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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: URB8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00778

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245244**

2.STATE VENDOR OR MEDICAID NO.
(L2) **278525100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH SYSTEM - LONG PRAIRIE**
(L4) **20 NINTH STREET SOUTHEAST**
(L5) **LONG PRAIRIE, MN** (L6) **56347**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/15/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **70** (L18)

13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Brenda Fischer - District Supervisor 08/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/25/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 08/30/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245244
August 24, 2016

Mr. Daniel Swenson, Administrator
Centracare Health System - Long Prairie
20 Ninth Street Southeast
Long Prairie, MN 56347

Dear Mr. Swenson:

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 July 29, 2016 the above facility is certified for or recommended for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 24, 2016

Mr. Daniel Swenson, Administrator
Centracare Health System - Long Prairie
20 Ninth Street Southeast
Long Prairie, MN 56347

RE: Project Number S5244025

Dear Mr. Swenson:

On July 14, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 30, 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 August 15, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 29, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 30, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of effective July 29, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 30, 2016, effective July 29, 2016 and therefore remedies outlined in our letter to you dated July 14, 2016, will not be imposed.

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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245244 Y1	A. Building B. Wing Y2	8/15/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0166	Correction	ID Prefix F0242	Correction	ID Prefix F0323	Correction
Reg. # 483.10(f)(2)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.25(h)	Completed
LSC	07/20/2016	LSC	07/21/2016	LSC	07/20/2016
ID Prefix F0329	Correction	ID Prefix F0425	Correction	ID Prefix F0428	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.60(a),(b)	Completed	Reg. # 483.60(c)	Completed
LSC	07/20/2016	LSC	07/21/2016	LSC	07/21/2016
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) BF/KJ	DATE 08/24/2016	SIGNATURE OF SURVEYOR 10562	DATE 08/15/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/30/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245244 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/29/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	07/15/2016	LSC K0025	07/10/2016	LSC K0144	07/29/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0147	06/29/2016	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) TL/KJ	DATE 08/24/2016	SIGNATURE OF SURVEYOR 10562	DATE 07/29/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
6/29/2016

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

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Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 24, 2016

Mr. Daniel Swenson, Administrator
Centracare Health System - Long Prairie
20 Ninth Street Southeast
Long Prairie, MN 56347

Re: Reinspection Results - Project Number S5244025

Dear Mr. Swenson:

On August 15, 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 June 30, 2016, with orders received by you on July 14, 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: URB8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00778

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245244**

2.STATE VENDOR OR MEDICAID NO.
(L2) **278525100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH SYSTEM - LONG PRAIRIE**
(L4) **20 NINTH STREET SOUTHEAST**
(L5) **LONG PRAIRIE, MN** (L6) **56347**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/30/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **70** (L18)
13.Total Certified Beds **70** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Maria King, Assistant Program Manager 08/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/12/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 08/18/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 14, 2016

Mr. Daniel Swenson, Administrator
Centracare Health System - Long Prairie
20 Ninth Street Southeast
Long Prairie, MN 56347

RE: Project Number S5244025

Dear Mr. Swenson:

On June 30, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

Informal Dispute Resolution - 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:

Pam Kerssen
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601
Pam.Kerssen@state.mn.us
Telephone: (218) 308-2129
Fax: (218) 308-2122

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 August 9, 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 August 9, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 30, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 30, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245244	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to address consistent complaints of noise in the environment for 1 of 1 residents (R56) reviewed who had expressed concerns to staff. Findings include: R56's quarterly Minimum Data Set (MDS), dated 4/4/16, identified R56 was cognitively intact, did not wear hearing aids, and had "adequate" hearing with "no difficulty in normal conversation, social interaction, listening to TV [television]."	F 166	F166 Facility failed to address consistent complaints of noise in the environment for 1 of 1 residents (R56) reviewed who had expressed concerns to staff. R56 was talked to regarding concern of noise in the environment. A Comment Card was completed with the residents concern. Resident will continue to notify staff if his roommates TV is too loud and staff will assist to turn TV down or off if resident is not watching it. R56 will continue to use ear plugs as he wishes to	7/20/16

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

Electronically Signed | 07/22/2016

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F 166	Continued From page 1 During an interview on 6/27/16, at 6:21 p.m., R56 stated, "My roommate has his TV very loud 24 hours a day...I have told staff about it and they will turn it down when I ask...I don't know what they can do about it." During an observation on 6/30/16, at 9:15 a.m., R56 was sitting in his recliner in his room, holding a book in his hand. R56's roommate was sitting in his recliner, and the privacy curtain was drawn between the two residents. Neither R56's or his roommate's television were on. On 6/30/16, at 11:14 a.m., R56 again stated, "They [staff] know. I tell them, they turn it down and pretty soon it's back up. It's all the time." R56's roommate was not in the room at this time, and the television was shut off. Review of R56's progress notes, dated 3/6/16, at 6:23 p.m., included, "C/O [complain of] room mate's TV was on to [sic] loud. Wanted it shut off. Did agree to turning volume down." Another progress note on 4/23/16, at 3:51 a.m., included, "Behavior: D: Client was wearing earplugs and was c/o that roommate's TV was too loud. NA/R [nursing assistant/registered] has turned the TV down x 3 so far." During an interview on 6/30/16, at 11:16 a.m., nursing assistant (NA)-C stated, "[R56] will just say he doesn't like it when his roommate turns his TV on. At night, he [R56] just puts his ear plugs in. The nurses are aware of it. We just turn the TV down." NA-C also stated, "[R56's] roommate doesn't sleep well, so he turns his TV on because he can't sleep. [R56] doesn't like the TV on when he's sleeping. He just says he can't sleep	F 166	block out noise. When available R56 or roommate may be changing rooms to accommodate both residents preferences. All staff are being reeducated on process of documenting concerns/grievances on Comment Forms. Audits will be conducted by DON or designee on all residents regarding satisfaction of noise levels at least quarterly. Audit results will be brought to QAA meetings. Completion date: 7-20-16	

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F 166	Continued From page 2	F 166		

because it's too loud."

During an interview on 6/30/16, at 1:21 p.m., social services manager stated she was unaware of any noise concerns for R56.

During an interview on 6/30/16, at 1:41 p.m., NA-D stated, "There was an issue when they [R56 and roommate] first moved in together [2/15/16] with [roommate's] TV being on too loud on evenings and nocs [nights], but he hasn't said anything on our shift [days]."

During an interview on 6/30/16, at 1:49 p.m., licensed practical nurse (LPN)-A stated, "[R56] gets upset on evenings and nights about [roommate's] TV being too loud, so if he complains, we just shut it off." LPN-A added, "It's not that big of an issue. If it would be, we would talk to social services."

During an interview on 6/30/16, at 2:50 p.m., NA-E stated she worked mostly evenings and some night shifts. NA-E stated, "[R56] has ear plugs. [R56] complains that it's [roommate's TV] too loud and he can't sleep. I just turn down the volume. It's been going on for quite a while." NA-E stated most complaints from R56 were on the night shift. NA-E stated, "We tell [R56] to let us know so we can turn it down or shut it off." NA-E stated the nurses were aware of R56's complaints.

During an interview on 6/30/16, at 3:06 p.m., LPN-B stated, "Two nights ago, [R56] asked to have [roommate's] TV turned down. At night, it's too loud for [R56] and he'll ask us to turn it down." LPN-B stated when there have been roommate issues in the past, "We let social services know."

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F 166	Continued From page 3 When asked if social services had been notified about this situation, LPN-B stated, "No, because he rings, and we turn the TV down. It's not a daily thing where they're getting angry at each other." A facility policy was requested for comfortable noise levels but was not provided.	F 166		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure bathing frequency preferences were honored for 1 of 3 residents (R6) reviewed for choices. Findings include: R6's admission record, dated 1/10/14, identified diagnoses which included obesity, history of fungal infection of the skin, history of pressure ulcer on the lower back, and urinary incontinence. R6's quarterly Minimum Data Set (MDS), dated 4/11/16, revealed R6 was cognitively intact and required physical help in part of bathing activity. R6's care plan, dated 4/9/16, indicated R6 received a shower on Monday and Thursday, and	F 242	F242 Facility failed to ensure bathing frequency preferences were honored for 1 of 3 residents (R6) reviewed for choices. R6 was questioned as to her preferences regarding frequency of bathing. This was care planned and a suitable schedule for the resident will be set up. All residents will be questioned upon admission regarding preference on frequency of bathing by activities staff and will be care planned as such. Residents will be audited by DON or designee at least quarterly to ensure that bathing frequency preference is being	7/21/16

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F 242	Continued From page 4 required assist of one staff. During an interview on 6/27/16, at 7:14 p.m., R6 stated she was not able to choose how many times a week she bathed, and stated, "I get two in a week, but I would really like more than two." R6 stated she bathed every day prior to coming to the facility and if she had her choice, she would like to bathe at least every other day, especially now that it's summer and it's been so hot. R6 stated she had told staff that she would like more baths two to three months ago, "It just hasn't happened because they are just so busy." During an interview on 6/29/16, at 7:48 a.m., activities director (AD)-A stated she completed the activity admission assessment when residents were admitted to the facility. She asked residents about the type of bath they prefer, but she didn't ask their preference for the number of baths they would like each week. AD-A stated, "Typically they get one [bath], but if they have a special request, I pass it on to the bath aide." During a review of R6's Interview for Daily Preferences and Activity, dated 12/30/15, R6 indicated it was "very important" to choose the type of bath she received, and included, "Shower/bath aide aware." It did not include R6's preference for the frequency of bathing. During an interview on 6/29/16, at 10:51 a.m., nursing assistant (NA)-F stated R6 received a shower twice a week, but had told her "a while ago" that she would prefer to have a shower every day. NA-F stated she wasn't able to provide R6 with more frequent baths at that time, and stated she had reported this to the director of nursing (DON). NA-F stated she hadn't received	F 242	honored. Audit results will be brought to the QAA Committee for review. Completion date: July 21, 2016	

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F 242	Continued From page 5 any direction from the DON. NA-F stated she did her best to accommodate resident requests for bathing frequency, but this wasn't always possible due to having other duties to complete during the day. NA-F stated, "She [R6] just told me again on Monday that she would like more baths." NA-F stated she discussed R6's most recent request with registered nurse (RN)-C and was directed to send an email to the DON, and was waiting for direction from her. Review of the facility's policy, Bathing and Grooming, dated 10/92, included, "All residents are bathed as often as necessary to maintain cleanliness, refresh, and stimulate circulation. Tub baths or showers are given by all nursing staff three times a week and as needed." Review of the facility's policy, Resident Choices, dated 10/96, included, "To allow alert residents choice in daily routine or to accommodate previous routine as reported by family, as prescribed by the Resident's Bill of Rights." Also included, "Residents choice of bath day and time will be accommodated by the nursing staff whenever possible."	F 242		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		7/20/16

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F 323	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate interventions were in place following falls, to minimize the risk of further falls for 1 of 3 residents (R45) reviewed for accidents. Findings include: R45's falls Care Area Assessment (CAA) dated 2/16/16, indicated R45 had a problem with falls. The CAA identified R54 had a difficulty maintaining sitting balance and had impaired balance during transitions. Medication catagories that added to R45's fall risk were antidepressant and antianxiety medications. The CAA identified the following internal risk factors: arthritis, cognitive impairment, dementia, anxiety disorder and incontinence. A care plan was developed to slow or minimize decline, maintain current level of function, minimize risks and provide symptom relief. R45's quarterly Minimum Data Set (MDS) dated 5/17/16, indicated R45 had moderate cognitive impairments and required extensive assistance with bed mobility, transfers and toileting. The MDS indicated R45 had a history of falls and had diagnoses that included dementia and anxiety disorder. R45's most recent fall risk evaluation dated 5/20/16, indicated R45 was at risk for falls. R45's care plan dated 5/18/16, indicated R45 had a potential for falls and R45 did not consistently ask for help or use her call light. The care plan also indicated that R45 had poor safety	F 323	F323 Facility failed to ensure appropriate interventions were in place following falls, to minimize the risk of further falls for 1 of 3 residents (R45) reviewed for falls. R45 had UA/UC done which turned up negative. R44 was screened by PT and is seeing as feels appropriate. A timed voiding schedule was done and resident is being toileted at times where high incidence of falls was noted. Falls Meetings will be held weekly and all falls will be reviewed. New interventions will be attempted for each new fall for all residents to prevent further falls for each resident. All staff will be reviewing the Fall Management policy and are being educated that residents must have a new intervention for each fall to prevent further falls. Audits will be completed by DON or designee to ensure that appropriate interventions are put in place for each new fall. Results of audits will be reviewed at QAA meeting. Completion Date: July 20, 2016	

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F 323	Continued From page 7	F 323		

awareness and forgot to use her walker and lock her brakes. Interventions included: chair check cushion in wheelchair and recliner, chair check tabs alarm while in bed, eye exams as requested, anti roll back locking mechanism on wheelchair, hearing evaluations as requested, keep call light with in reach, although staff report she no longer utilized it and staff check on her about every two hours, low bed with floor mat on each side, remind resident that the floor is wet and needs to wait until doors to the activity room are open to go in, staff to pull window curtains and room divider during suppertime in anticipation of residents needs, and wear gripper socks or shoes at all times.

R45's Post Fall Follow Up forms were reviewed from 9/3/15, through 6/27/16. R45 had 14 falls during this time. The following falls did not indicate an appropriate fall intervention was put into place:

- 12/14/15, at 9:50 p.m. R45 was found on the floor near her bed and was incontinent at the time of her fall. R45 stated she was on her way back from the bathroom. It was noted that there was a puddle of urine halfway between the bathroom and bed. No new fall interventions were indicated. The corresponding progress note dated 12/14/15, at 10:20 p.m. indicated R45 sustained 4.5 x 2 centimeter bruise with a lump to her left thumb from the fall.

- 2/24/16, at 1:00 a.m. R45 was found sitting on the floor with her back against the nightstand with her knees bent. R45 was not incontinent at this time and stated she fell out of bed. Family indicated they wanted R45 to continue to be independent with transfers. No new fall

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F 323	Continued From page 8	F 323		

interventions were indicated. The corresponding progress note dated 2/24/16, at 3:17 p.m. indicated there was no injury from the fall.

- 4/9/16, at 7:30 p.m. R45 was found on the floor near her bed. R45 was noted to be upset prior to the fall that she couldn't keep her hearing aids and dentures in the drawer. New intervention listed was "chair check pad in w/c [wheelchair] and recliner and chair check tab alarm while in bed," however this was the same intervention listed on the previous fall dated 4/7/16. The corresponding progress note dated 4/9/16, at 9:42 p.m. indicated R45 sustained an abrasion to her left shoulder blade from the fall.

- 4/20/16, at 7:00 p.m. R45 was found on the floor next to her bed. it was noted to be dark in the room. The new intervention listed was "as of 4-11-16 chair check pad in place in w/c and recliner and chair check tabs alarm while in bed." However this was not a new intervention for R45 and was identified as implemented following the fall on 4/7/16. The corresponding progress note dated 4/20/16, at 11:22 p.m.. indicated there was no injury from the fall.

- 4/25/16, at 11:20 p.m. was found on the floor near her bed. R45 had stated she needed to use the bathroom. No new fall interventions were indicated, however it noted that alarms had been recently applied to prevent falls and the alarm intervention needed to be further evaluated to determine effectiveness. The medical record lacked any evaluation of the fall alarms. The corresponding progress note dated 4/26/16, at 1:32 a.m. indicated there was no injury from the fall.

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F 323	Continued From page 9	F 323		

- 5/19/16, at 3:25 a.m., R45 was found on the floor leaning on her bed and was incontinent. R45 stated she needed to use the bathroom. A comment noted that alarms were put into place to notify staff of R45's self transfers and there had been "somewhat" of a reduction in falls since. It also noted that R45 had some med changes recently to assist in anxiety and confusion. No new fall intervention put into place. The corresponding progress note dated 5/19/16, at 3:25 a.m. indicated there was no injury from the fall.

- 6/25/16, at 9:30 p.m. R45 was found on the floor leaning against her bed. The form indicated a possible urinary tract infection. No new interventions were put into place. A review of R45's medical record did not indicate a urinalysis was obtained to rule out a urinary tract infection. The corresponding progress note dated 6/25/16, at 11:32 p.m. indicated there was no injury from the fall.

On 6/29/16, at 7:18 a.m. R45 was observed sitting in her wheelchair in her room reading a facility newsletter. R45 dropped the newsletter on the floor and bent over to pick up the newsletter. When R45 bent over it initiated her tabs alarm alerting the staff. Trained medication aid (TMA)-A immediately entered R45's room and picked up the newsletter and reset the tabs alarm. TMA-A engaged R45 in conversation then wheeled R45 to the day room to do some coloring.

On 6/29/16, at 10:59 a.m. nursing assistant (NA)-B stated that R45 fell more often in the evening when she got more confused. NA-B further stated that R45 had fallen recently and was not aware of any new fall interventions for

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F 323	Continued From page 10	F 323		

R45.

On 6/30/16, at 9:52 a.m. NA-A stated R45 was usually continent and was toileted every two hours and as needed. NA-A stated R45 fell more on the evening and night shift. NA-A stated that R45 had moved onto the wing from another area in the facility, a few months ago. There was supposed to be a sign near the residents name by their room indicating someone was at a higher risk for falls, however R45 did not have that signage near her name.

On 6/30/16, at 10:01 a.m. licensed practical nurse (LPN)-A stated that after a resident fell the resident was assessed by a registered nurse (RN) for any injuries, the nurse filled out a fall report and notified the physician and family. LPN-A also stated the environment and situation was reviewed and then the RN was to put a new intervention into place and then the fall committee reviewed the interventions and made any needed changes. LPN-A stated R45 was moved to this wing a few months back for increased supervision as she was falling frequently.

When interviewed on 6/30/16, at 10:08 a.m. RN-A stated that the evening charge nurse or the director of nursing (DON) reviewed the fall reports and filled out the second section with interventions, usually within three days of the fall. RN-A stated there was a fall committee and she believed they met on a weekly basis to go over falls including appropriate interventions. However she wasn't sure how extensive the fall meetings were. R45's falls and interventions were reviewed with RN-A. RN-A verified that an order to obtain an urinalysis was not followed through on for the fall of 6/25/16. RN-A also stated R45 had not

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F 323	Continued From page 11	F 323		

been screened by physical therapy since 10/13/15, and R45 had not been assessed for a timed voiding schedule. RN-A stated that R45 was moved to another wing on 5/13/16, to increase her supervision, however staff had not been directed to increase supervision for R45.

On 6/30/16, at 2:04 p.m. rehabilitation aid (RA)-A stated that she organized the fall committee and kept record of the meetings. RA-A stated the fall committee met three times a month for one hour on Tuesdays. RA-A further stated the purpose of the fall committee was to discuss the falls since the previous meeting and to review and implement interventions. RA-A stated there was "very very poor attendance" at the meetings, and lately only a couple people were attending and frequently there was not a RN present at the meetings. RA-A stated that unless a nurse is present she didn't have access to the resident record to look up current interventions or past failed interventions. RA-A stated that very seldom were new interventions put into place following the fall committee meetings and that it was the responsibility of the floor nurse to do so. RA-A further stated that the one hour time frame of the meetings was frequently only enough time to write down a description of falls that had occurred since the previous meeting. RA-A stated the committee had never referred a resident to therapy for screening following a fall and there wasn't a therapist member on the the fall committee.

When interviewed on 6/30/16, RN-C stated she expected RN's to put interventions into place at the time of falls and that was the facility's current practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245244	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12 The facility policy Fall Management reviewed on 8/15, indicated "based on previous evaluations and current data, the staff will identify interventions related to the resident/ patient's specific risks and causes to try to prevent the resident/ patient from falling and to try to minimize complications from falling."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		7/20/16

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CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347

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F 329	Continued From page 13 Based on interview, and record review, the facility failed to ensure appropriate laboratory monitoring of medications for 1 of 5 residents (R40) reviewed for unnecessary medications. Findings include: R40's signed physician order sheet, dated 6/2/16, identified R40 had type two diabetes, hypothyroidism, and anemia. R40's physician order sheet dated 6/2/16, indicated R40 took ferrous sulfate (iron supplement) 20 mg (milligrams) once a day, lantus insulin 10 units at bedtime and synthryoid (thyroid med) 200 mcg (micrograms) once daily. Review of R40's laboratory report dated 11/10/15, identified R40's last hemoglobin was 12.0 gm/dL (grams per deciliter); normal range was 13.1 to 17.1 gm/dL. R40's laboratory report dated 8/12/14, indicated R40's hemoglobin A1C (average blood sugar level over 3 month period) was 5.8% with a normal range considered to be 4-6%. R40's last TSH (thyroid stimulating hormone) laboratory level dated 9/9/14, was 0.69 IU (international units) which had a normal range of 0.47 to 5.00. R40's dietary assessment notes dated 5/12/16, and 2/12/16, identified R40 needed follow up labs for his iron and hemoglobin. R40's dietary assessment recommended further follow up on his A1C as R40's last three random blood glucose levels were above 120 mmol/L (Millimoles per Liter). During a routine physician visit dated 9/16/14, R40's primary physician identified no blood work	F 329	F329 Facility failed to ensure appropriate laboratory monitoring of medications for 1 of 5 residents (R40) reviewed for unnecessary medications. R40 labs were reviewed and actions were taken to ensure residents wishes and MD orders were completed appropriately. Discussed process of Dietician writing recommendations with Dietician and process will be that she will write recommendations and orders in the Physician Orders section of the chart so nursing will not miss a recommendation written. All nursing staff are being reeducated that all recommendations from dietary or pharmacy consultant must be followed up on by next MD visit. Audits of Pharmacy Consultant recommendations and Dietician recommendations will be done by DON or designee to ensure timely responses to these. Results of audits will be taken to QAA and reviewed. Completion date: July 20,2016	

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CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347

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F 329	Continued From page 14 was to be completed on R40. During interview 6/26/16, at 12:26 p.m. registered nurse (RN)-A stated R40 had not received annual laboratory monitoring on his A1C, TSH, hemoglobin or iron levels. RN-A also acknowledged R40's dietary assessment recommendations had not been followed up with R40's primary physician. The facility's consultant pharmacist was contacted on 6/30/16 at 3:30 p.m. and again on 7/1/16 at 1:46 p.m. Messages were left, however the consultant pharmacist did not return the phone calls. A review of an undated policy titled, "Consultant Pharmacist Medication Regimen Review" identified an unnecessary drug is any drug which is used without adequate monitoring. All comments for physician are intended to be addressed at the next scheduled physician visit for the resident.	F 329		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425		7/21/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347

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F 425	Continued From page 15 the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure an as needed (PRN) medication was discontinued as ordered by the physician for 1 of 5 residents (R45) reviewed for unnecessary medications. Findings include: R45's quarterly Minimum Data Set dated 5/17/16, indicated R45 had moderate cognitive impairments and had diagnoses of anxiety and dementia. R45's physician orders dated 4/12/16, included an order for Trazodone (antidepressant) 25 milligrams (mg) at noon and an additional dose at HS (hours of sleep) if anxious or agitated. R45's physician orders dated 5/13/16, included an order to increase the Trazodone to 25 mg three times daily (TID), "not PRN". The order also included Seroquel (antipsychotic) 12.5 mg up to twice daily (BID) PRN for agitation/aggression. R45's Electronic Medical Administration Record (EMAR) after 5/13/16, included Trazodone 25 mg by mouth (po) TID, Trazodone 25 mg po every 24 hours at HS, and Seroquel 12.5 mg po BID PRN for agitation/aggression. R45 received PRN Trazodone HCL 25 mg on the following dates 5/14/16, 6/1/16, 6/26/16 and 6/27/16, after the physician ordered it to be	F 425	F425 Facility failed to ensure an as needed (PRN) medication was discontinued as ordered by the physician for 1 of 5 residents (R45) reviewed for unnecessary medications. R45 had medication orders clarified and PRN order was discontinued per MD orders. All nursing staff are being reeducated on physician orders and if there is a question or confusion on an order that it must be clarified with ordering physician. Policy Orders, Physician, Transcribing was reviewed and edited as needed. Five residents charts will be audited weekly by DON or designee to ensure accurate order transcription. Results of audits will be taken to QAA and reviewed there. Completion: July 21, 2016	

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F 425	Continued From page 16	F 425		

discontinued.
R45's care plan dated 5/18/16, directed staff to administer medications as ordered.
When interviewed on 6/30/16, at 10:48 a.m. registered nurse (RN)-A reviewed the physician orders dated 5/13/16, and stated she would need to call the psychiatric office to clarify the orders as it was not clear if R45 was to continue the PRN dose of Trazodone especially with the addition of the PRN Seroquel.
On 6/30/16, at 1:08 p.m. RN-A reported she had contacted the psychiatric office and clarified the Trazodone order. RN-A stated the order was for Trazodone 25 mg TID and there was not to be an order for PRN Trazodone. It had been transcribed incorrectly and should have been clarified when the order was received. RN-A verified that R45 had received four doses of PRN Trazodone after the medication should have been discontinued.
The consulting pharmacist's (CP) notes were reviewed for May and June of 2016. On 5/28/16, the CP indicated several medication changes but did not note any irregularities to the the physician. On 6/27/16, the CP recommended a decrease in Trazodone due to increased falls and noted R45 had an order for PRN Trazodone 25 mg at HS but did not note the order discrepancy or ask for a clarification from the ordering physician.
A call was placed to the CP on 6/30/16, at 2:03 p.m. and the CP could not be reached via telephone.
On 6/30/16, at 2:37 p.m. RN-C stated she would not expect nursing to clarify the order from the psychiatrist on 5/13/16, as she didn't feel there was any confusion with the order. It was a natural step to increase the trazodone and also keep the PRN dose, as well as the addition of PRN Seroquel, because they were ordered by a psychiatrist.

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F 425	Continued From page 17 On 6/30/16, 1:46 p.m. a second attempt to contact the CP was attempted via telephone and the CP was again not able to be reached. The facility policy Orders, Physician, Transcribing revised 9/15, did not address a process for double checking or clarifying orders. The facility policy Consultant Pharmacist Review of Drug Regimen revised 8/15, indicated the pharmacist determined that drug records are in order and provided review of each resident's drug regimen. The pharmacist must report any irregularities to the attending physician or the director of nursing.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete routine lab work for medication monitoring for 1 of 5 residents (R40) reviewed for unnecessary medication use. Findings include: R40's signed physician order sheet, dated 6/2/16, identified R40 had type two diabetes, hypothyroidism, and anemia.	F 428	F428 Facility failed to complete routine lab work for medication monitoring for 1 of 5 residents (R40) reviewed for unnecessary medication use. R40 had lab work reviewed and any incomplete lab work was done per residents wishes and MD order.	7/21/16

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	245244	A. BUILDING _____ B. WING _____	06/30/2016

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F 428	Continued From page 18 R40's physician order sheet dated 6/2/16, indicated R40 took ferrous sulfate (iron supplement) 20 mg (milligrams) once a day, lantus insulin 10 units at bedtime and synthryoid (thyroid med) 200 mcg (micrograms) once daily. Review of R40's laboratory report dated 11/10/15, identified R40's last hemoglobin was 12.0 gm/dL (grams per deciliter); normal range was 13.1 to 17.1 gm/dL. R40's laboratory report dated 8/12/14, indicated R40's hemoglobin A1C (average blood sugar level over 3 month period) was 5.8% with a normal range considered to be 4-6%. R40's last TSH (thyroid stimulating hormone) laboratory level dated 9/9/14, was 0.69 IU (international units) which had a normal range of 0.47 to 5.00. R40's dietary assessment notes dated 5/12/16, and 2/12/16, identified R40 needed follow up labs for his iron and hemoglobin. R40's dietary assessment recommended further follow up on his A1C as R40's last three random blood glucose levels were above 120 mmol/L (Millimoles per Liter). During a routine physician visit dated 9/16/14, R40's primary physician identified no blood work was to be completed on R40. During interview 6/26/16, at 12:26 p.m. registered nurse (RN)-A stated R40 had not received annual laboratory monitoring on his A1C, TSH, hemoglobin or iron levels. RN-A also acknowledged R40's dietary assessment recommendations had not been followed up with R40's primary physician.	F 428	DON talked to Dietician about where she documents recommendations and process was changed to ensure that recommendations get followed up on timely. Order for no blood work was put onto residents Physicians Order sheet to avoid confusion related to orders of lab work. All nursing staff are being reeducated on follow up on Pharmacist Consultant recommendations and Dietician recommendations and that these should be followed up on by next physician visit. Consultant Pharmacist Medication Regimen Review Policy was reviewed and updated as needed. Audits of Consultant Pharmacist recommendations follow up and dietician recommendation follow ups will be done monthly to ensure timely followup. Results of audits will be reviewed at QAA Committee Meetings. Completed: July 21, 2016	

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F 428	Continued From page 19 Review of R40's documented titled, Pharmacist Drug Regimen Review, dated 3/25/16, recommended R40 have annual medication monitoring for TSH, A1C and Ferratin labs. Review of document titled Pharmacy Review, dated 3/25/16, indicated facility staff needed to check with R40's primary physician about annual labs per pharmacists recommendations. The consulting pharmacist monthly drug regimen review notes from 4/18/16 through 6/27/16 did not mention further follow up lab work for R40. There was no indication this issue was addressed with the physician. Review of physician progress noted from 1/5/16 through 5/5/16 did not identify any labs to be completed. The facility's consultant pharmacist was contacted on 6/30/16 at 3:30 p.m. and again on 7/1/16 at 1:46 p.m. Messages were left, however the consultant pharmacist did not return the phone calls. On 6/29/16, at 12:20 p.m. when asked about having blood work drawn, R40 stated, "you can do whatever you want". During interview 6/26/16, at 12:26 p.m. registered nurse (RN)-A indicated all pharmacists requests should be followed up by the residents primary physician. RN-A acknowledged R40's primary physician had not followed up with the pharmacists requests for annual medication monitoring labs and stated, "it must have gotten missed." A review of an undated policy titled, "Consultant Pharmacist Medication Regimen Review" identified comments requiring nursing attention should be addressed at the next physician visit for the resident. The consultant pharmacist will also verify prior months comments have been addressed at next time of visit.	F 428		

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	245244	A. BUILDING _____ B. WING _____	06/30/2016

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	245244	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST** **LONG PRAIRIE, MN 56347**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey CentraCare Health System Long Prairie NH was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/21/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245244	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2016**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency CentraCare Health System Long Prairie C & NC was built in 1963 with additions in 1966 and 1976. The 1963 building is 1- story, without a basement and was determined to be Type II (111) construction. In 1966 an addition to the south of the original building was built, is 1-story without a basement and was determined to be of a Type II (111) construction. The 1976 addition to the east of the 1966 addition is 1-story with a partial basement and was determined to be of Type V (000) construction. The building is divided into 6 smoke zones by 1/2 hour fire barriers. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building is completely protected with an automatic fire sprinkler system that is installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes	K 000		

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K 000	Continued From page 2 some corridor smoke detection, with additional detection in all common areas and a doors that are held open. The fire alarm system has been installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The fire alarm has automatic fire department notification. The facility has a capacity of 70 beds and had a census of 67 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 018	Door was adjusted to meet the required	7/15/16

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	245244	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST** **LONG PRAIRIE, MN 56347**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 3 facility failed to maintain the smoke resistance of 1 resident room door according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 22 of the 67 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 8:00 am to 11:15 am on 06/29/2016 observations and staff interview revealed resident room door 203 did not fit tightly in the frame. This deficient condition was verified by the Maintenance Engineer.	K 018	gaps between the door and the frame. Completed 7-15-16	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper construction of 1 of 5 smoke barrier walls according to the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect 20 of the 67 residents and an undetermined amount of staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include:	K 025	Reviewed smoke penetrations in Rose Lane smoke barrier. Repaired Rose Lane smoke barriers per UL listed penetration code. Repaired 7-10-16.	7/10/16

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CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	**20 NINTH STREET SOUTHEAST** **LONG PRAIRIE, MN 56347**

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K 025	Continued From page 4 On the facility tour between 8:00 am to 11:15 am on 06/29/2016 observations and staff interview revealed penetrations above the ceiling in the Rose Lane smoke barrier. This deficient condition was verified by the Maintenance Engineer.	K 025		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to provide the required generator panels in accordance with the requirements of NFPA 110 - 1999 edition. This deficient practice could affect the safety of all 67 residents and an undetermined amount of staff and visitors if staff was not notified in a timely manner of a generator malfunction. Findings include: On the facility tour between 8:00 am to 11:15 am on 06/29/2016 observations and staff interview revealed no remote annunciater panel in a constantly monitored location. This deficient condition was verified by the Maintenance Engineer.	K 144	Reviewed potential locations for annunciator panel and determined that the West Nursing Home desk is the best location. The new annunciator panel will be installed 7-29-16.	7/29/16
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in	K 147		6/29/16

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K 147	Continued From page 5 accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and interview with the staff, the facility was using an unapproved electrical device that is not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of 10 of the 67 residents, and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 11:15 am on 06/29/2016 observations and staff interview revealed in resident room 301a power strip in use that did not have overcurrent protection. This deficient condition was verified by the Maintenance Engineer.	K 147	Removed power strip without an over current protection and installed a power strip that has over current protection. Completed 6-29-16.	

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
July 14, 2016

Mr. Daniel Swenson, Administrator
Centracare Health System - Long Prairie
20 Ninth Street Southeast
Long Prairie, MN 56347

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5244025

Dear Mr. Swenson:

The above facility was surveyed on June 27, 2016 through June 30, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00778	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH SYSTEM - LONG PRAIRIE	20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 6/27/16 to 6/30/16 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview, and record review, the facility failed to ensure appropriate laboratory monitoring of medications for 1 of 5 residents (R40) reviewed for unnecessary medications. Findings include:	21540	Corrected.	7/21/16

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21540	Continued From page 3 R40's signed physician order sheet, dated 6/2/16, identified R40 had type two diabetes, hypothyroidism, and anemia. R40's physician order sheet dated 6/2/16, indicated R40 took ferrous sulfate (iron supplement) 20 mg (milligrams) once a day, lantus insulin 10 units at bedtime and synthryoid (thyroid med) 200 mcg (micrograms) once daily. Review of R40's laboratory report dated 11/10/15, identified R40's last hemoglobin was 12.0 gm/dL (grams per deciliter); normal range was 13.1 to 17.1 gm/dL. R40's laboratory report dated 8/12/14, indicated R40's hemoglobin A1C (average blood sugar level over 3 month period) was 5.8% with a normal range considered to be 4-6%. R40's last TSH (thyroid stimulating hormone) laboratory level dated 9/9/14, was 0.69 IU (international units) which had a normal range of 0.47 to 5.00. R40's dietary assessment notes dated 5/12/16, and 2/12/16, identified R40 needed follow up labs for his iron and hemoglobin. R40's dietary assessment recommended further follow up on his A1C as R40's last three random blood glucose levels were above 120 mmol/L (Millimoles per Liter). During a routine physician visit dated 9/16/14, R40's primary physician identified no blood work was to be completed on R40. During interview 6/26/16, at 12:26 p.m. registered nurse (RN)-A stated R40 had not received annual laboratory monitoring on his A1C, TSH, hemoglobin or iron levels. RN-A also acknowledged R40's dietary assessment	21540		

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21540	Continued From page 4 recommendations had not been followed up with R40's primary physician. The facility's consultant pharmacist was contacted on 6/30/16 at 3:30 p.m. and again on 7/1/16 at 1:46 p.m. Messages were left, however the consultant pharmacist did not return the phone calls. A review of an undated policy titled, "Consultant Pharmacist Medication Regimen Review" identified an unnecessary drug is any drug which is used without adequate monitoring. All comments for physician are intended to be addressed at the next scheduled physician visit for the resident. Based on interview and document review the facility failed to ensure an as needed (PRN) medication was discontinued as ordered by the physician for 1 of 5 residents (R45) reviewed for unnecessary medications. Findings include: R45's quarterly Minimum Data Set dated 5/17/16, indicated R45 had moderate cognitive impairments and had diagnoses of anxiety and dementia. R45's physician orders dated 4/12/16, included an order for Trazodone (antidepressant) 25 milligrams (mg) at noon and an additional dose at HS (hours of sleep) if anxious or agitated. R45's physician orders dated 5/13/16, included an order to increase the Trazodone to 25 mg three times daily (TID), "not PRN". The order also included Seroquel (antipsychotic) 12.5 mg up to twice daily (BID) PRN for agitation/aggression. R45's Electronic Medical Administration Record (EMAR) after 5/13/16, included Trazodone 25 mg by mouth (po) TID, Trazodone 25 mg po every 24 hours at HS, and Seroquel 12.5 mg po BID PRN	21540		

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21540	Continued From page 5 for agitation/aggression. R45 received PRN Trazodone HCL 25 mg on the following dates 5/14/16, 6/1/16, 6/26/16 and 6/27/16, after the physician ordered it to be discontinued. R45's care plan dated 5/18/16, directed staff to administer medications as ordered. When interviewed on 6/30/16, at 10:48 a.m. registered nurse (RN)-A reviewed the physician orders dated 5/13/16, and stated she would need to call the psychiatric office to clarify the orders as it was not clear if R45 was to continue the PRN dose of Trazodone especially with the addition of the PRN Seroquel. On 6/30/16, at 1:08 p.m. RN-A reported she had contacted the psychiatric office and clarified the Trazodone order. RN-A stated the order was for Trazodone 25 mg TID and there was not to be an order for PRN Trazodone. It had been transcribed incorrectly and should have been clarified when the order was received. RN-A verified that R45 had received four doses of PRN Trazodone after the medication should have been discontinued. The consulting pharmacist's (CP) notes were reviewed for May and June of 2016. On 5/28/16, the CP indicated several medication changes but did not note any irregularities to the the physician. On 6/27/16, the CP recommended a decrease in Trazodone due to increased falls and noted R45 had an order for PRN Trazodone 25 mg at HS but did not note the order discrepancy or ask for a clarification from the ordering physician. A call was placed to the CP on 6/30/16, at 2:03 p.m. and the CP could not be reached via telephone. On 6/30/16, at 2:37 p.m. RN-C stated she would not expect nursing to clarify the order from the psychiatrist on 5/13/16, as she didn't feel there was any confusion with the order. It was a natural step to increase the trazodone and also keep the	21540		

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21540	Continued From page 6 PRN dose, as well as the addition of PRN Seroquel, because they were ordered by a psychiatrist. On 6/30/16, 1:46 p.m. a second attempt to contact the CP was attempted via telephone and the CP was again not able to be reached. The facility policy Orders, Physician, Transcribing revised 9/15, did not address a process for double checking or clarifying orders. The facility policy Consultant Pharmacist Review of Drug Regimen revised 8/15, indicated the pharmacist determined that drug records are in order and provided review of each resident's drug regimen. The pharmacist must report any irregularities to the attending physician or the director of nursing. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could develop systems to ensure medications are routinely reviewed for unnecessary medications, physician orders, and pharmacist recommendations. The DON could educate all appropriate staff. The DON could develop monitoring systems to ensure ongoing compliance and review monitoring with the quality assurance committee for recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not	21942		7/21/16

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CENTRACARE HEALTH SYSTEM - LONG PRAI	20 NINTH STREET SOUTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21942	Continued From page 7 function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to establish a family council at least once every calendar year as required. That had the potential to affect all 67 residents in the facility. Findings include: A letter dated 9/5/14, regarding the facility's attempts at forming a family council was provided by the social worker. When the social worker was interviewed on 6/30/16, at 10:37 a.m. she stated she thought the last attempt to continue family council had been made June 2014, but acknowledged the last attempt had been greater than a two years prior (24 months). SUGGESTED METHOD OF CORRECTION: The administrator could develop systems to ensure attempts are made to form a family council on a regular basis. The administrator could review the process to ensure each resident's family/significant other is aware of the opportunity. The administrator could implement systems to ensure family feedback is obtained as appropriate until a family council is developed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00778	A. BUILDING: _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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