



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered  
September 3, 2024

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

RE: CCN: 245371  
Cycle Start Date: July 30, 2024

Dear Administrator:

On August 15, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)



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Electronically delivered

September 3, 2024

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

Re: Reinspection Results  
Event ID: YFOU12

Dear Administrator:

On August 15, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 30, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
August 13, 2024

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

RE: CCN: 245371  
Cycle Start Date: July 30, 2024

Dear Administrator:

On July 30, 2024, a 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.

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

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

Prairie View Senior Living

August 13, 2024

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the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

## DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

Rochester District Office

3425 40th Avenue NW, Suite 115

Rochester, MN 55901

Email: [Lisa.Krebs@state.mn.us](mailto:Lisa.Krebs@state.mn.us)

Office (507) 206-2728

## 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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

If substantial compliance with the regulations is not verified by October 30, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 30, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.**

#### **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/lrc\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/lrc_idr.cfm)

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](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.

Prairie View Senior Living

August 13, 2024

Page 4

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a loop at the end of the last name.

Kamala Fiske-Downing

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)



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Electronically delivered  
August 13, 2024

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

Re: State Nursing Home Licensing Orders  
Event ID: YFOU11

Dear Administrator:

The above facility was surveyed on July 30, 2024 through July 30, 2024 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](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.

Prairie View Senior Living

August 13, 2024

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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:

**Lisa Krebs, Regional Operations Supervisor, Rapid Response**

**Licensing and Certification Program**

**Health Regulation Division**

**Minnesota Department of Health**

**Rochester District Office**

**3425 40th Avenue NW, Suite 115**

**Rochester, MN 55901**

**Email: [Lisa.Krebs@state.mn.us](mailto:Lisa.Krebs@state.mn.us)**

**Office (507) 206-2728**

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 feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)

Prairie View Senior Living

August 13, 2024

Page 3

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

PRINTED: 08/15/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245371</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/30/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE VIEW SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>250 FIFTH STREET EAST TRACY, MN 56175</b>
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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
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>On 7/30/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed H53716300C (MN00105195), H53716301C (MN00105188), and H53716362C (MN00105266) with a incidental deficiency cited at F689.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>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.</p>	F 000		
F 689 SS=D	<p><b>Free of Accident Hazards/Supervision/Devices</b> CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document</p>	F 689	1. In Continuing Compliance with	8/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>08/13/2024</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245371</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/30/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE VIEW SENIOR LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>250 FIFTH STREET EAST TRACY, MN 56175</b>		
(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 689	<p>Continued From page 1</p> <p>review, the facility failed follow manufacturer's safety instructions for safe transfers for 1 of 2 residents (R4) who was not transferred with the appropriate mechanical lift sling.</p> <p>Findings include:</p> <p>R1's quarterly minimum data set (MDS) dated 5/9/24, indicated severe cognitive impairment with the diagnoses of aphasia, dementia, anxiety, and depression. R4 had physical and verbal behaviors toward others, and rejection of cares one to three days during the look back period. R4 had impairment to one side of upper extremity and used a wheelchair. R4 was dependent for all his activities of daily living (ADLs) except for dressing of upper body, which required partial assist. R4 did not walk.</p> <p>R4's ADL care related to transfers dated 12/7/23, directed staff to use two staff assistance to transfer with mechanical lift. R4's care plan did not identify the size and type of sling R4 required.</p> <p>During an observation on 7/30/24 at 12:17 p.m., R4 had returned from hospital and was sitting in wheelchair on Guldman ceiling lift sling that the hospital had used to transfer R4 to his chair to return to the facility. R4's room was not observed to have a ceiling lift. Nursing assistants (NA's) brought a Valaro total body lift into R4's room. NA-T and NA-K hooked the Guldman sling to the Valaro lift. NA's lifted R4 into the air, they did not stop the lift to check the tension of the sling straps and transferred R4 from wheelchair to the bed. NA-T and NA-K stated they were not aware the Guldman sling was not approved by Valaro manufacturer to use with Valaro lifts. Interview on 7/30/24 at 3:31 p.m., Administrator</p>	F 689	<p>F689, Free of Accident Hazards/Supervision/Devices, Prairie View Senior Living corrected the deficiency by Executive Director Brian Hinrichs immediately providing a written coaching on using the correct brand of lift sling to the three staff involved on 7/30/2024.</p> <p>2. To ensure the deficiency does not reoccur Prairie View Senior Living ensured the incorrect sling was returned to the transferring hospital on 7/30/2024. A search of the facility was conducted on 7/30/2024 to ensure there were no other non-Valaro slings in the facility. All nursing staff will be educated that when operating a lift, the sling brand must always match the brand of lift per the manufacturer's safety instructions for safe transfers by 8/15/2024 by the Director of Nursing. The Executive Director and/or designee will audit lift transfers for correct sling brand and lift brand within facility twice per week for 3 months and then randomly to ensure continued compliance.</p> <p>3. As part of Prairie View Senior Livings' ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.</p>	

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

PRINTED: 08/15/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245371</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/30/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE VIEW SENIOR LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>250 FIFTH STREET EAST</b> <b>TRACY, MN 56175</b>		
(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 689	<p>Continued From page 2</p> <p>stated that NA-T and NA-K informed him that I watched the transfer of R4 with the wrong sling and Administrator stated he re-educated the staff they should have changed the sling out to the Volaro sling as the Guldman sling was not compatible to use with the Volaro lift.</p> <p>During an interview on 7/30/24 at 4:07 p.m., Valaro lift representative (LR)-A stated the manufacturer would not recommend the use of any other sling with the Volaro total body lift. LR-A stated he would have advised the staff to change out the sling with a Volaro sling prior to the transfer to ensure safety.</p> <p>During a clarification interview on 8/7/24 at 2:24 p.m., administrator stated they did not have a policy regarding transferring resident but use the competencies to verify correct usage of mechanical lifts.</p> <p>Valaro Operator's manual included Use only Valaro slings and accessories designed for use with the Volaro lift models</p>	F 689		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00342</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/30/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE VIEW SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>250 FIFTH STREET EAST TRACY, MN 56175</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;"><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 7/30/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>08/13/24</b>
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00342</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/30/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE VIEW SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>250 FIFTH STREET EAST TRACY, MN 56175</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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2 000	<p>Continued From page 1</p> <p>identify the date when they will be completed.</p> <p>The following complaints were reviewed: H53716300C (MN00105195), H53716301C (MN00105188), and H53716362C (MN00105266) with a licensing order issued at . 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.</p> <p>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 &lt;<a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a>&gt; 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</p>	2 000		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00342</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/30/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE VIEW SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>250 FIFTH STREET EAST TRACY, MN 56175</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2  state form.  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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General  Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.  This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed follow manufacturer's safety instructions for safe transfers for 1 of 2 residents (R4) who was not transferred with the appropriate mechanical lift sling.  Findings include:  R1's quarterly minimum data set (MDS) dated 5/9/24, indicated severe cognitive impairment with the diagnoses of aphasia, dementia, anxiety,	2 830	Corrected	8/15/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00342</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/30/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PRAIRIE VIEW SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>250 FIFTH STREET EAST TRACY, MN 56175</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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2 830	<p>Continued From page 3</p> <p>and depression. R4 had physical and verbal behaviors toward others, and rejection of cares one to three days during the look back period. R4 had impairment to one side of upper extremity and used a wheelchair. R4 was dependent for all his activities of daily living (ADLs) except for dressing of upper body, which required partial assist. R4 did not walk.</p> <p>R4's ADL care related to transfers dated 12/7/23, directed staff to use two staff assistance to transfer with mechanical lift. R4's care plan did not identify the size and type of sling R4 required.</p> <p>During an observation on 7/30/24 at 12:17 p.m., R4 had returned from hospital and was sitting in wheelchair on Guldmann ceiling lift sling that the hospital had used to transfer R4 to his chair to return to the facility. R4's room was not observed to have a ceiling lift. Nursing assistants (NA's) brought a Valaro total body lift into R4's room. NA-T and NA-K hooked the Guldmann sling to the Valaro lift. NA's lifted R4 into the air, they did not stop the lift to check the tension of the sling straps and transferred R4 from wheelchair to the bed. NA-T and NA-K stated they were not aware the Guldmann sling was not approved by Valaro manufacturer to use with Valaro lifts.</p> <p>Interview on 7/30/24 at 3:31 p.m., Administrator stated that NA-T and NA-K informed him that I watched the transfer of R4 with the wrong sling and Administrator stated he re-educated the staff they should have changed the sling out to the Valaro sling as the Guldmann sling was not compatible to use with the Valaro lift.</p> <p>During an interview on 7/30/24 at 4:07 p.m., Valaro lift representative (LR)-A stated the manufacturer would not recommend the use of any other sling with the Valaro total body lift. LR-A</p>	2 830		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00342</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/30/2024</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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2 830	<p>Continued From page 4</p> <p>stated he would have advised the staff to change out the sling with a Volaro sling prior to the transfer to ensure safety.</p> <p>During a clarification interview on 8/7/24 at 2:24 p.m., administrator stated they did not have a policy regarding transferring resident but use the competencies to verify correct usage of mechanical lifts.</p> <p>Valaro Operator's manual included Use only Volaro slings and accessories designed for use with the Volaro lift models</p> <p><b>SUGGESTED METHOD OF CORRECTION:</b> The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure staff are appropriately trained to operate mechanical lifts according to manufacturer's instructions. The facility should ensure lift manuals are easily accessible and staff are deemed competent to operators instructions. The director of nursing or designee, should conduct audits of the delivery of care with lift use and competencies are performed. The results of those audits should be taken to QAPI to determine compliance or the need for ongoing monitoring.</p> <p><b>TIMEFRAME FOR CORRECTION:</b> Twenty-One (21) days.</p>	2 830		
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