p.m. DON stated facility had not had an adequate supply of N95 masks, the facility just received another 500 N95 masks a week or two ago. The DON stated, "prior to this my best guesstimate was we had 50 N95 masks left." The DON stated, "we are considering contingency use as it took us a long while to get those 500 masks and maintenance is working on ordering more as they are able," but DON stated they had not reached out to the state for an emergency supply. The DON stated, "staff right now should be using an N95 for any COVID-19 positive resident or residents on precautions." The DON stated, "it was recommended, and we have given them the option to wear an N95 even if they have not been fit tested."

When interviewed on 3/2/22, at 2:21 p.m. Environmental Service Director (EVSD) stated he checked the PPE supplies daily, and had been comfortable with their level of supplies, including N95 masks in the first part of January. EVSD stated he was not aware of any shortage. EVSD had last ordered on 2/22/22 and did not anticipate any problems in keeping an adequate supply of

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PPE or N95 masks.

When interviewed on 3/3/22, at 8:50 a.m. the medical director stated expectation for transmission- based precautions for COVID-19 positive resident care included isolation to a specific hall within the facility. Medical director indicated PPE use to include gloves, gowns, eyewear, and N95 masks. Medical director expressed concern there would be an increase in transmission due to COVID-19 positive residents not isolated from COVID-19 negative residents with doors remaining open to the hallway.

When interviewed on 3/3/22, at 10:31 a.m. DON stated expectation is to change surgical mask upon leaving COVID-19 positive room as facility has a surplus of surgical masks at the time.

During observation on 3/1/22, at 9:01 a.m. a laundry aide (LA)-A left R9's room wearing a surgical mask and gloves, carrying a bag of soiled laundry. LA-A placed the laundry in the laundry cart. LA-A stated staff needed to wear gowns if a resident was in isolation, but they did not need to use a special mask (N95) or change the surgical mask they had worn into the room. LA-A was not observed to remove her gloves or perform hand hygiene at that time. LA-A pushed the laundry cart from the hall. LA-A touched the door code lock pad with her soiled gloves and exited to the laundry area without sanitizing the code pad.

During observation on 3/1/22, at 9:58 a.m. LA-A was observed to go from room to room on the left hallway of the facility gathering bags of soiled personal laundry and placing them in a laundry cart. LA-A did not remove her gloves and perform

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hand hygiene after leaving one room and entering another, or after finished picking up all the soiled laundry on the unit. LA-A proceeded to the door code lock, typed in the code, used the same soiled gloves, and then proceeded to the soiled laundry room without sanitizing contaminated touch pad.

During an observation of the soiled laundry area of the facility on 3/2/22, at 11:01 a.m. two large bins were observed with soiled personal laundry. LA-A stated she sorts the dirty laundry by color after she brings it to the soiled laundry area. LA-A stated, "I know you are going to say I should be wearing a gown. The facility has not instructed me to wear a gown when separating dirty laundry unless it was for a resident on isolation." LA-A stated she was the one who did the facility laundry and confirmed she wore her standard uniform while sorting soiled laundry. LA-A stated she was the person responsible for washing the soiled clothing and then folding the clean clothing after it was done.

When interviewed on 3/3/22, at 11:37 a.m. the environmental service director (EVSD) stated expectation would be to wear all PPE which includes a gown when sorting dirty laundry as all laundry is considered infectious. EVSD completed training for infection control for housekeeping and laundry staff annually. Annual education and training were completed January 2022 which included wearing gowns when touching dirty laundry.

When interviewed on 3/3/22, at 12:23 p.m. DON stated expectation was for all staff to perform hand hygiene upon entering and leaving all resident rooms.

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F 880	Continued From page 16 The facility policy titled Standard Transmission Based Precautions reviewed December 2019 indicated it is best practice to assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting and apply the following infection control practices during the delivery of health care. -Hand hygiene continues to be the primary means of preventing the transmission of infection. The policy also included: -Wear PPE (gloves, gown, mask) when the nature of the anticipated patient interaction indicates that contact with blood or body fluids may occur. -A gown may need to be worn if patient is on precautions for droplet or contact precautions. -A mask may need to be worn if patient is on precautions for droplet or airborne measures. This will be implemented by the nurse initiating precaution techniques. The facility policy titled Gloving Policy and Procedure reviewed on 2/5/21 specified disposable gloves are used to protect against the spreading of germs and bacteria from one person to another. The facility policy titled Washing Procedure for Total Isolation Linens and Red Bag Linens revised on 4/18/21, indicated that gown and gloves should be worn when handling dirty linen and that all soiled linen is treated as infectious.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/01/2022. At the time of this survey, PRAIRIE MANOR CARE CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/25/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. PRAIRIE MANOR CARE CENTER is a one-story building with a partial basement. The building was constructed at (3) different times. The original building was constructed in 1970 and was determined to be of Type II (222) construction. In 1987 an addition was constructed and was determined to be of Type II (222) construction. In 1991 an addition was constructed (Chapel) and was determined to be of Type II (222) construction. Because the original building	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 and the (2) additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors, which is monitored for automatic fire department notification. There is a 2-hour fire separation between the Skilled Nursing Facility and the Assisted Living. The facility has a capacity of 40 beds and had a census of 30 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		3/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 3 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5 and 9.7.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1, 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 03/01/2022, between 09:00 AM and 01:00 PM, it was revealed by observation that sprinkler heads located in the Linen Over-flow Room were covered with paint and ceiling spackling. 2. On 03/01/2022, between 09:00 AM and 01:00 PM, it was revealed by observation that sprinkler heads located in the common corridor just outside of the Linen Over-flow Room were covered with paint. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	The mentioned sprinkler heads were replaced by Summitt Fire Protection, on 03/02/2022. (See attached work order and pictures) In addition to the annual sprinkler head inspection and testing done by Summitt Fire Protection, we have established a monthly fire sprinkler head visual inspection, recorded on a clip board hanging on the EVS office wall. These inspections will be monitored by the EVS Director to ensure compliance with NFPA 101 (2012 edition), Sections 9.7.5 & 9.7.6, as well as the standards listed in NFPA 25.	