Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 14, 2023

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

RE: CCN: 245371
Cycle Start Date: February 9, 2023

Dear Administrator:

On March 1, 2023, we notified you a remedy was imposed. On March 27, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 14, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 16, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 1, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 9, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 14, 2023

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

Re: Reinspection Results
Event ID: HSU712

Dear Administrator:

On March 27, 2023 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 February 9, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 17, 2023

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

RE: CCN: 245371
Cycle Start Date: February 9, 2023

Dear Administrator:

On March 1, 2023, we informed you of imposed enforcement remedies.

On March 8, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 16, 2023, will remain in effect.

This Department continues to recommend 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 March 16, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 16, 2023.

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.

As we notified you in our letter of March 1, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 9, 2023.

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.

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

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

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

DEPARTMENT CONTACT

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 9, 2023 (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

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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 17, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: HSU711

Dear Administrator:

The above facility was surveyed on March 8, 2023 through March 8, 2023 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
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 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 feel free to call me with any questions.

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

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 03/08/2023

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 3/8/23, 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. The following complaints were reviewed. H53719043C (MN91599) with a deficiency issued at F610 and F755. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		3/14/23

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

Electronically Signed | 03/20/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 610	Continued From page 1 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 observation, interview, and document review the facility failed to thoroughly investigate potential drug diversion and misappropriation of property for 4 of 7 residents (R1, R4, R6, and R7) with verified narcotic count discrepancies. Findings include: Review of the report to the State agency (SA) on 3/3/23, indicated a bottle of liquid morphine sulfate (a narcotic medication used for pain control at end of life) belonging to R1 was missing and not found. A follow-up facility investigation report made to the SA on 3/7/23, indicated the facility had no further findings related to the incident, did not suspect diversion by the alleged perpetrator mentioned in the initial report and had educated nursing on properly storing narcotic medications. On 3/8/23, the Individual Narcotic Record book was reviewed, and found four (4) additional narcotic discrepancies. R1's Individual Narcotic Record page 106, noted on 2/28/23, at 7:35 p.m. licensed practical nurse (LPN)-A administered 0.25 mL (milliliters) of Roxanol (brand name for liquid morphine sulfate) with 4.00 ml remaining in the bottle. The next documentation noted at 2/28/23, at 9:17 p.m.), LPN-A administered 0.25 L's of Roxanol to R1	F 610	1. In Continuing Compliance with F610, Investigate/Prevent/Correct/Alleged Violation, Prairie View Senior corrected the deficiency by auditing the narcotic records for additional discrepancies for R1, R4, R6, R7 and all like residents on 3/9/2023. LPN-A was resuspended on 3/9/2023, RN-B received immediate re-education on the controlled substance policy on 3/8/2023 by Director of Nursing Services. On 3/8/2023 the facility initiated an additional OHFC report for R4, R6, and R7 based on the new information found during the survey and notified the local police department. 2. To correct the deficiency and ensure the problem does not recur education was provided to Director of Nursing on 3/9/2023 by Executive Director on ensuring narcotic books are audited when a narcotic discrepancy is reported. The Executive Director and/or designee will audit all reportable incident reports for thorough investigations for 4 months and then randomly to ensure continued compliance. Director of Nursing Services and/or designee will audit narcotic reconciliation three times per week for 4 weeks, two times per week for 4 weeks, then weekly for 8 weeks, then randomly to	

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F 610	Continued From page 2 with zero (0) ml's remaining in the bottle. LPN-A noted "discrepancy due to use of syringe" dated 2/28/23. A discrepancy of 3.75 mL was noted which is equal to 15 doses not accounted for. R4's Individual Narcotic Record page 9, noted on 2/26/23, at 1:11 p.m., registered nurse (RN)-A administered 0.25 ml of Roxanol to R4 with 6.5 ml's remaining in the bottle. The next documentation noted on 2/26/23, at 2:30 p.m., LPN-A administered 0.25 ml of Roxanal to R4 with zero (0) ml's remaining in the bottle. LPN-A noted "discrepancy due to use of syringe". A discrepancy of 6.25 mL of Roxanol was noted which is equal to 25 doses not accounted for. R6's Individual Narcotic Record page 42 noted on 1/28/23, at 2:30 a.m., LPN-B administered a 0.25 mg (milligram) tablet of Alprazolam (a controlled medication used for anxiety) to R6 with 24 tablets remaining. A note by an unidentified author indicated "DC'd [discharged] home, meds still here". No other documentation of tablets given were noted. The section of the page titled, Disposition of Unused Drug indicates that 22 tablets were destroyed by RN-A and LPN-C. A discrepancy of two (2) tablets were not accounted for. R7's Individual Narcotic Record page 86 noted on 12/26/22, at 5:40 p.m., RN-B administered 0.25 ml of Roxanol to R7 with 7.5 ml's remaining in the bottle. On 12/26/22, at 2020 (8:20 p.m.) RN-B administered 0.25 ml of Roxanol to R7 with 7.25 mL's remaining in the bottle. Immediately following that entry is a note, "bottle empty" signed by RN-B. No other doses or explanation for the 7.25 ml discrepancy was noted. A discrepancy of 7.25 mL is equal to 29 doses not	F 610	ensure continued compliance. Director of Nursing Services and/or designee will audit narcotic count 4 times/week for 4 weeks, 2 times/week for 8 weeks, weekly for 4 weeks, and then randomly to ensure continued compliance. 3. As part of Prairie View Senior Livings ongoing commitment to quality assurance, the Executive Director and Director of Nursing Services and/or designees will present Audit findings to monthly and quarterly QAPI to ensure continued compliance and seek further recommendation suggestions.	

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

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F 610	Continued From page 3 accounted for. During an observation on 3/8/23, at 1:45 p.m. LPN-C and RN-B were doing a shift-to-shift narcotic reconciliation count. LPN-C indicated there was 12 ml's of Roxanol in a bottle but there was only 9.5 ml's in the bottle. When asked about the discrepancy of the amounts, LPN-C stated, "it shows up that way but will work itself out by the bottom of the bottle". During an interview on 3/8/23, at 12:50 p.m. the director of nursing (DON) reported being a part of the facility's internal investigation regarding the potential diversion of R1's Roxanol but stated that she did not look at the Individual Narcotic Record book as a part of the investigation and was not aware of the discrepancies until this interview. Further, stated she does not routinely look at or audit the Individual Narcotic Record book. During an interview on 3/8/23, at 1:27 p.m. the administrator reported being a part of the facility's internal investigation regarding the potential diversion of R1's Roxanol. He had not looked at the Individual Narcotic Record book as a part of the investigation and wasn't sure if the DON had or not. He was not informed that the "narcotic books were off" and was not aware of the discrepancies until this interview. During an interview on 3/8/23, at 2:32 p.m. the pharmacy consultant (RPh)-A indicated liquid morphine is a highly diverted drug and was not aware of the facility's potential diversion investigation. RPh indicated liquid morphine sulfate has a little overfill but not as much as the narcotic record discrepancies indicate.	F 610		

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F 610	Continued From page 4 The Facility's Controlled Substances policy updated 10/19/22, indicated (controlled substance medications) discrepancies found at any time, change of shift or other, are to be immediately reported to the director of nursing. The director will initiate an investigation to determine the cause of the inaccuracy and call the pharmacist for assistance.	F 610		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		3/14/23

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F 755	Continued From page 5 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop and implement a system of to account for controlled medications disposition in sufficient detail to enable an accurate reconciliation for the use of controlled medications and had the potential to include all residents on controlled medications. The facility also failed to develop and implement a system of identifying and reporting control medication discrepancies for 4 of 4 residents (R1, R4, R6, and R7). A facility reported incident (FRI) made to the State agency (SA) on 3/3/23, indicated a bottle of liquid morphine sulfate (a narcotic medication used for pain control at end of life) belonging to R1 was missing and not found. During an observation on 3/8/23, at 1:45 p.m. LPN-C and RN-B were doing a shift-to-shift narcotic reconciliation count. LPN-C indicated there was 12 ml (milliliters)'s of Roxanol in a bottle but there was only 9.5 ml's according to the Individual Narcotic Record. When asked about the discrepancy of the amounts, LPN-C stated, "it shows up that way but will work itself out by the bottom of the bottle". RN-B indicated the count on the liquid morphine was usually off. R1's Individual Narcotic Record page 106, noted on 2/28/23, at 7:35 p.m. licensed practical nurse (LPN)-A administered 0.25 mL (milliliters) of Roxanol (brand name for liquid morphine sulfate)	F 755	1. In continuing compliance with F 755, Pharmacy Srvcs/Procedures/Pharmacist/Records, Prairie View Senior Living corrected the deficiency by auditing the narcotic records for additional discrepancies for R1, R4, R6, R7 and all like residents on 3/9/2023. LPN-A was resuspended on 3/9/2023, RN-B received immediate re-education on the controlled substance policy on 3/8/2023 by Director of Nursing Services. On 3/8/2023 the facility initiated an additional OHFC report for R4, R6, and R7 based on the new information found during the survey and notified the local police department. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses and TMA's were reeducated on 3/9/2023 or prior to starting their next shift on the controlled substance policy which includes narcotic destruction and notification to the Director of Nursing Services with any discrepancy. LPN-A's employment was terminated on 3/13/2023. RN-B received a written warning for no notification of discrepant narcotic count to Director of Nursing Services and not following correct procedures for narcotic counts on 3/13/2023. LPN-C received a written warning on 3/14/2023 for not completing	

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	245371	A. BUILDING _____ B. WING _____	C 03/08/2023

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F 755	Continued From page 6 with 4.00 ml remaining in the bottle. The next documentation noted at 2/28/23, at 9:17 p.m.), LPN-A administered 0.25 L's of Roxanol to R1 with zero (0) ml's remaining in the bottle. LPN-A noted "discrepancy due to use of syringe" dated 2/28/23. A discrepancy of 3.75 mL was noted which is equal to 15 doses not accounted for. R4's Individual Narcotic Record page 9, noted on 2/26/23, at 1:11 p.m., registered nurse (RN)-A administered 0.25 ml of Roxanol to R4 with 6.5 ml's remaining in the bottle. The next documentation noted on 2/26/23, at 2:30 p.m., LPN-A administered 0.25 ml of Roxanal to R4 with zero (0) ml's remaining in the bottle. LPN-A noted "discrepancy due to use of syringe". A discrepancy of 6.25 mL of Roxanol was noted which is equal to 25 doses not accounted for. R6's Individual Narcotic Record page 42 noted on 1/28/23, at 2:30 a.m., LPN-B administered a 0.25 mg (milligram) tablet of Alprazolam (a controlled medication used for anxiety) to R6 with 24 tablets remaining. A note by an unidentified author indicated "DC' d [discharged] home, meds still here". No other documentation of tablets given were noted. The section of the page titled, Disposition of Unused Drug indicates that 22 tablets were destroyed by RN-A and LPN-C. A discrepancy of two (2) tablets were not accounted for. R7's Individual Narcotic Record page 86 noted on 12/26/22, at 5:40 p.m., RN-B administered 0.25 ml of Roxanol to R7 with 7.5 ml's remaining in the bottle. On 12/26/22, at 2020 (8:20 p.m.) RN-B administered 0.25 ml of Roxanol to R7 with 7.25 mL's remaining in the bottle. Immediately following that entry is a note, "bottle empty"	F 755	correct procedures for narcotic counts. RN-A received individualized education on ensuring narcotic records are accurately completed on 3/10/2023 by the Director of Nursing Services. The facility will begin using pre-filled morphine syringes once the current supply is depleted. Director of Nursing Services and/or designee will audit narcotic reconciliation three times per week for 4 weeks, two times per week for 4 weeks, then weekly for 8 weeks, then randomly to ensure continued compliance. Director of Nursing Services and/or designee will audit narcotic count 4 times/week for 4 weeks, 2 times/week for 8 weeks, weekly for 4 weeks, and then randomly to ensure continued compliance. 3. As part of Prairie View Senior Livings ongoing commitment to quality assurance, the Director of Nursing Services and/or designee will present Audit findings to monthly and quarterly QAPI to ensure continued compliance and seek further recommendation suggestions.	

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F 755	Continued From page 7 signed by RN-B. No other doses or explanation for the 7.25 ml discrepancy was noted. A discrepancy of 7.25 mL is equal to 29 doses not accounted for. A review of the Individual Narcotic Records for R1, R2, R3, R4, R5, R6, and R7 do not include the RX (prescription) numbers necessary to be able to track the disposition of the medication. A review of the Medication Disposition Sheet further labeled "Omnicare Narcotics" includes entries for four (4) controlled substance that were destroyed by RN-RN-B and LPN an RX number but does not include a resident name to be able to adequately reconcile and prevent diversion of the controlled medications. During an interview on 3/8/23, at 11:30 a.m. the director of nursing (DON) indicated if a discrepancy (in controlled substance count) is noted, the nurses are to notify her immediately. Stated she received a report only one other time in the past year. A follow-up interview at 12:50 p.m. the DON reported being a part of the facility's internal investigation regarding the potential diversion of R1's Roxanol but stated that she did not look at the Individual Narcotic Record book as a part of the investigation and was not aware of the discrepancies until this interview. Further stated she does not routinely look at or audit the Individual Narcotic Record book or Medication Disposition. Verified the Individual Narcotic Record lacked the identifying information to adequately. During an interview on 3/8/23, at 1:27 p.m. the administrator reported being a part of the facility's internal investigation regarding the potential diversion of R1's Roxanol. Indicated he was not	F 755		

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F 755	Continued From page 8 informed that the "narc books were off" and was not aware of the discrepancies until this interview. Further indicated the facility had recently changed pharmacies. During an interview LPN-A had been employed at the facility less than three months. Further indicated she was not aware of a facility policy or received any direction during her training on what to do if the controlled substance counts were off so continued to follow the guidance she received at a previous employer. Stated frequently, when doing the controlled substance counts, the nurses would announce that the morphine sulfate wasn't used so the count hadn't changed and it wasn't counted. During an interview on 3/8/23, at 2:32 p.m. the pharmacy consultant (O)-A indicated consulted with the facility until March. Indicated she looked at the Individual Narcotic Record Book as part of her monthly pharmacy review and had reviewed them last in January. O-A recognized the need for improvement regarding tracking the chain of custody of the controlled substances and mentioned to the DON the need to complete the Individual Narcotic Record completely and have a better system of reconciling and tracking the destruction of controlled substances. Indicated she "thought it had improved a little". The Facility's Controlled Substances policy updated 10/19/22, indicated (controlled substance medications) discrepancies found at any time, change of shift or other, are to be immediately reported to the director of nursing. The director will initiate an investigation to determine the cause of the inaccuracy and call the pharmacist for assistance. Further indicates	F 755		

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F 755	Continued From page 9 when the nurse received the controlled medication, the nurse will need to fill out the top portion of the controlled drug administration record (information about the medication), the bottom part where the resident name goes, and the first line on the section that counts the medication down.	F 755		

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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 3/8/23, 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 order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H53719043C (MN91599) with a licensing order issued at 1635. 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		
21635	MN Rule 4658.1350 Subp. 3 Disposition of Medications; Loss or spillage Subp. 3. Loss or spillage. When a loss or spillage of a prescribed Schedule II drug occurs, an explanatory notation must be made in a Schedule II record. The notation must be signed by the person responsible for the loss or spillage and by one witness who must also observe the destruction of any remaining contaminated drug by flushing into the sewer system or wiping up the spill. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to develop and implement a system of to account for controlled medication disposition in sufficient detail to enable an accurate reconciliation for residents reviewed for use of controlled medications and had the potential to include all residents on controlled medications. The facility also failed to develop and implement a system of identifying and reporting control medication discrepancies for 4 of 4 residents (R1, R4, R6, and R7). A facility reported incident (FRI) made to the State agency (SA) on 3/3/23, indicated a bottle of liquid morphine sulfate (a narcotic medication used for pain control at end of life) belonging to R1 was missing and not found.	21635	Corrected	3/14/23

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21635	Continued From page 3 During an observation on 3/8/23, at 1:45 p.m. LPN-C and RN-B were doing a shift-to-shift narcotic reconciliation count. LPN-C indicated there was 12 ml (milliliters)'s of Roxanol in a bottle but there was only 9.5 ml's according to the Individual Narcotic Record. When asked about the discrepancy of the amounts, LPN-C stated, "it shows up that way but will work itself out by the bottom of the bottle". RN-B indicated the count on the liquid morphine was usually off. R1's Individual Narcotic Record page 106, noted on 2/28/23, at 7:35 p.m. licensed practical nurse (LPN)-A administered 0.25 mL (milliliters) of Roxanol (brand name for liquid morphine sulfate) with 4.00 ml remaining in the bottle. The next documentation noted at 2/28/23, at 9:17 p.m.), LPN-A administered 0.25 L's of Roxanol to R1 with zero (0) ml's remaining in the bottle. LPN-A noted "discrepancy due to use of syringe" dated 2/28/23. A discrepancy of 3.75 mL was noted which is equal to 15 doses not accounted for. R4's Individual Narcotic Record page 9, noted on 2/26/23, at 1:11 p.m., registered nurse (RN)-A administered 0.25 ml of Roxanol to R4 with 6.5 ml's remaining in the bottle. The next documentation noted on 2/26/23, at 2:30 p.m., LPN-A administered 0.25 ml of Roxanal to R4 with zero (0) ml's remaining in the bottle. LPN-A noted "discrepancy due to use of syringe". A discrepancy of 6.25 mL of Roxanol was noted which is equal to 25 doses not accounted for. R6's Individual Narcotic Record page 42 noted on 1/28/23, at 2:30 a.m., LPN-B administered a 0.25 mg (milligram) tablet of Alprazolam (a controlled medication used for anxiety) to R6 with 24 tablets remaining. A note by an unidentified author	21635		

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21635	Continued From page 4 indicated "DC' d [discharged] home, meds still here". No other documentation of tablets given were noted. The section of the page titled, Disposition of Unused Drug indicates that 22 tablets were destroyed by RN-A and LPN-C. A discrepancy of two (2) tablets were not accounted for. R7's Individual Narcotic Record page 86 noted on 12/26/22, at 5:40 p.m., RN-B administered 0.25 ml of Roxanol to R7 with 7.5 ml's remaining in the bottle. On 12/26/22, at 2020 (8:20 p.m.) RN-B administered 0.25 ml of Roxanol to R7 with 7.25 mL's remaining in the bottle. Immediately following that entry is a note, "bottle empty" signed by RN-B. No other doses or explanation for the 7.25 ml discrepancy was noted. A discrepancy of 7.25 mL is equal to 29 doses not accounted for. A review of the Individual Narcotic Records for R1, R2, R3, R4, R5, R6, and R7 do not include the RX (prescription) numbers necessary to be able to track the disposition of the medication. A review of the Medication Disposition Sheet further labeled "Omnicare Narcotics" includes entries for four (4) controlled substance that were destroyed by RN-RN-B and LPN an RX number but does not include a resident name to be able to adequately reconcile and prevent diversion of the controlled medications. During an interview on 3/8/23, at 11:30 a.m. the director of nursing (DON) indicated if a discrepancy (in controlled substance count) is noted, the nurses are to notify her immediately. Stated she received a report only one other time in the past year. A follow-up interview at 12:50 p.m. the DON reported being a part of the facility's internal investigation regarding the	21635		

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21635	Continued From page 5 potential diversion of R1's Roxanol but stated that she did not look at the Individual Narcotic Record book as a part of the investigation and was not aware of the discrepancies until this interview. Further stated she does not routinely look at or audit the Individual Narcotic Record book or Medication Disposition. Verified the Individual Narcotic Record lacked the identifying information to adequately. During an interview on 3/8/23, at 1:27 p.m. the administrator reported being a part of the facility's internal investigation regarding the potential diversion of R1's Roxanol. Indicated he was not informed that the "narc books were off" and was not aware of the discrepancies until this interview. Further indicated the facility had recently changed pharmacies. During an interview LPN-A had been employed at the facility less than three months. Further indicated she was not aware of a facility policy or received any direction during her training on what to do if the controlled substance counts were off so continued to follow the guidance she received at a previous employer. Stated frequently, when doing the controlled substance counts, the nurses would announce that the morphine sulfate wasn't used so the count hadn't changed and it wasn't counted. During an interview on 3/8/23, at 2:32 p.m. the pharmacy consultant (O)-A indicated consulted with the facility until March. Indicated she looked at the Individual Narcotic Record Book as part of her monthly pharmacy review and had reviewed them last in January. O-A recognized the need for improvement regarding tracking the chain of custody of the controlled substances and mentioned to the DON the need to complete the	21635		

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21635	Continued From page 6 Individual Narcotic Record completely and have a better system of reconciling and tracking the destruction of controlled substances. Indicated she "thought it had improved a little". The Facility's Controlled Substances policy updated 10/19/22, indicated (controlled substance medications) discrepancies found at any time, change of shift or other, are to be immediately reported to the director of nursing. The director will initiate an investigation to determine the cause of the inaccuracy and call the pharmacist for assistance. Further indicates when the nurse received the controlled medication, the nurse will need to fill out the top portion of the controlled drug administration record (information about the medication), the bottom part where the resident name goes, and the first line on the section that counts the medication down. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and proceduresto prevent potential diversion. Nursing and/or medication aide staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21635		