Electronically Submitted
August 16, 2021

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

RE: CCN: 245371
Cycle Start Date: July 26, 2021

Dear Administrator:

On July 26, 2021, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On July 26, 2021, the situation of immediate jeopardy to potential health and safety cited at was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 31st.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 31st, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 31st, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 26, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

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

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely

will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Prairie View Senior Living is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 26, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102

Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 26, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's

Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245371	A. BUILDING _____ B. WING _____	C 07/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/22/21 through 7/26/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5371029C (MN74882 and MN72676) with deficiencies cited at F600, F609, and F744. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F744 began on 5/9/21, when R1 had physically assaulted R3 by grabbing R3's arm and pinching her. The facility's administrator and director of nursing (DON) were notified of the IJ on 7/23/21 at 2:52 p.m. The IJ was removed on 7/26/21 at 11:00 a.m., when it could be verified staff had assessed R1 and implemented appropriate interventions for when R1 would become physically aggressive and re-educated staff to those changes. Staff were to also provide 1:1 supervision when R1 was identified as wandering or had behaviors to ensure her behaviors had not escalated which may result in abuse. The above findings constituted Substandard Quality of Care, and an extended survey was conducted on 7/26/21. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will	F 000		

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

Electronically Signed | 08/19/2021

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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 5 of 35 residents (R2, R3, R5, R6, and 1 unidentified resident) were free of physical abuse by 1 of 1 resident (R1) when staff failed to assess, monitor and intervene when R1 had increasing physical behaviors resulting in abuse to the above-mentioned residents with skin tears, a lacerated lip, and 2 puncture wounds caused by R1 biting. R1 was also at risk for abuse when 1 of 1 resident (R4) threatened to harm R1.	F 600	F (600) 1. No further action is needed for the resident affected by the deficient practice as she was discharged from the facility on 7/30/2021. 2. Facility had conducted a Vulnerable Adult assessment on all residents by 8/24/2021, to identify those with potential to have aggressive behaviors or at risk to be abused, neglected, or exploited. A behavior note was completed on all residents by 8/24/2021. Those residents	8/26/21

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F 600	Continued From page 2 Findings include: R1's 6/17/21, quarterly Minimum Data Set (MDS) identified R1 had severely impaired cognition and was independent with walking throughout the facility. R1 had diagnoses of dementia with behaviors, anxiety, and was bipolar. Her 12/24/20, Care Area Assessments identified R1 triggered for behaviors, mood, and this was to be addressed in her care plan. R1's current, undated care plan identified R1 was able to ambulate independently in the facility with use of a walker and needed cueing and reminders to use her walker. R1 had cognitive loss and dementia. Staff were to administer her medication as ordered and observe for side effects and effectiveness. Staff were to notify the doctor (MD)-A for mental health and medication adjustments. Staff were to cue and supervise as needed. R1 was noted to wander frequently into other resident's rooms. Staff were to redirect R1 as they are made aware or discover that occurring. R1 was identified as being dependent on staff for activities. R1 was noted to have a history of traveling with her spouse to all states and overseas, played cards, watched high school sporting events, and was active with walking, riding bike, bowling, church, baking, sewing, crotchet and played clarinet. R1's current preferences included reading, visiting with others, attending church, playing bingo and card games, attend outings, shopping, being outdoors and do independent religious devotions. Staff were to encourage exercise and activity games, reminisce in topics form her years of being a homemaker. She preferred to watch TV stations and shows like "old time dancing" on the pioneer channel. R1 was noted to use anti-psychotic	F 600	identified to be at risk will have a weekly behavior note made. Seven residents were identified to be at risk, R10, R11, R12, R13, R14, R15, R16. On those seven residents identified, their care plan was modified to include a behavioral management plan. Behavioral Management plans were communicated to staff on 8/23/2021 & 8/24/2021. 3. To correct the deficiency and to ensure the problem does not reoccur VA eval and monthly behavioral review will be done quarterly with their MDS. Behavioral rounds are done weekly, on all annual and quarterly MDS's due and other residents with ongoing behaviors. All staff were educated on the requirement to report any abuse or neglect per facility vulnerable adult policy on 7/26/2021 by Executive Director and/or Interim Director of Nursing. Facility Executive Director was educated on 7/29/2021 by Megan Kleinsasser, Regional Vice President to Accura's reporting requirements and what was required from a state and federal reporting standpoint. MDS Coordinator Jennifer Otto completed the MDS Excellence – Introduction to the Complete RAI Process through Pathways virtual training. 4. The Director of Nursing and/or designee will Audit 24 hour summary report X2 weekly and the MAR/TAR for behavior monitoring X2 weekly for three months to identify dementia incidents found, behavior notes made, behavior management plan implemented if needed, care plan updated, and new behavioral management plans provided to staff for	

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F 600	Continued From page 3 medication, anti-depressant medication, and anti-anxiety medication. Interventions for those medications were: R1 was to be free of drug related complications. Staff were to attempt non-pharmacological interventions of golf or football on the facility's iPad, offer cooking magazines, and sweet treats and observe for effectiveness. Staff were also to observe and record R1's target behaviors and symptoms and document per facility protocol. Staff were to consult with pharmacy and the MD when considering a dosage reduction, monitor for medication side effects and complications from medication complications and offer behavior health consults as needed. There was no mention staff had identified R1 had physical behaviors of abuse towards others and was also at risk for abuse. Observation on 7/22/21 at 10:10 a.m. identified R1 was actively participating in kick-ball in the day room. R1 appeared to be engaged in the activity and was seen moving from sitting to standing at a very fast rate. Observation and interview on 7/22/21 at 12:20 p.m. with R1 in the dining room identified she was seated at a table with 4 other residents and 1 staff. R1 was unable to answer basic questions like "how is your food?". R1 would only repeat "Someone stole my clothes." R1 ate quietly and was easily redirected by staff when she appeared to be wanting to leave. Review of R1's progress notes revealed the following. On: 1) 5/9/21 at 7:15 p.m., R1 was busy "walking around" prior to supper and "in a good mood". She then sat at the dinner table and dozed off, so	F 600	education. As part of Prairie View Senior Living's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's Quality Assurance Process Improvement committee.	

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F 600	Continued From page 4	F 600		

staff assisted her to her room. She was "a little irritated" but was willing to get washed up. R1 then got up and started walking in her room and walked into a wall R1 refused to open her eyes when asked. Despite staff noted being calm and taking their time with R1, she became physically aggressive. R1 began kicking and hitting, pinching, grabbing wrists, and ripping a staff's glasses off their face. Staff then left R1 "in a safe manner". R1 was noted to have stayed in her room about 10 minutes, then was seen wandering room to room. R1 got a phone call and staff were able to sit her in the hallway where she was able to talk on the phone. A later note at 9:00 p.m., staff documented R1 was in a "weird position" in a chair in the hall. R3 wheeled herself around R1. R1 then dropped the phone and grabbed R3's arm and began pinching her. R1 "eventually let go" and the other [unknown] resident came to the nurses station to report the incident. R1 was then put on 15 min checks.
2) 5/10/21 at 1:59 p.m., staff documented R1 came out to the day room and had reached out to touch another resident's (R4) oxygen tank. R4 said he was going to "hit her over the head with the oxygen tank if she touched it". Staff intervened and moved the resident away from the area.
3) 5/24/21 at 10:38 p.m., R1 was noted to be entering other resident rooms and went into R2's room and her unidentified roommate at that time. R2 and the unidentified resident became upset. R1 began to scream. Staff were kicked and punched by R1 trying to remove R1 from R2's room. Once staff got R1 into her room, she kicked staff again and told them to "get the hell out". R1 was noted to sit in her room and when she was "rechecked on, she was much calmer".
4) 6/3/21 at 11:08 p.m., staff noted at around 4:20

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F 600	Continued From page 5	F 600		

that day, R1 began yelling, screaming, and telling staff and residents "they were fired", calling police, banging on the entrance door, picking up her walker, shoving walker into staff, exit seeking, and dragging chairs. Staff documented environmental or situational events were R1 was in the dining room. She was easily directed when staff observed her attempting to push another resident in a wheelchair. Staff toileted R1 then set her down in a wheelchair. She "appeared to be calm then suddenly she became upset and angry". Details of behavior included the above observations as well as getting a skin tear while she hit staff members picking up her walker as if she was going to attempt to throw it and kicking at "anyone" who came near. R1's family member (FM)-A was called and arrived at the facility. R1 continued her behaviors directed at her son and was not noted as calm for another 30 minutes. Interventions listed were toileting, walking, 1:1, monitor, re-approach by another staff, remove other residents, redirect visitors to another door, escort to a different environment, have supper in her room. And her son to provide 1:1.

5) 6/8/21 at 11:51 a.m., staff documented R1 received a rectal suppository that morning which was known to upset R1 and escalate her behaviors. An unknown nurse aide (NA) was trying to toilet R1 when R1 began hitting the NA. R1 hit the unidentified staff in the face, and kicked and squeezed staff in an unknown location on on the NA's body.

6) 6/15/21 at 10:29 p.m., R1 was documented to have been screaming during evening cares, pinching staff's upper arms resulting in bruising to staff. Interventions tried were walking with R1, toileting, and providing 1:1 were effective for short periods of time, then restless and wandering started up again.

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F 600	Continued From page 6 7) 6/17/21 at 11:34 a.m., the social services designee (SSD) documented a Vulnerable Adult (VA) note indicating a VA assessment was completed and inaccurately included "No history of abuse towards others or self noted". 8) 6/18/21 at 12:45 p.m., R1 was observed dropping her pants in the tub room. Staff attempted to stop her. R1 hit and kicked at them. One staff member was noted to have been punched in the shoulder. 9) 6/18/21 at 11:40 p.m., R1 removed her shirt in the dining room. When staff attempted to put R1's shirt back on, she became aggressive and started hitting the NA's. R1 also "accidentally" hit another resident in the back that was close by. Staff documented they felt she "never meant to intentionally hit another resident". When staff assisted R1 to her room, she continued to swing at staff. R1 taken to her room and laid down to bed. 10) 6/21/21, at 1:01 p.m. R1 hitting, kicking, punching and trying to bite staff and moving furniture around in the dayroom. R1 was unable to be redirected. R1 was sent to emergency room to rule out outstanding medical reasons. Further review of R1's progress notes revealed the following. On: 1) 6/24/21 at 10:22 p.m., staff noted they received a call from the ER. R1 was returning to the facility with diagnosis of aggressive behavior due to dementia. During R1's visit to the ER, she was "very cooperative". No physical behaviors were reported. The facility received orders for an as needed (PRN) Haldol (anti-psychotic) injection as well as a PRN dose of Seroquel to be given in addition to her scheduled dose. 2) 6/26/21 at 9:54 a.m., staff documented R1 was toileted when she screamed, "blocked", kicked,	F 600		

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and scratched staff. During this episode, R1 "bumped" the right side of her head on the doorway. No redness or bruising was noted.
3) 6/26/21 at 12:07 p.m., R1 was using profanity at staff, grabbing another unidentified resident's shirt and would not let go. She repeatedly hollered while twisting staff's fingers, kicking, and had bumped her knee on a table while attempting to kick staff. R1 was "angry" with an "unknown cause". R1 was noted prior to the event to be sitting by the nurses station when she began yelling at other unidentified residents. When staff intervened, they were able to get R1's grip released on the other unidentified resident. Staff removed other residents away. This occurred during the entirety of the lunch hour. After yelling, R1 was wandering around the dining room and sat by another resident who removed themselves away from her. Interventions noted were for staff to approach R1 with a smile, attempt to talk, offer sweets, attempt to toilet, redirect her, attempt to remove her from the area, monitor her and other residents' safety, remove other residents away, and approach by other staff members. Staff noted all interventions were ineffective until R1 calmed down but did note it was "best to leave in a safe manner and monitor".
4) 6/28/21 at 6:10 p.m., staff documented R1 was restless and wandering into other residents' rooms, telling staff to "get away", attempting to sit in random areas, pick items off the floor that were not present, and punched staff in the stomach when staff tapped R1 on the shoulder when they noticed she was not wearing socks or shoes while wandering. Staff interventions attempted were to guide her to the bathroom, offer to wash her up, assist her when taking her clothes off, leave her in a safe manner then re-approach or re-approach with a different staff member, walk

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with her, and bring her walker to her. Staff noted none of the interventions were effective for long periods.
5) 6/28/21 at 11:33 p.m., staff noted they administered a PRN Seroquel as R1 was demonstrating behaviors of reaching for items on the floor, "almost falling", restless, agitated, uncooperative. Staff also noted she was wandering and going into another resident's room. Staff reoriented her to time, offered toileting, sweet treats.
6) 7/1/21 at 11: 24 p.m., staff documented they found R1 on another (unidentified) resident's bed. Staff took her back to her room. R1 became upset. R1 punched staff in the nose. "Later when resident had a fall, resident also kicked and pinched staff". R1's blood pressure was taken and recorded to be low. FM-A was notified and opted for R1 to be seen in the clinic the next day, 1:1 supervision for safety.
7) 7/3/21 at 11:36 a.m., R1 returned from a brief admission to the hospital for heart concerns. Staff documented "Almost immediately upon her return, [R1] became combative". R1 was stripping her clothes off wanting to put "different ones on". R1 "became mad" because she wanted her original clothing. Staff noted she settled down and laid down. At an unknown time, R5 put his call light on. R1 was trying to lie down with him. 3 staff were "required" to get R1 out of R5's room. R1 was hitting, punching, attempting to bite staff and tried to sit down. R1 was held up by staff when trying to sit down and put into a wheelchair. Staff took R1 to her room where she "finally" laid down and fell asleep. Staff noted they did not wake her for lunch.
8) 7/5/21 at 10:35 p.m.,behavior note staff documented earlier that day at 4:14 p.m., prior to R1's second fall, she was observed smacking

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F 600	Continued From page 9 another resident (unknown identity) on his back as she was pushing him into his room. When staff attempted to redirect R1, she was "feisty and uncooperative". A male resident (unknown) reported R1 bit his shoulder. Staff "confirmed circular shaped teeth marks". 9) 7/6/21 at 12:59 p.m., staff documented Behavior Note. R1 was found walking down the north hallway naked except for a T-shirt. R1 was redirected back to her room and was dressed. R1 slept for a while, then got up, walked to kitchen, pulled her pants down and urinated on the kitchen floor. Staff then intervened and toileted R1. She was noted to later be going into other residents rooms but "settled down" and ate her lunch and was currently eating. 10) 7/16/21 at 10:22 p.m. staff noted R1 had scratched and hit another resident (R2). Staff contacted the on-call MD to request an increase to R1's Seroquel. The on-call MD agreed. 11) 7/17/21 at 1:40 p.m., staff documented R1 was in the dining room for lunch when she began wandering and trying to take other residents' water glasses so she could "brush her teeth". Staff "got other resident's waters away from her, but she was hitting and kicking at staff as they did it". Staff noted they were "finally able to calm her down and she is currently in bed sleeping". 12) 7/19/21 at 10:51 p.m., R1 was wandering to different hallways, attempting to go into other resident's rooms, repeatedly stated she was tired or needed to sit. When staff offered her a chair she would get up and wander again. R1 had crying behaviors when staff provided brief 1:1, toileting, and walking. R1's Behavioral Committee (BC) Notes identified the behavioral management team had	F 600		

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documented twice on R1's behaviors and accuracy of her care plan. Notes are as follows:
1) 6/3/21 at 8:56 a.m., staff documented they performed an evaluation of R1's behaviors. Psychoactive medications were "ordered and in-use". The committee recommended a psychiatry (psych) consult. R1's care plan was reported to be reviewed and updated. R1's dementia was noted to be progressing. R1 had an overall decline. No mention was made that staff identified R1's physical behaviors and lack of supervision when those behaviors occurred or had identified the care plan lacked interventions specific to her physical aggression.
2) 7/1/21 at 12:12 p.m., staff documented they performed an evaluation of R1's behaviors. Psych meds were ordered and in-use. Recommendations were made for a psych consultation. The care plan was noted to be reviewed and updated.

R1's progress notes, identified numerous incidents of physical behaviors and abuse perpetrated on the above-mentioned residents by R1. The notes lacked further indicated R1's behaviors had been reassessed and interventions implemented as R1's behaviors continued after 5/9/21.

Interview on 7/22/21 at 10:46 a.m. with the social services designee (SSD) identified R1 had resided at the facility prior to her employment in October, 2020. R1 has steadily declined in her cognition due to her dementia. The SSD was not at the facility on 7/16/21 when the incident between R1 and R2 occurred. On Monday, 7/19/21, she followed up with R1. R1 would be restless and wander, once in a while she would "pop into other resident rooms". Earlier this

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month, the SSD reported she spoke with FM-A and explored options for R1's potential placement in other facilities in a locked memory care. R1 saw a psychologist weekly (MD-A), at the clinic across the street. If staff start to see R1's behaviors "ramping up", staff are to call for an ambulance to transfer to the regional hospital in Marshall to seek placement in an inpatient behavioral health facility. Staff have requested to have R1's medication adjusted. When this occurred, she would "mellow a little". The SSD stated "1:1 were the best to do". When it came to non-pharmacological interventions, she left that up to the interim director of nursing (IDON). The SSD stated she thought wandering was more of the "issue". When R1 wanders, "she feels it is her space and her room". Staff try to redirect "if they see" her wandering.

Interview on 7/22/21 at 2:02 p.m. with registered nurse (RN)-A and licensed practical nurse (LPN)-A identified when R1 exhibited behaviors she would get restless and have wandering behaviors and would often go into other residents' rooms. Staff attempt to "distract her". Nurses do not assign anyone to increase her supervision when she exhibits restlessness or immediately prior to her physical behaviors. "We just know her and everyone helps. If nurses are busy and the nurse aides (NA) are busy, the kitchen helps watch her as well". They have no plan or method care planned to identify specific interventions on her care plan to prevent potential future incidents from occurring. "We do what we can". Neither RN-A or LPN-A were aware R1 had increased mental health visits with MD-A. The facility has previously requested to increase her medications to see "if that helps".

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Interview and document review on 07/22/21 at 2:32 with the IDON identified she was aware of R1's physical aggression and abuse towards other residents. Staff do behavior rounds monthly and have a behavior committee meeting. The IDON agreed R1's behaviors have escalated since 5/9/21. The facility plan to prevent further physical abuse to residents and staff from R1 was to call the ambulance and send R1 to Marshall hospital for her mental health exam as that is the only way the facility can get R1 admitted to a behavioral health inpatient program. The IDON stated she felt the facility had interventions care planned to manage her behaviors. Staff were to offer R1 an iPad with football or golf on it, cooking magazines, or offer her sweets. The IDON stated if R1 was "agitated" staff were to do 1:1 supervision. Staff often "lead her to her room, but they can anger her even more". The facility "has tried a lot of things" but nothing worked for very long. the IDON stated she felt staff were providing appropriate supervision and they had gotten her psych medications increased to see if that helped with R1's behaviors. R1 was now seeing MD-A weekly since the 7/16/21 incident when R1 assaulted R2.

Review of R1's mental health provider (MD-A)'s progress notes revealed the following:
1) R1 was seen on 5/10/21 after she had assaulted R3 on 5/9/21. MD-A identified R1 came to the clinic for a 3 month follow-up after initially being referred by the facility for behaviors of agitation with dementia and poor sleep. R1 was "not counseling with anyone and never has". MD-A stated R1 had previous medication of Trazodone which was causing unstable gait and was of no help for behaviors or her sleep. MD-A reviewed R1's history of past medications R1 had

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tried. R1 was noted to be "in a good mood". MD-A was aware R1 scratched R3. "Evidently this is the only incident that happened in the past 3 months". Follow-up in 3 months and to call MD-A if there were problems before that time.
2) 7/14/21, MD-A identified R1 was seen for a 2 month follow-up. MD-A documented R1 had been urinating in various places in the facility. R1 had no prior mental health hospitalizations. The note inaccurately listed "No psychiatric consults ever". R1's medications were once again discussed. MD-A identified R1's Seroquel was increased due to her aggressive behavior. MD-A and FM-A discussed "cutting back R1's morning dose of Seroquel to see if she can be awake a little bit more in the mornings and try to eat as she has lost a couple pounds in the past couple of days". MD-A noted R1 was deteriorating more since spring and adjusted medications and to follow up in 2 weeks, and call if problems before that time. There was no indication MD-A was aware of the increased physical aggression R1 was exhibiting, nor if she had been asked to assist the facility in identifying if non-pharmacological interventions were appropriate.

MD-A was unavailable for interview at the time of the survey.

Interview on 7/23/21 at 10:54 a.m. with FM-A identified he was aware of R1's recent incident with R2. R1 had scratched R2. R1 had a recent mental decline. He attended a care conference on 7/20/21. "Everyone sees escalating behaviors" and these occurred more since Memorial day, 2021. Facility staff told him "if there is another altercation, she will be sent to ER then to inpatient psych on a behavioral health unit".

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F 600	Continued From page 14 Interview on 7/23/21 at 11:45 a.m. with trained medication aide (TMA)-A identified staff would often try to redirect R1 when she had behaviors. Staff were to leave her in a safe space. Interventions included to have her watch golf on the iPad. When asked how staff communicate interventions they had tried she stated "We try to pass it along if anything works". The facility had tried to put up banners across other residents rooms to deter R1. That did not work. R1 was very into her appearance in the past so they try and braid her hair or put it up in a bun. TMA-A identified R1's wandering always preceded her physical behaviors...but her wandering would not necessarily "start them". If she exhibited behaviors, staff were to stay with her until they "think" she is calm. There was no set time to directly monitor her. Interview and document review on 7/23/21 at 12:41 p.m. with the administrator identified he agreed R1's care plan lacked appropriate interventions and supervision required and made no mention of R1's physical behaviors or that she was also at risk for abuse herself. Interview and document review on 7/23/21 at 2:00 p.m. with the MDS coordinator (MDS-A) identified she was the sole staff responsible to update care plans in the facility. MDS-A stated she also worked on the floor providing direct care and often provided direct care or medication administration to R1. She agreed the care plan made no mention of R1's physical behaviors and lacked interventions and appropriate supervision required to prevent future incidents of abuse, and failed to identify R1 was at risk of potential abuse from others.	F 600		

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Interview on 7/26/21 at 11:54 a.m., with MD-B identified he would see residents at the facility if he was their primary care physician. he was not R1's physician. MD-B was unaware of R1's physical behaviors. He was the medical director as the facility "needs a doctor to attend QAPI. those meeting are just generalized. We really don't dig into or analyze issues". MD-B reported he had "little involvement" with the facility. He was not able to recall if R1 was discussed at the June meeting, but stated he attended. The facility had a psych provider for behavioral health issues "to deal with those residents".

Review of the January 2020, VA policy identified abuse was the willful infliction of injury resulting in physical harm, pain, or mental anguish. Willful means the individual must have acted deliberately in their actions. All resident-to-resident altercations were reportable to the SA. The facility was to have systems in place to identify residents who were at risk for abusing other residents. During the shift the allegation of abuse occurred, staff were to report to their supervisor. the supervisor was to immediately report to the administrator and DON. An immediate investigation was to begin and include interviews, environmental reviews, behavior reviews, and medication reviews. Abuse prevention was to include assessment of the resident's environment and adequate staffing and supervision of staff to identify inappropriate behaviors. Residents were to be continually assessed, care planned, and monitored in order to identify needs and behaviors.

Review of the Mood and behavior Rounds Guideline policy identified mood and behavior rounds were specific meetings with staff that were

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F 600	Continued From page 16 to provide care dedicated to the knowledge of the resident. Meetings were to be conducted routinely and each resident reviewed monthly. Staff were to have discussion regarding prior observations of resident behavior, assess non pharmacological interventions and determine appropriate interventions. Staff were to discuss potential triggers for behaviors and review the medical record for adverse effects of medications such as falls, weight loss, to determine if the medication and/or dosage was appropriate. The resident's care plan was to be reviewed to determine if all areas on the care plan were appropriate. At the end of the evaluation, the committee was to determine an action plan and further follow-up. There was no policy specific to dementia care provided at the time of the survey.	F 600		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		8/26/21

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F 609	Continued From page 17 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed immediately, no later than 2 hours, report to the State agency 4 of 4 incidents of resident to resident abuse involving R1. Findings include: Review of the 5/9/21 at 11:04 p.m., report filed to the State Agency (SA) identified earlier that day on 5/9/21 at 6:00 p.m., R3 was wheeling down the hall in her wheelchair. R1 was talking on the telephone. R1 turned to R3, stated "I told you to stay away!", reached for R3's arm and scratched and pinched her. R3 pulled her arm away, and reported the incident to the nurse. After hearing the report by R3, staff went to the hall to redirect R1 back to her room. R1 was noted to be self-ambulatory and needed redirection of place and room placement due to her dementia. Staff documented "typically, [R1] is pleasant and easily redirectable" however, she had gone out for the day with her family member (FM)-A. When she returned she was tired and "more agitated". Staff noted what led up to the incident was R1 was busy walking around prior to supper and was reported to be in a good mood. She was very	F 609	F (609) 1. No further action is needed for the resident affected by the deficient practice as she was discharged from the facility on 7/30/2021. Residents identified to have been effected by the aggressive behavior of resident R1 are no longer at risk due to resident being discharged from facility on 7/30/2021. 2. Facility conducted a Vulnerable Adult assessment on all residents by 8/24/2021, to identify those with potential to have aggressive behaviors or at risk to be abused, neglected, or exploited. A behavior note was completed on all residents prior to 8/24/2021. Those residents identified to be at risk will have a weekly behavior note made. Seven residents were identified to be at risk. On those seven residents identified, their care plan will be modified to include a behavioral management plan. Behavioral Management plans were communicated to staff on 8/23/2021 & 8/24/2021. 3. The measures put into place will include weekly behavioral rounds on all	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 18 sleepy at the table and dozed off. Staff took R1 back to her room. R1 got "a little irritated" but was willing to get washed up...then "something changed". She got up, started walking around her room independently and walked into a wall. Staff documented "despite being calm, taking our time and reassuring her, she became aggressive and started hitting, kicking, and grabbing wrists. In addition, she ripped off staff's glasses. Staff then left her. R1 stayed in her room "for about 10 minutes" when she began wandering room to room. R1 had a phone call, staff were able to retrieve a chair and sit her in the hall so she could speak on the phone. Staff then left. Shortly after, R3 reported the incident. Law enforcement was notified and was redirected back to her room. 15 min checks were started to "determine her location. Facility will attempt to ensure [R1] is away from [R3] and no further altercation occurs". There was no mention staff had reported the incident within 2 hours for an allegation of abuse. R1's progress and behavioral notes identified other incidents of reportable abuse. On: 1) 5/10/21 at 1:59 p.m., staff documented R1 came out to the day room and had reached out to touch another resident's (R4) oxygen tank. R4 said he was going to "hit her over the head with the oxygen tank if she touched it". Staff intervened and moved the resident away from the area. There was no indication the threat of physical violence towards R1 was reported to the SA. 2) 7/5/21 at 1:40 p.m., staff documented on 7/3/21, when R5 alerted staff R1 was in his bed, R1 had bitten R5's hand. R5's family came to the facility to visit R5. He told them about the incident and they reported to the nurse they saw a slight bite mark. Staff noted "it is gone now". R5 was	F 609	residents with reported behaviors. DON met with medical director on 8/26/2021 to educate on role and responsibilities related to all residents who may be at risk for abuse or neglect. All staff were educated on the requirement to report any abuse or neglect per facility vulnerable adult policy on 7/26/2021 by executive Director and/or Interim Director of Nursing. Facility Executive Director was educated on 7/29/2021 by Megan Kleinsasser, Regional Vice President to Accura's reporting requirements and what was required from a state and federal reporting standpoint. Nurses were educated on 7/26/2021 on the need to notify the medical doctor of any incident of resident to resident or resident to staff altercations. 4. The Executive Director and/or designee will Audit 24 hour summary report X2 weekly and the MAR/TAR for behavior monitoring X2 weekly for three months to identify incidents requiring reporting to state agency and ensure incident reports were made timely to OHFC. As part of Prairie View Senior Living's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's Quality Assurance Process Improvement committee.	

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F 609	Continued From page 19 told to use his call light if R1 goes into his room so "we [staff] can get her out". The administrator was notified. There was no indication FM-A or R1's MD was notified, a report filed to the SA, or a full assessment was conducted on R5 to identify potential additional injuries cause by physical abuse from R1. 3) 7/5/21 at 10:35 p.m., staff documented also earlier that day at 4:14 p.m., prior to R1's second fall, she was observed smacking another resident (unknown identity) on his back as she was pushing him into his room. When staff attempted to redirect R1, she was "feisty and uncooperative". A male resident (unknown) reported R1 bit his shoulder. Staff "confirmed circular shaped teeth marks". FM-A was notified. It was unknown if the other resident was assessed for the severity of their injuries or of the wound had been treated in any way. There was no indication the MD was notified, or if the unknown resident's family and MD were notified, or a report was filed to the SA. Interview and document review on 7/23/21 at 12:41 p.m., with the administrator identified he agreed the above-mentioned incidents were not reported to the SA timely or at all as required. Review of the January 2020, VA policy identified abuse was the willful infliction of injury resulting in physical harm, pain, or mental anguish. Willful means the individual must have acted deliberately in their actions. All resident-to-resident altercations were reportable to the SA. The facility was to have systems in place to identify residents who were at risk for abusing other residents. During the shift the allegation of abuse occurred, staff were to report to their supervisor. the supervisor was to immediately report to the	F 609		

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F 609	Continued From page 20 administrator and DON. An immediate investigation was to begin and include interviews, environmental reviews, behavior reviews, and medication reviews. Abuse prevention was to include assessment of the resident's environment and adequate staffing and supervision of staff to identify inappropriate behaviors. Residents were to be continually assessed, care planned, and monitored in order to identify needs and behaviors. There was no mention of the time-frames for reporting abuse or threats of abuse in a timely manner.	F 609		
F 744 SS=K	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to appropriately assess, monitor, and intervene when 1 of 1 resident (R1) with known increasing physical behaviors caused by dementia, physically abused 5 of 35 residents (R2, R3, R5, R6 and 1 unknown resident) resulting in skin tears, a lacerated lip, and 2 puncture wounds caused by biting. R1 was also at risk for abuse when 1 of 1 resident (R4) threatened to harm R1 with his oxygen tank. This resulted in an immediate jeopardy (IJ). The IJ began on 5/9/21, when R1 had physically assaulted R3 by grabbing R3's arm and pinching her and the facility failed to assess R1's dementia and behaviors and develop interventions to	F 744	F (744) PLAN OF CORRECTION 1. No further action is needed for the resident affected by the deficient practice as she was discharged from the facility on 7/30/2021. Residents identified to have been affected by the aggressive behavior of resident R1are no longer at risk due to resident being discharged from facility due to resident being discharged form facility on 7/30/2021. 2. Facility reviewed all resident charts and identified seven residents R10, R11, R12, R13, R14, R15, R16 with a diagnosis of Dementia with behavioral disturbance. A	8/26/21

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F 744	Continued From page 21 manage behaviors and prevent further resident to resident altercations. The facility's administrator and director of nursing (DON) were notified of the IJ on 7/23/21 at 2:52 p.m. The IJ was removed on 7/26/21 at 11:00 a.m.. Non-compliance remained at the lower scope and severity of E (pattern), no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's 6/17/21, quarterly Minimum Data Set (MDS) identified R1 had severely impaired cognition and was independent with walking throughout the facility. R1 had diagnoses of dementia with behaviors, anxiety, and was bipolar. Her 12/24/20, Care Area Assessments identified R1 triggered for behaviors, mood, and this was to be addressed in her care plan. R1's current, undated care plan identified R1 was able to ambulate independently in the facility with use of a walker and needed cueing and reminders to use her walker. R1 had cognitive loss and dementia. Staff were to administer her medication as ordered and observe for side effects and effectiveness. Staff were to notify the doctor (MD)-A for mental health and medication adjustments. Staff were to cue and supervise as needed. R1 was noted to wander frequently into other resident's rooms. Staff were to redirect R1 as they are made aware or discover that occurring. R1 was identified as being dependent on staff for activities. R1 was noted to have a history of traveling with her spouse to all states and overseas, played cards, watched high school sporting events, and was active with walking, riding bike, bowling, church, baking, sewing, crotchet and played clarinet. R1's current	F 744	behavioral management plan was developed for each resident and all staff was made aware of each resident specific management plan on 8/23/21 & 8/24/21. To protects residents from any resident, identified as having an aggressive behavior will be supervised 1:1 for the duration for the aggressive behavior. 3. All staff were educated on facility vulnerable adult policy on 7/26/2021 by Executive Director and/or Interim Director of Nursing. All resident care plans were reviewed and revised as needed to ensure proper assessment of behaviors on 8/13/2021 by Lisa Johnson, Regional Clinical Reimbursement Specialist. MDS Coordinator Jennifer Otto completed the MDS Excellence – Introduction to the Complete RAI Process through Pathways virtual training on 7/30/2021. Residents with a diagnosis of dementia with behavioral disturbance upon admission will have a behavioral management plan developed by nursing management team. Current residents with a change in behavior will have a behavioral note completed and a behavioral plan developed as needed by the nursing management team. All staff will be educated on each resident's specific plan as written. All facility staff completed educational videos by 8/24/2021, "Persons with Dementia: Skills for Addressing Challenging Behaviors", and a "Day in the Life of Henry: A Dementia Experience." Facility will continue to provide CARES dementia training upon new staff hire. Staff were educated on redirection of behaviors and or	

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F 744	Continued From page 22 preferences included reading, visiting with others, attending church, playing bingo and card games, attend outings, shopping, being outdoors and do independent religious devotions. Staff were to encourage exercise and activity games, reminisce in topics form her years of being a homemaker. She preferred to watch TV stations and shows like "old time dancing" on the pioneer channel. R1 was noted to use anti-psychotic medication, anti-depressant medication, and anti-anxiety medication. Interventions for those medications were: R1 was to be free of drug related complications. Staff were to attempt non-pharmacological interventions of golf or football on the facility's iPad, offer cooking magazines, and sweet treats and observe for effectiveness. Staff were also to observe and record R1's target behaviors and symptoms and document per facility protocol. Staff were to consult with pharmacy and the MD when considering a dosage reduction, monitor for medication side effects and complications from medication complications and offer behavior health consults as needed. There was no mention staff had identified R1 had physical behaviors of abuse towards others and was also at risk for abuse. Observation on 7/22/21 at 10:10 a.m. identified R1 was actively participating in kick-ball in the day room. R1 appeared to be engaged in the activity and was seen moving from sitting to standing at a very fast rate. Observation and interview on 7/22/21 at 12:20 p.m. with R1 in the dining room identified she was seated at a table with 4 other residents and 1 staff. R1 was unable to answer basic questions like "how is your food?". R1 would only repeat	F 744	aggressiveness from residents on 8/23/21 & 8/24/21. Education included the following: a). Behaviors-recognize triggering events and de-escalate quickly. Look for targeting behaviors and non-pharmacological interventions on the care plan for techniques to redirect. b). Speak to resident in a calm, slow voice at eye level. Approach residents from the front with gentle touch. Avoid overstimulation and loud music/voices. c). Nurses – medical provider needs to be notified of any aggressive behaviors and abuse such as resident to resident altercations and resident to staff altercations with full and accurate details. Notify ED/DON to ensure state reporting requirements are met. d). Staff notify to charge nurse immediately of any incidents of resident to resident or resident to staff altercation, after resident or residents have been made safe. e). Nurses – All behavioral situations need to be charted on with full details and all interventions that you tried. You need to chart how the situation ended and what finally caused the behavior to cease. Be sure to be thorough and detailed – What was the triggering event; What was going on at the time of the incident; Did the resident need the bathroom; Was the environment loud; Were they wandering just prior to the incident; Was medication given if needed. 4.Director of Nursing or designee will audit 24-hour report summary X2 weekly, along with the MAR/TAR behavior monitoring, weekly X2, and incidents to meet requirements for dementia related service, ensuring residents have	

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F 744	Continued From page 23 "Someone stole my clothes." R1 ate quietly and was easily redirected by staff when she appeared to be wanting to leave. Review of R1's progress notes revealed the following. On: 1) 5/9/21 at 7:15 p.m., R1 was busy "walking around" prior to supper and "in a good mood". She then sat at the dinner table and dozed off, so staff assisted her to her room. She was "a little irritated" but was willing to get washed up. R1 then got up and started walking in her room and walked into a wall R1 refused to open her eyes when asked. Despite staff noted being calm and taking their time with R1, she became physically aggressive. R1 began kicking and hitting, pinching, grabbing wrists, and ripping a staff's glasses off their face. Staff then left R1 "in a safe manner". R1 was noted to have stayed in her room about 10 minutes, then was seen wandering room to room. R1 got a phone call and staff were able to sit her in the hallway where she was able to talk on the phone. A later note at 9:00 p.m., staff documented R1 was in a "weird position" in a chair in the hall. R3 wheeled herself around R1. R1 then dropped the phone and grabbed R3's arm and began pinching her. R1 "eventually let go" and the other [unknown] resident came to the nurses station to report the incident. R1 was then put on 15 min checks. 2) 5/10/21 at 1:59 p.m., staff documented R1 came out to the day room and had reached out to touch another resident's (R4) oxygen tank. R4 said he was going to "hit her over the head with the oxygen tank if she touched it". Staff intervened and moved the resident away from the area. 3) 5/24/21 at 10:38 p.m., R1 was noted to be entering other resident rooms and went into R2's	F 744	necessary behavioral management plans, for three months. As part of Prairie View Senior Living ongoing commitment to quality assurance, the Director or Nursing and/or designee will report identified concerns through the community's Quality Assurance Process Improvement committee.	

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room and her unidentified roommate at that time. R2 and the unidentified resident became upset. R1 began to scream. Staff were kicked and punched by R1 trying to remove R1 from R2's room. Once staff got R1 into her room, she kicked staff again and told them to "get the hell out". R1 was noted to sit in her room and when she was "rechecked on, she was much calmer".
4) 6/3/21 at 11:08 p.m., staff noted at around 4:20 that day, R1 began yelling, screaming, and telling staff and residents "they were fired", calling police, banging on the entrance door, picking up her walker, shoving walker into staff, exit seeking, and dragging chairs. Staff documented environmental or situational events were R1 was in the dining room. She was easily directed when staff observed her attempting to push another resident in a wheelchair. Staff toileted R1 then set her down in a wheelchair. She "appeared to be calm then suddenly she became upset and angry". Details of behavior included the above observations as well as getting a skin tear while she hit staff members picking up her walker as if she was going to attempt to throw it and kicking at "anyone" who came near. R1's family member (FM)-A was called and arrived at the facility. R1 continued her behaviors directed at her son and was not noted as calm for another 30 minutes. Interventions listed were toileting, walking, 1:1, monitor, re-approach by another staff, remove other residents, redirect visitors to another door, escort to a different environment, have supper in her room. And her son to provide 1:1.
5) 6/8/21 at 11:51 a.m., staff documented R1 received a rectal suppository that morning which was known to upset R1 and escalate her behaviors. An unknown nurse aide (NA) was trying to toilet R1 when R1 began hitting the NA. R1 hit the unidentified staff in the face, and

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F 744	Continued From page 25 kicked and squeezed staff in an unknown location on on the NA's body. 6) 6/15/21 at 10:29 p.m., R1 was documented to have been screaming during evening cares, pinching staff's upper arms resulting in bruising to staff. Interventions tried were walking with R1, toileting, and providing 1:1 were effective for short periods of time, then restless and wandering started up again. 7) 6/17/21 at 11:34 a.m., the social services designee (SSD) documented a Vulnerable Adult (VA) note indicating a VA assessment was completed and inaccurately included "No history of abuse towards others or self noted". 8) 6/18/21 at 12:45 p.m., R1 was observed dropping her pants in the tub room. Staff attempted to stop her. R1 hit and kicked at them. One staff member was noted to have been punched in the shoulder. 9) 6/18/21 at 11:40 p.m., R1 removed her shirt in the dining room. When staff attempted to put R1's shirt back on, she became aggressive and started hitting the NA's. R1 also "accidentally" hit another resident in the back that was close by. Staff documented they felt she "never meant to intentionally hit another resident". When staff assisted R1 to her room, she continued to swing at staff. R1 taken to her room and laid down to bed. 10) 6/21/21, at 1:01 p.m. R1 hitting, kicking, punching and trying to bite staff and moving furniture around in the dayroom. R1 was unable to be redirected. R1 was sent to emergency room to rule out outstanding medical reasons. Further review of R1's progress notes revealed the following. On: 1) 6/24/21 at 10:22 p.m., staff noted they received a call from the ER. R1 was returning to the facility	F 744		

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with diagnosis of aggressive behavior due to dementia. During R1's visit to the ER, she was "very cooperative". No physical behaviors were reported. The facility received orders for an as needed (PRN) Haldol (anti-psychotic) injection as well as a PRN dose of Seroquel to be given in addition to her scheduled dose.
2) 6/26/21 at 9:54 a.m., staff documented R1 was toileted when she screamed, "blocked", kicked, and scratched staff. During this episode, R1 "bumped" the right side of her head on the doorway. No redness or bruising was noted.
3) 6/26/21 at 12:07 p.m., R1 was using profanity at staff, grabbing another unidentified resident's shirt and would not let go. She repeatedly hollered while twisting staff's fingers, kicking, and had bumped her knee on a table while attempting to kick staff. R1 was "angry" with an "unknown cause". R1 was noted prior to the event to be sitting by the nurses station when she began yelling at other unidentified residents. When staff intervened, they were able to get R1's grip released on the other unidentified resident. Staff removed other residents away. This occurred during the entirety of the lunch hour. After yelling, R1 was wandering around the dining room and sat by another resident who removed themselves away from her. Interventions noted were for staff to approach R1 with a smile, attempt to talk, offer sweets, attempt to toilet, redirect her, attempt to remove her from the area, monitor her and other residents' safety, remove other residents away, and approach by other staff members. Staff noted all interventions were ineffective until R1 calmed down but did note it was "best to leave in a safe manner and monitor".
4) 6/28/21 at 6:10 p.m., staff documented R1 was restless and wandering into other residents' rooms, telling staff to "get away", attempting to sit

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in random areas, pick items off the floor that were not present, and punched staff in the stomach when staff tapped R1 on the shoulder when they noticed she was not wearing socks or shoes while wandering. Staff interventions attempted were to guide her to the bathroom, offer to wash her up, assist her when taking her clothes off, leave her in a safe manner then re-approach or re-approach with a different staff member, walk with her, and bring her walker to her. Staff noted none of the interventions were effective for long periods.

5) 6/28/21 at 11:33 p.m., staff noted they administered a PRN Seroquel as R1 was demonstrating behaviors of reaching for items on the floor, "almost falling", restless, agitated, uncooperative. Staff also noted she was wandering and going into another resident's room. Staff reoriented her to time, offered toileting, sweet treats.

6) 7/1/21 at 11: 24 p.m., staff documented they found R1 on another (unidentified) resident's bed. Staff took her back to her room. R1 became upset. R1 punched staff in the nose. "Later when resident had a fall, resident also kicked and pinched staff". R1's blood pressure was taken and recorded to be low. FM-A was notified and opted for R1 to be seen in the clinic the next day, 1:1 supervision for safety.

7) 7/3/21 at 11:36 a.m., R1 returned from a brief admission to the hospital for heart concerns. Staff documented "Almost immediately upon her return, [R1] became combative". R1 was stripping her clothes off wanting to put "different ones on". R1 "became mad" because she wanted her original clothing. Staff noted she settled down and laid down. At an unknown time, R5 put his call light on. R1 was trying to lie down with him. 3 staff were "required" to get R1 out of R5's room. R1

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was hitting, punching, attempting to bite staff and tried to sit down. R1 was held up by staff when trying to sit down and put into a wheelchair. Staff took R1 to her room where she "finally" laid down and fell asleep. Staff noted they did not wake her for lunch.
8) 7/5/21 at 10:35 p.m.,behavior note staff documented earlier that day at 4:14 p.m., prior to R1's second fall, she was observed smacking another resident (unknown identity) on his back as she was pushing him into his room. When staff attempted to redirect R1, she was "feisty and uncooperative". A male resident (unknown) reported R1 bit his shoulder. Staff "confirmed circular shaped teeth marks".
9) 7/6/21 at 12:59 p.m., staff documented Behavior Note. R1 was found walking down the north hallway naked except for a T-shirt. R1 was redirected back to her room and was dressed. R1 slept for a while, then got up, walked to kitchen, pulled her pants down and urinated on the kitchen floor. Staff then intervened and toileted R1. She was noted to later be going into other residents rooms but "settled down" and ate her lunch and was currently eating.
10) 7/16/21 at 10:22 p.m. staff noted R1 had scratched and hit another resident (R2). Staff contacted the on-call MD to request an increase to R1's Seroquel. The on-call MD agreed.
11) 7/17/21 at 1:40 p.m., staff documented R1 was in the dining room for lunch when she began wandering and trying to take other residents' water glasses so she could "brush her teeth". Staff "got other resident's waters away from her, but she was hitting and kicking at staff as they did it". Staff noted they were "finally able to calm her down and she is currently in bed sleeping".
12) 7/19/21 at 10:51 p.m., R1 was wandering to different hallways, attempting to go into other

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	245371	A. BUILDING _____ B. WING _____	C 07/26/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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resident's rooms, repeatedly stated she was tired or needed to sit. When staff offered her a chair she would get up and wander again. R1 had crying behaviors when staff provided brief 1:1, toileting, and walking.

R1's Behavioral Committee (BC) Notes identified the behavioral management team had documented twice on R1's behaviors and accuracy of her care plan. Notes are as follows:
1) 6/3/21 at 8:56 a.m., staff documented they performed an evaluation of R1's behaviors. Psychoactive medications were "ordered and in-use". The committee recommended a psychiatry (psych) consult. R1's care plan was reported to be reviewed and updated. R1's dementia was noted to be progressing. R1 had an overall decline. No mention was made that staff identified R1's physical behaviors and lack of supervision when those behaviors occurred or had identified the care plan lacked interventions specific to her physical aggression.
2) 7/1/21 at 12:12 p.m., staff documented they performed an evaluation of R1's behaviors. Psych meds were ordered and in-use. Recommendations were made for a psych consultation. The care plan was noted to be reviewed and updated.

R1's progress notes, identified multiple notes between 5/9/21 and 7/23/21 of incidents of physical behaviors and abuse perpetrated on the above-mentioned residents by R1. The notes lacked further indicated R1's behaviors had been reassessed and interventions implemented as R1's behaviors continued after 5/9/21.

Interview on 7/22/21 at 10:46 a.m. with the social

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services designee (SSD) identified R1 had resided at the facility prior to her employment in October, 2020. R1 has steadily declined in her cognition due to her dementia. The SSD was not at the facility on 7/16/21 when the incident between R1 and R2 occurred. On Monday, 7/19/21, she followed up with R1. R1 would be restless and wander, once in a while she would "pop into other resident rooms". Earlier this month, the SSD reported she spoke with FM-A and explored options for R1's potential placement in other facilities in a locked memory care. R1 saw a psychologist weekly (MD-A), at the clinic across the street. If staff start to see R1's behaviors "ramping up", staff are to call for an ambulance to transfer to the regional hospital in Marshall to seek placement in an inpatient behavioral health facility. Staff have requested to have R1's medication adjusted. When this occurred, she would "mellow a little". The SSD stated "1:1 were the best to do". When it came to non-pharmacological interventions, she left that up to the interim director of nursing (IDON). The SSD stated she thought wandering was more of the "issue". When R1 wanders, "she feels it is her space and her room". Staff try to redirect "if they see" her wandering.

Interview on 7/22/21 at 2:02 p.m. with registered nurse (RN)-A and licensed practical nurse (LPN)-A identified when R1 exhibited behaviors she would get restless and have wandering behaviors and would often go into other residents' rooms. Staff attempt to "distract her". Nurses do not assign anyone to increase her supervision when she exhibits restlessness or immediately prior to her physical behaviors. "We just know her and everyone helps. If nurses are busy and the nurse aides (NA) are busy, the kitchen helps

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watch her as well". They have no plan or method care planned to identify specific interventions on her care plan to prevent potential future incidents from occurring. "We do what we can". Neither RN-A or LPN-A were aware R1 had increased mental health visits with MD-A. The facility has previously requested to increase her medications to see "if that helps".

Interview and document review on 07/22/21 at 2:32 with the IDON identified she was aware of R1's physical aggression and abuse towards other residents. Staff do behavior rounds monthly and have a behavior committee meeting. The IDON agreed R1's behaviors have escalated since 5/9/21. The facility plan to prevent further physical abuse to residents and staff from R1 was to call the ambulance and send R1 to Marshall hospital for her mental health exam as that is the only way the facility can get R1 admitted to a behavioral health inpatient program. The IDON stated she felt the facility had interventions care planned to manage her behaviors. Staff were to offer R1 an iPad with football or golf on it, cooking magazines, or offer her sweets. The IDON stated if R1 was "agitated" staff were to do 1:1 supervision. Staff often "lead her to her room, but they can anger her even more". The facility "has tried a lot of things" but nothing worked for very long. the IDON stated she felt staff were providing appropriate supervision and they had gotten her psych medications increased to see if that helped with R1's behaviors. R1 was now seeing MD-A weekly since the 7/16/21 incident when R1 assaulted R2.

Review of R1's mental health provider (MD-A)'s progress notes revealed the following:
1) R1 was seen on 5/10/21 after she had

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F 744	Continued From page 32 assaulted R3 on 5/9/21. MD-A identified R1 came to the clinic for a 3 month follow-up after initially being referred by the facility for behaviors of agitation with dementia and poor sleep. R1 was "not counseling with anyone and never has". MD-A stated R1 had previous medication of Trazodone which was causing unstable gait and was of no help for behaviors or her sleep. MD-A reviewed R1's history of past medications R1 had tried. R1 was noted to be "in a good mood". MD-A was aware R1 scratched R3. "Evidently this is the only incident that happened in the past 3 months". Follow-up in 3 months and to call MD-A if there were problems before that time. 2) 7/14/21, MD-A identified R1 was seen for a 2 month follow-up. MD-A documented R1 had been urinating in various places in the facility. R1 had no prior mental health hospitalizations. The note inaccurately listed "No psychiatric consults ever". R1's medications were once again discussed. MD-A identified R1's Seroquel was increased due to her aggressive behavior. MD-A and FM-A discussed "cutting back R1's morning dose of Seroquel to see if she can be awake a little bit more in the mornings and try to eat as she has lost a couple pounds in the past couple of days". MD-A noted R1 was deteriorating more since spring and adjusted medications and to follow up in 2 weeks, and call if problems before that time. There was no indication MD-A was aware of the increased physical aggression R1 was exhibiting, nor if she had been asked to assist the facility in identifying if non-pharmacological interventions were appropriate. MD-A was unavailable for interview at the time of the survey. Interview on 7/23/21 at 10:54 a.m. with FM-A	F 744		

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identified he was aware of R1's recent incident with R2. R1 had scratched R2. R1 had a recent mental decline. He attended a care conference on 7/20/21. "Everyone sees escalating behaviors" and these occurred more since Memorial day, 2021. Facility staff told him "if there is another altercation, she will be sent to ER then to inpatient psych on a behavioral health unit".

Interview on 7/23/21 at 11:45 a.m. with trained medication aide (TMA)-A identified staff would often try to redirect R1 when she had behaviors. Staff were to leave her in a safe space. Interventions included to have her watch golf on the iPad. When asked how staff communicate interventions they had tried she stated "We try to pass it along if anything works". The facility had tried to put up banners across other residents rooms to deter R1. That did not work. R1 was very into her appearance in the past so they try and braid her hair or put it up in a bun. TMA-A identified R1's wandering always preceded her physical behaviors...but her wandering would not necessarily "start them". If she exhibited behaviors, staff were to stay with her until they "think" she is calm. There was no set time to directly monitor her.

Interview and document review on 7/23/21 at 12:41 p.m. with the administrator identified he agreed R1's care plan lacked appropriate interventions and supervision required and made no mention of R1's physical behaviors or that she was also at risk for abuse herself.

Interview and document review on 7/23/21 at 2:00 p.m. with the MDS coordinator (MDS-A) identified she was the sole staff responsible to update care plans in the facility. MDS-A stated she also

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worked on the floor providing direct care and often provided direct care or medication administration to R1. She agreed the care plan made no mention of R1's physical behaviors and lacked interventions and appropriate supervision required to prevent future incidents of abuse, and failed to identify R1 was at risk of potential abuse from others.

Interview on 7/26/21 at 11:54 a.m., with MD-B identified he would see residents at the facility if he was their primary care physician. he was not R1's physician. MD-B was unaware of R1's physical behaviors. He was the medical director as the facility "needs a doctor to attend QAPI. those meeting are just generalized. We really don't dig into or analyze issues". MD-B reported he had "little involvement" with the facility. He was not able to recall if R1 was discussed at the June meeting, but stated he attended. The facility had a psych provider for behavioral health issues "to deal with those residents".

Review of the January 2020, VA policy identified abuse was the willful infliction of injury resulting in physical harm, pain, or mental anguish. Willful means the individual must have acted deliberately in their actions. All resident-to-resident altercations were reportable to the SA. The facility was to have systems in place to identify residents who were at risk for abusing other residents. During the shift the allegation of abuse occurred, staff were to report to their supervisor. the supervisor was to immediately report to the administrator and DON. An immediate investigation was to begin and include interviews, environmental reviews, behavior reviews, and medication reviews. Abuse prevention was to include assessment of the resident's environment

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F 744	Continued From page 35 and adequate staffing and supervision of staff to identify inappropriate behaviors. Residents were to be continually assessed, care planned, and monitored in order to identify needs and behaviors. Review of the Mood and behavior Rounds Guideline policy identified mood and behavior rounds were specific meetings with staff that were to provide care dedicated to the knowledge of the resident. Meetings were to be conducted routinely and each resident reviewed monthly. Staff were to have discussion regarding prior observations of resident behavior, assess non pharmacological interventions and determine appropriate interventions. Staff were to discuss potential triggers for behaviors and review the medical record for adverse effects of medications such as falls, weight loss, to determine if the medication and/or dosage was appropriate. The resident's care plan was to be reviewed to determine if all areas on the care plan were appropriate. At the end of the evaluation, the committee was to determine an action plan and further follow-up. There was no policy specific to dementia care provided at the time of the survey. The IJ was removed when it could be verified staff had assessed R1 and implemented appropriate interventions for when R1 would become physically aggressive. Staff were to provide 1:1 supervision when R1 was identified as wandering or had behaviors to ensure behaviors had not escalated. Staff were educated to the interventions and R1's care plan was updated.	F 744		

Electronically delivered
August 16, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: KJIG11

Dear Administrator:

The above facility was surveyed on July 22, 2021 through July 26, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the

statement, "This MN Requirement 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:

Nicole Osterloh, RN, Unit Supervisor
Licensing and Certification Program
Health Regulation Division, Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: On 7/22/21 through 7/26/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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

Electronically Signed | 08/19/21

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5371029C (MN74882 and MN72676) with a licensing order issued at 1980. 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	21980		8/24/21

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PRAIRIE VIEW SENIOR LIVING	250 FIFTH STREET EAST TRACY, MN 56175

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21980	Continued From page 3 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed immediately, no later than 2 hours, report to the State agency 4 of 4 incidents of resident to resident abuse involving R1. Findings include: Review of the 5/9/21 at 11:04 p.m., report filed to the State Agency (SA) identified earlier that day on 5/9/21 at 6:00 p.m., R3 was wheeling down the hall in her wheelchair. R1 was talking on the telephone. R1 turned to R3, stated "I told you to stay away!", reached for R3's arm and scratched and pinched her. R3 pulled her arm away, and reported the incident to the nurse. After hearing the report by R3, staff went to the hall to redirect R1 back to her room. R1 was noted to be self-ambulatory and needed redirection of place and room placement due to her dementia. Staff	21980	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00342	A. BUILDING: _____ B. WING _____	C 07/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21980	Continued From page 4 documented "typically, [R1] is pleasant and easily redirectable" however, she had gone out for the day with her family member (FM)-A. When she returned she was tired and "more agitated". Staff noted what led up to the incident was R1 was busy walking around prior to supper and was reported to be in a good mood. She was very sleepy at the table and dozed off. Staff took R1 back to her room. R1 got "a little irritated" but was willing to get washed up...then "something changed". She got up, started walking around her room independently and walked into a wall. Staff documented "despite being calm, taking our time and reassuring her, she became aggressive and started hitting, kicking, and grabbing wrists. In addition, she ripped off staff's glasses. Staff then left her. R1 stayed in her room "for about 10 minutes" when she began wandering room to room. R1 had a phone call, staff were able to retrieve a chair and sit her in the hall so she could speak on the phone. Staff then left. Shortly after, R3 reported the incident. Law enforcement was notified and was redirected back to her room. 15 min checks were started to "determine her location. Facility will attempt to ensure [R1] is away from [R3] and no further altercation occurs". There was no mention staff had reported the incident within 2 hours for an allegation of abuse. R1's progress and behavioral notes identified other incidents of reportable abuse. On: 1) 5/10/21 at 1:59 p.m., staff documented R1 came out to the day room and had reached out to touch another resident's (R4) oxygen tank. R4 said he was going to "hit her over the head with the oxygen tank if she touched it". Staff intervened and moved the resident away from the area. There was no indication the threat of physical violence towards R1 was reported to the SA.	21980		

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21980	Continued From page 5 2) 7/5/21 at 1:40 p.m., staff documented on 7/3/21, when R5 alerted staff R1 was in his bed, R1 had bitten R5's hand. R5's family came to the facility to visit R5. He told them about the incident and they reported to the nurse they saw a slight bite mark. Staff noted "it is gone now". R5 was told to use his call light if R1 goes into his room so "we [staff] can get her out". The administrator was notified. There was no indication FM-A or R1's MD was notified, a report filed to the SA, or a full assessment was conducted on R5 to identify potential additional injuries cause by physical abuse from R1. 3) 7/5/21 at 10:35 p.m., staff documented also earlier that day at 4:14 p.m., prior to R1's second fall, she was observed smacking another resident (unknown identity) on his back as she was pushing him into his room. When staff attempted to redirect R1, she was "feisty and uncooperative". A male resident (unknown) reported R1 bit his shoulder. Staff "confirmed circular shaped teeth marks". FM-A was notified. It was unknown if the other resident was assessed for the severity of their injuries or of the wound had been treated in any way. There was no indication the MD was notified, or if the unknown resident's family and MD were notified, or a report was filed to the SA. Interview and document review on 7/23/21 at 12:41 p.m., with the administrator identified he agreed the above-mentioned incidents were not reported to the SA timely or at all as required. Review of the January 2020, VA policy identified abuse was the willful infliction of injury resulting in physical harm, pain, or mental anguish. Willful means the individual must have acted deliberately in their actions. All resident-to-resident altercations were reportable to the SA. The facility	21980		

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21980	Continued From page 6 was to have systems in place to identify residents who were at risk for abusing other residents. During the shift the allegation of abuse occurred, staff were to report to their supervisor. the supervisor was to immediately report to the administrator and DON. An immediate investigation was to begin and include interviews, environmental reviews, behavior reviews, and medication reviews. Abuse prevention was to include assessment of the resident's environment and adequate staffing and supervision of staff to identify inappropriate behaviors. Residents were to be continually assessed, care planned, and monitored in order to identify needs and behaviors. There was no mention of the time-frames for reporting abuse or threats of abuse in a timely manner. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff identified in the citation to policies and procedures, and audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		