



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 26, 2024

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

RE: CCN: 245482
Cycle Start Date: February 14, 2024

Dear Administrator:

On February 22, 2024, we notified you a remedy was imposed. On March 20, 2024 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 15, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 8, 2024 be discontinued as of March 15, 2024. (42 CFR 488.417 (b))

In our letter of February 22, 2024, 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 14, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



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Electronically delivered

March 26, 2024

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

Re: Reinspection Results
Event ID: 6RLY12

Dear Administrator:

On March 20, 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 February 14, 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, appearing to read 'M. Poepping'.

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
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Electronically Submitted
February 22, 2024

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

RE: CCN: 245482
Cycle Start Date: February 14, 2024

Dear Administrator:

On February 14, 2024, 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 isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 13, 2024, the situation of immediate jeopardy to potential health and safety cited at F684 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location 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 March 8, 2024.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 8, 2024 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 8, 2024, (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 \$11,995; 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 February 14, 2024. 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 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. 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.

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 Manor Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 14, 2024. 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" and/ or "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: 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 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

Prairie Manor Care Center

February 22, 2024

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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 14, 2024 (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:

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
202-795-7490

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.

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://forms.web.health.state.mn.us/form/NHDisputeResolution>

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:

Prairie Manor Care Center

February 22, 2024

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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,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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
February 22, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 6RLY11

Dear Administrator:

The above facility was surveyed on February 9, 2024 through February 14, 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. 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: 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.



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

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

PRINTED: 03/19/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245482	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/14/2024
NAME OF PROVIDER OR SUPPLIER PRAIRIE MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 THIRD STREET NORTHWEST BLOOMING PRAIRIE, MN 55917		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/9/24, and 2/12/24 through 2/14/24, 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. The following complaints were reviewed: H54829723C (MN00100628) with deficiencies issued at F580 and F684. The survey resulted in an Immediate Jeopardy (IJ) at tag number F684 when the facility failed to assess, implement care and interventions, and provide timely notification for change in condition to a provider for an unresponsive resident (R1) that delayed care and BIPAP support resulting in risk of seizure, coma, or death to 1 of 3 residents (R1). at F684. The IJ began on 2/6/24, and the immediacy was removed on 2/13/24. The above findings constituted substandard quality of care, and an extended survey was conducted 2/14/24. 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 580	Notify of Changes (Injury/Degrade/Room, etc.)	F 580			3/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/29/2024

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 580 SS=D	Continued From page 1 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580			

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F 580	Continued From page 2 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide timely notification for change in condition to a provider and family for an unresponsive resident (R1) and for the same resident (R1) who, during a transfer between two surfaces, felt a pop sensation near her right knee, and afterwards reported severe pain, and could no longer bear weight. Findings include: R1 was admitted to the facility on 1/29/24 with diagnoses of pneumonia, chronic respiratory failure with hypercapnia, chronic obstructive pulmonary disease, acidosis, and neuropathy. R1's Minimum Data Set (MDS) dated 2/2/24, indicated mild cognitive impairment, assist of two staff for bed mobility, transfers, toileting, and set-up assistance for eating. R1's care plan dated 2/9/24, indicated R1 had shortness of breath with exertion, chronic obstructive pulmonary disease (COPD), pneumonia, and pulmonary hypertension, and required the assistance of two for most activities	F 580	The change in condition policy was updated to reflect time frames for physician notification if no response from the provider listed as on call. All nurses informed of these updates on 2/13/24, as well as completed educational training on educare regarding change in condition. All nurses passed the quiz accompanying the training. Nursing department meeting on 2/19 held and department staff informed of changes as well as given handout with additional information on change in condition and instructions that the nurse is to be notified IMMEDIATELY as well as nurse to complete assessment ASAP and notify provider. In addition this tag heavily focuses on the incident in F684 so i will post that response It was identified by a survey member, that compliance and protocol involving assessment and implementation of care and interventions including timely notification for change in condition for an		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 580	Continued From page 3 of daily living (ADLs). During an interview on 2/9/24 at 11:30 a.m., family member (FM)-A stated there were two events recently for R1 in which the family was not notified timely. FM-A stated the first incident was on 2/2/24, when a nursing assistant (NA) transferred R1, R1's right leg twisted during the transfer, and R1 could no longer bear weight on the right leg because the pain was intolerable. FM-A stated he was not notified of the incident until R1 was transferred to the hospital on 2/3/23. FM-A stated the second incident was 2/6/24, when R1 was found unresponsive at around 7:30 a.m., but he was not notified of the change in condition until 11:58 a.m., and further stated, "She could have been gone in that amount of time. I wasn't told about it until after they sent her to the hospital. They should have called me. I would have asked them to send her right away." R1's progress note on 2/2/24 at 10:26 p.m., indicated R1 complained of right knee discomfort immediately following transfer from recliner to wheelchair, R1 stated she thought she injured it while pivoting, ice was applied but refused Tylenol, and the nurse would continue to monitor. The progress note lacked notification to family or a provider of the change in condition. R1's progress note on 2/3/24 at 10:18 a.m., indicated staff reported R1 was unable to stand the prior evening due to right knee pain, and was transferred to bed with a mechanical lift. The progress indicated R1's right knee was swollen and warm to touch, and R1 complained of pain rated as 10/10. Additionally, the note indicated R1 requested staff notify her son, and subsequently R1's son requested R1 transfer to the hospital.	F 580	unresponsive resident was delayed and may have contributed to the hospitalization or illness of a resident in our care. Specifically, nursing failed to promptly or properly assess a change in condition and this delayed notification to provider and EMS. To extinguish the possibility of a scenario like this happening again, Prairie Manor will complete review of policies regarding change in condition and monitoring/assessment of change in condition. Will ensure that the policy and procedure includes a system for WHO to identify, including if the primary provider is unavailable. Prairie Manor will begin training of all staff on 2/13/24 that are involved with direct cares to residents (including LPN's, RN's, TMA's and CNA's). Specifically, each CNA/TMA (including pool aides) will be educated to inform the charge nurse immediately if there is any noted change to resident's usual condition, including if any resident does not respond appropriately to spoken voice, cares, or usual methods of communication, and will be provided with written education on when and who to notify as well as copies of any policy changes. This information will be disbursed via smartlinx messaging system as well as the nursing communication book, and reviewed again at the nursing department meeting scheduled for 2/19/24. LPN's and RN's will be educated on assessment of change in condition including WHEN to contact provider, and		

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F 580	Continued From page 4 During an interview on 2/9/24 at 2:39 p.m., LPN-C stated R1 reported to LPN-C before supper on 2/2/24, around 3:00 p.m., R1 felt a pop in her right leg near the knee during a pivot transfer at around 3:00 p.m., that same day. LPN-C stated she assessed the leg and there was no bruising or swelling, "I just know it hurt her to move on it." LPN-C stated she did not ask R1 to rate her pain, but instead relied on facial expressions to determine it was not severe pain, and further stated, "I just used my judgement." LPN-C stated R1 did not ask for pain medication, but LPN-C offered Tylenol because R1 stated the leg bother her when she stood on it. LPN-C further acknowledged R1 did not normally have pain in her right leg when standing, the aide reported R1 had pain when R1 stood, and LPN-C stated, "I thought it was a possibility [R1] was injured, but thought at that time of night, I didn't think I needed to send her for an X-ray. I did not report it to the provider or family. I just put in a progress note, monitored it, and charted what I did." During an interview on 2/9/24 at 2:33 p.m., LPN-A stated she assessed R1's right knee on 2/3/24 between 9:30 a.m. and 10:00 a.m., and found the right knee was swollen and warm. LPN-A further stated the night nurse, registered nurse (RN)-C informed her in morning report RN-C iced the area on night shift, R1 complained of pain on evening shift, and was unable to bear weight on it, even though R1 was noted to be assist of one staff for transfers. LPN-A stated, "I don't know why she wasn't sent to the hospital on the 2nd. [February 2nd.]. It was warm to the touch and really big when I saw it, so I sent her in."	F 580	WHO to call if usual provider is unavailable. RN and LPN staff will be provided with copies of any policy changes. A Change in Condition Clinical Competency module on Educare will be assigned to all RNs and LPNs on 2/13/24 to be completed prior to the start of their next shift, which includes a competency test with the module that will be completed to demonstrate their understanding of this assessment. DON or designee will keep a copy of these competencies on file to demonstrate proof of competency, and they will be reviewed and updated as needed. If a staff member's training cannot be completed by the end of the day on 2/13/2024 they will receive training prior to start their next shift. There is a scheduled all staff nursing meeting on 2/19/24 at 10:30am where this information will also be reviewed with the nursing department staff. Training will be conducted by DON, ADON, or designee. Additionally, the DON, ADON, MDS coordinator, or designee will complete an audit on 2/13/2024 of all current resident charts and care plans to identify the following: 1) Any resident at risk for hypercapnia or respiratory failure 2) Any resident with history or diagnosis of respiratory failure Care plans will be updated to include risk for and monitoring for respiratory failure. DON, ADON, MDS coordinator or designee will complete ongoing audits of care plans for NEW residents to ensure		

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F 580	Continued From page 5 R1's progress noted dated 2/3/24 at 7:54 p.m., indicated R1 returned from the hospital at 5:20 p.m., with a right fractured tibial plateau (a break of the larger lower leg bone below the knee that breaks into the knee joint itself.) During an interview on 2/9/24 at 2:15 p.m., nursing assistant (NA)-A stated on 2/6/24 NA-A entered R1's room between 7:30 and 8:00 a.m., R1 was not responding and "was really out of it". NA-A stated she provided morning cares for approximately 30 minutes and even though R1 did not respond or react in any way she did not notify the nurse. NA-A stated LPN-A looked in the room around 8:00 a.m. and then left again. NA-A further stated it was not until after morning cares were complete around 8:30 a.m. NA-A reported to LPN-A R1 was unresponsive. During an interview on 2/12/24 at 12:28 p.m., LPN-A stated on 2/6/24, LPN-A entered R1's room for the first time that shift around 8:00 a.m., and found R1 snoring and sleeping, so LPN-A returned around 8:30 a.m., saw the NA changing R1's pad, and at that time NA-A reported R1 didn't respond at all during cares. LPN-A acknowledged she returned to R1's room at approximately 9:00 a.m., reported to RN-A around 9:30 a.m., and acknowledged she had not called a provider of the family. R1's progress noted on 2/6/24 at 11:55 a.m., indicated RN-A noted she was notified by LPN-A R1 was lethargic and did not awaken for morning medications, vital signs (VS) were taken by LPN-A and were normal, and R1 was not arousable with a sternal rub. RN-A notified the director of nursing (DON), who advised RN-A to call the on-call provider. RN-A called the medical	F 580	that any at risk for respiratory acidosis or hypercapnia are included in care plan including protocols for monitoring and interventions. All applicable internal policies relating to change in condition will be reviewed by ADON, DON, or designee before staff training begins, so that all staff can be informed of any changes. With this plan by the end of day 2/13/2024 the risk for immediate jeopardy will be mitigated as staff will have been (or will be before they work next) educated regarding assessment of and monitoring for change in condition. Additionally, all current residents care plans will have reviewed and updated for risk of hyercapnia and respiratory failure to include monitoring and interventions in place.		

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F 580	Continued From page 6 service to inquire who was covering the facility as the regular provider was out ill. RN-A was advised at 11:00 a.m., about which provider to call, and left a voice mail for the provider at 11:08 a.m. The covering provider called back at 11:47 a.m., and advised RN-A to discontinue oxycodone, administer Narcan (medication used to reverse the effects of opioid overdose), and transport R1 to the hospital via ambulance if the Narcan was ineffective. The progress note lacked mention of a call to a provider or family. R1's progress noted on 2/6/24 at 12:44 p.m., indicated emergency medical services (EMS) arrived around 12:06 p.m., two doses of Narcan were administered with no response from the resident except one moan after the first dose, R1's son was notified, and R1's son questioned if R1's carbon dioxide (CO2) levels were elevated as R1 had a history of elevated CO2 levels. During an interview on 2/13/24 at 8:47 a.m., RN-A stated NA-A should have reported to the nurse when she found R1 unresponsive. RN-A further stated LPN-A notified her on 2/6/24 at about 9:30 a.m. that R1 was unresponsive, and then RN-A performed a sternal rub which R1 did not respond to and checked pedal pulses and found them to be present and normal. RN-A reported to the director of nursing, and then a provider was called. The regular provider was not able to be reached, however RN-A did not call senior services until 11:00 a.m. to inquire about a covering provider. She then called the provider that was indicated as on-call. During an interview on 2/12/24 at 4:48 p.m., nurse practitioner (NP)-A stated the expectation when a resident was found unresponsive was call	F 580			

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F 580	Continued From page 7 911, then call the provider, and reiterated staff should not wait for a provider to respond. During an interview on 2/13/24 at 9:27 a.m., the director of nursing stated the expectation was for staff to report change in condition right away, a nurse would perform an assessment as soon as the change in condition was noted, and nursing staff would call 911 and family. The Change in Condition Policy dated 1/28/21, indicated nursing staff will notify the primary physician and/or the on-call MD and the resident/ responsible party or family member immediately with any significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychological status in either life-threatening conditions or clinical complications (development of a stage 2 pressure sore, onset or recurrent periods of delirium, recurrent UTI [urinary tract infection], or onset of depression etc.).	F 580			
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess, implement care and	F 684			3/15/24
			It was identified by a survey member, that compliance and protocol involving		

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F 684	Continued From page 8 interventions, and provide timely notification for change in condition to a provider for an unresponsive resident (R1) that delayed care resulting in risk of seizure, coma, or death to 1 of 3 residents (R1). Additionally, the facility failed to assess, implement care and interventions, and provide timely notification for a change condition to a provider for a resident (R1) who, during a transfer between two surfaces, felt a pop sensation near her right knee, and afterwards reported severe pain, and could no longer bear weight. The immediate jeopardy began on 2/6/24 when R1 was unresponsive during morning cares at approximately 8:00 a.m., was not assessed by a nurse until 9:00 a.m., was not continuously monitored, and was transferred to the hospital at 12:14 p.m., and was identified on 2/13/24. The director nursing, with the administrator on the phone, was notified of the immediate jeopardy on 2/13/24 at 11:38 a.m. The immediate jeopardy was removed on 2/13/24, at 6:00 p.m., but noncompliance remained at the lower scope and severity level of a D-isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm, that is not immediate jeopardy. Findings include: R1 was admitted to the facility on 1/29/24, with diagnoses of pneumonia, chronic respiratory failure with hypercapnia (too much carbon dioxide in the blood), and chronic obstructive pulmonary disease. R1's Minimum Data Set (MDS) dated 2/2/24, indicated mild cognitive impairment, assist of two	F 684	assessment and implementation of care and interventions including timely notification for change in condition for an unresponsive resident was delayed and may have contributed to the hospitalization or illness of a resident in our care. Specifically, nursing failed to promptly or properly assess a change in condition and this delayed notification to provider and EMS. To extinguish the possibility of a scenario like this happening again, Prairie Manor will complete review of policies regarding change in condition and monitoring/assessment of change in condition. Will ensure that the policy and procedure includes a system for WHO to identify, including if the primary provider is unavailable. Prairie Manor will begin training of all staff on 2/13/24 that are involved with direct cares to residents (including LPN's, RN's, TMA's and CNA's). Specifically, each CNA/TMA (including pool aides) will be educated to inform the charge nurse immediately if there is any noted change to resident's usual condition, including if any resident does not respond appropriately to spoken voice, cares, or usual methods of communication, and will be provided with written education on when and who to notify as well as copies of any policy changes. This information will be disbursed via smartlinx messaging system as well as the nursing communication book, and reviewed again at the nursing department meeting scheduled for 2/19/24.		

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F 684	Continued From page 9 staff for bed mobility, transfers, toileting, and set-up assistance for eating. R1's care plan dated 2/9/24, indicated R1 had shortness of breath with exertion, chronic obstructive pulmonary disease (COPD), pneumonia, and pulmonary hypertension, but lacked indication of history of hypercapnia or interventions related to the diagnosis. R1's face sheet printed dated 2/14/24, identified, R1's code status was DNR/DNI (do not resuscitate/ do not intubate (a tube inserted in mouth to keep airway open), but did not have orders for limited treatments. During an interview on 2/9/24 at 11:30 a.m., family member (FM)-A stated there were two events recently for R1 in which care was delayed. FM-A stated the first incident was on 2/2/24, when a nursing assistant (NA) transferred R1, R1's right leg twisted during the transfer, and R1 could no longer bear weight on the right leg because the pain was intolerable. FM-A stated R1 was transferred to the hospital on 2/3/24 due to the pain and was diagnosed with a tibial fracture on the right leg. FM-A stated the second incident was 2/6/24, when R1 was found unresponsive at around 7:30 a.m., but not sent to the hospital until several hours later. FM-A further stated, "They should have called me. I would have asked them to send her right away. She had several episodes where her CO2 [carbon dioxide] was too high." Additionally, FM-A stated, "Now she is in the hospital taking pain meds, strong antibiotics, has a urinary infection, and maybe a blood infection." R1's progress note on 2/2/24 at 5:14 p.m., indicated R1 may transfer with assist of one per	F 684	LPN□s and RN□s will be educated on assessment of change in condition including WHEN to contact provider, and WHO to call if usual provider is unavailable. RN and LPN staff will be provided with copies of any policy changes. A Change in Condition Clinical Competency module on Educare will be assigned to all RNs and LPNs on 2/13/24 to be completed prior to the start of their next shift, which includes a competency test with the module that will be completed to demonstrate their understanding of this assessment. DON or designee will keep a copy of these competencies on file to demonstrate proof of competency, and they will be reviewed and updated as needed. If a staff member□s training cannot be completed by the end of the day on 2/13/2024 they will receive training prior to start their next shift. There is a scheduled all staff nursing meeting on 2/19/24 at 10:30am where this information will also be reviewed with the nursing department staff. Training will be conducted by DON, ADON, or designee. Additionally, the DON, ADON, MDS coordinator, or designee will complete an audit on 2/13/2024 of all current resident charts and care plans to identify the following: 1) Any resident at risk for hypercapnia or respiratory failure 2) Any resident with history or diagnosis of respiratory failure Care plans will be updated to include risk for and monitoring for respiratory failure.		

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F 684	Continued From page 10 physical therapy recommendations. During an interview on 2/9/24 at 3:16 p.m., nursing assistant (NA)-D stated on 2/6/24 at about 3:00 p.m., during a pivot transfer to a chair, R1's knee made a pop sound, R1 yelped, and said her knee hurt. "The pop was loud. She [R1] hollered out, it was horrible. She was definitely in pain." NA-D stated he and other NA tried to assist R1 to a standing position later, but R1 could not stand up and bear weight on her right leg anymore. NA-D stated when he transferred R1 on previous work shift, R1 could bear weight on the right leg, and could transfer without an EZ Stand. NA-A acknowledged he did not inform licensed practical nurse (LPN)-C about the incident when it occurred. Additionally, NA-D stated when R1 went to bed around 9:00 p.m., R1 stated her pain was rated at a 9/10, and NA-D reported that finding to LPN-C. During an interview on 2/9/24 at 2:59 p.m., NA-C stated on 2/2/24 at bedtime, she and NA-D tried to help R1 stand to pivot transfer, and NA-C stated, "[R1] said she couldn't stand, she said, 'I can't, I can't.' [R1] sounded like she was in pain. [R1] was trying to get up with her lift chair and said, 'I'm trying, I'm trying. I can't.'" NA-C stated she reported the problem to LPN-C who instructed NA-C to use an EZ Stand (a transfer-assist unit which actively engages the patient in the standing process, thus reducing the need for caregiver assistance) and have R1 stand only on her non-injured leg for the transfer. NA-C stated she and NA-D put R1 to bed using the EZ Stand as instructed and noticed R1's right leg was slightly swollen at that time. During an interview on 2/9/24 at 2:39 p.m.,	F 684	DON, ADON, MDS coordinator or designee will complete ongoing audits of care plans for NEW residents to ensure that any at risk for respiratory acidosis or hypercapnia are included in care plan including protocols for monitoring and interventions. All applicable internal policies relating to change in condition will be reviewed by ADON, DON, or designee before staff training begins, so that all staff can be informed of any changes. With this plan by the end of day 2/13/2024 the risk for immediate jeopardy will be mitigated as staff will have been (or will be before they work next) educated regarding assessment of and monitoring for change in condition. Additionally, all current residents care plans will have reviewed and updated for risk of hyercapnia and respiratory failure to include monitoring and interventions in place.		

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F 684	Continued From page 11 LPN-C stated R1 reported to her before supper on 2/2/24, around 3:00 p.m., R1 felt a pop in her right leg near the knee during a pivot transfer at around 3:00 p.m., that same day. LPN-C stated she assessed the leg and there was no bruising or swelling, "I just know it hurt her to move on it." LPN-C explained she did not ask R1 to rate her pain, but instead relied on facial expressions to determine it was not severe pain, and further stated, "I just used my judgement." R1 did not ask for pain medication, but LPN-C offered Tylenol because R1 stated the leg bothered her when she stood on it. LPN-C further acknowledged R1 did not normally have pain in her right leg when standing, the aide reported R1 had pain when R1 stood. LPN-C further stated, "I thought it was a possibility [R1] was injured, but thought at that time of night, I didn't think I needed to send her for an X-ray. I did not report it to the provider or family. I just put in a progress note, monitored it, and charted what I did." R1's progress note dated 2/2/13 at 8:30 p.m., written by LPN-C indicated R1 complained of right knee discomfort immediately following a transfer from recliner to wheelchair earlier in the day and further indicated R1 thought she injured the knee while pivoting. Ice was applied, R1 refused Tylenol, and the note indicated the nurse would continue to monitor R1. R1's progress noted dated 2/2/24 at 10:52 p.m., indicated 1000 mg Tylenol was administered, but lacked a pain rating. In review of R1's record on 2/2/24 between 3:00 p.m. and 10:00 a.m. on 2/3/24, it was not evident a comprehensive assessment or monitoring of R1's injury was completed that would include	F 684			

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F 684	Continued From page 12 observation of the lower extremity, range of motion, or comprehensive pain assessments. During an interview on 2/9/24 at 2:33 p.m., LPN-A stated she assessed R1's right knee on 2/3/24 between 9:30 a.m. and 10:00 a.m., and found the right knee was swollen and warm. LPN-A further stated the night nurse, registered nurse (RN)-C informed her in morning report RN-C iced the area on night shift, R1 complained of pain on evening shift, and was unable to bear weight on it, even though R1 was noted to be assist of one staff for transfers. LPN-A stated, "I don't know why she wasn't sent to the hospital on the 2nd. [February 2nd.]. It was warm to the touch and really big when I saw it, so I sent her in." R1's progress note written by LPN-D on 2/3/24 at 10:18 a.m., indicated staff reported R1 was unable to stand the prior evening (2/2/24) due to right knee pain, and was transferred to bed with a mechanical lift. The progress indicated R1's right knee was swollen and warm to touch, and R1 complained of pain rated as 10/10. Additionally, the note indicated R1 requested staff notify her family member (FM), and subsequently R1's FM requested R1 transfer to the hospital. R1's progress note dated 2/3/24 at 10:38 a.m., indicated R1 left the facility by ambulance. During an interview on 2/12/24 at 11:06 a.m., physical therapy assistant (PTA)-A stated R1, at baseline, had no pain in her knees. During an interview on 2/12/24 at 11:22 a.m. occupation therapist (OT)-A stated if R1 had no pain, and then complained of pain up to a rating			F 684			

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F 684	Continued From page 13 of 9/10, was a concern. During an interview on 12/12/24 at 12:57 p.m., LPN-D stated if R1 heard a pop, had subsequent pain, and couldn't bear weight, the change in condition should have been reported to a provider. R1's progress noted dated 2/3/24 at 7:54 p.m., indicated R1 returned from the hospital at 5:20 p.m., with a right fractured tibial plateau (a break of the larger lower leg bone below the knee that breaks into the knee joint itself.) During an interview on 2/12/24 at 11:59 a.m., NA-F stated if she heard a pop during a transfer and then the resident complained of pain, then there could be a problem and it should be reported to the nurse. Additionally, NA-F stated if a resident was found unresponsive, she would report it to a nurse immediately. R1's progress note dated 2/5/24 at 8:51 p.m., indicated R1 required assistance of one staff for bed mobility, dressing, and hygiene and R1 was able to communicate needs. R1's progress note 2/6/24 at 12:04 a.m., indicated R1 was alert and able to make her needs known. R1's progress note dated 2/6/24 at 12:05 a.m., indicated RN-C administered oxycodone HCl (opioid pain medication) 5 mg (milligrams). R1's progress noted dated 2/6/24 at 5:28 a.m., indicated RN-C rated R1's pain as 1/10 and indicated the dose of oxycodone was effective.	F 684			

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F 684	Continued From page 14 During an interview on 2/9/24 at 2:00 p.m., NA-B stated she assisted NA-A to boost R1 up in bed on 2/6/24, around 7:00 a.m., and noticed R1 was unresponsive. NA-B stated she didn't know R1 well, but didn't think that was normal for R1, inquired about it to licensed practical nurse (LPN)-A, who said she tried to awaken R1, but R1 did not wake up. NA-B stated, "I was surprised with the boost she didn't make any noise. I carried on caring for my people after that. When I worked with her before, she was already awake and already had her pills and breakfast by 8:00 a.m. " During an interview on 2/9/24 at 2:15 p.m., nursing assistant (NA)-A stated on 2/6/24 NA-A entered R1's room between 7:30 and 8:00 a.m., R1 was not responding and "was really out of it". NA-A stated she provided morning cares for approximately 30 minutes and even though R1 did not respond or react in any way she did not notify the nurse. NA-A stated LPN-A looked in the room around 8:00 a.m. and then left again. NA-A further stated it was not until after morning cares were complete around 8:30 a.m. she reported to LPN-A that R1 was unresponsive. During an interview on 2/12/24 at 12:28 p.m., LPN-A stated on 2/6/24 at approximately 8:00 a.m., NA-A was in R1's room providing morning care, and R1 was still asleep. LPN-A acknowledged she did not assess R1 at that time but acknowledged R1 was typically out of bed by 8:00 a.m. LPN-A further stated at approximately 8:30 a.m., during another check, LPN-A saw NA-A change R1's incontinent pad, and at that time NA-A reported R1 was unresponsive. LPN-A returned to R1's room at approximately 9:00 a.m. to assess vital signs and since the registered	F 684			

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F 684	Continued From page 15 nurses (RN) had gone to report, LPN-A did not alert RN-A to R1's condition until after report, around 9:30 a.m. R1's vital signs (VS) were stated to be within normal limits but were not recorded in the medical record until 2/9/24 as a late entry and were as follows: blood pressure 124/66, pulse 79 beats per minute, respirations 16/ min, temperature 97.6 F, and blood oxygen (O2) saturation 97%. LPN-A acknowledged she did not contact the provider or family. During an interview on 2/12/24 at 12:07 p.m., LPN-B stated R1 had a routine in the morning in which R1 turned on the call light between 7:00 a.m. and 7:30 a.m., wanted two of her medications, and then wanted to sit up in bed or in her wheelchair for breakfast. LPN-B further stated it would be odd for R1 to be asleep at 9:00 a.m. and had not ever refused medications. Additionally, LPN-B stated NA-A should not have continued cares for an unresponsive resident, and instead, should have notified a nurse immediately, and the nurse should have called 911 immediately upon knowing R1 was unresponsive. R1's progress noted dated 2/6/24 at 11:55 a.m., indicated RN-A noted she was notified by LPN-A R1 was lethargic and did not awaken for morning medications, vital signs (VS) were taken by LPN-A and were normal, and R1 was not arousable with a sternal rub. RN-A notified the director of nursing (DON), who advised RN-A to call the on-call provider. RN-A called the facility's medical service to inquire who was covering the facility as the regular provider was out ill. RN-A was advised at 11:00 a.m., about which provider to call, and left a voice mail for that provider at 11:08 a.m. The covering provider called back at	F 684			

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F 684	Continued From page 16 11:47 a.m., and advised RN-A to discontinue R1's oxycodone, administer Narcan (medication used to reverse the effects of opioid overdose), and transport R1 to the hospital via ambulance if the Narcan was ineffective. R1's record lacked evidence R1 was continuously monitored or assessed between 8:00 a.m. and 12:00 p.m. when EMS (emergency medical services) arrived. A progress note dated 2/6/24 at 12:22 p.m., indicated emergency medical services (EMS) arrived around 12:06 p.m., administered two doses of Narcan with no response from R1, family was notified, and R1 left via ambulance at 12:14 p.m. R1's progress noted dated 2/6/24 at 12:44 p.m., indicated emergency medical services (EMS) arrived around 12:06 p.m., two doses of Narcan were administered with no response from the resident except one moan after the first dose, R1's son was then notified, and R1's son questioned if R1's carbon dioxide (CO2) levels were elevated as R1 had a history of elevated CO2 levels. R1 was transferred to the hospital via ambulance. During an interview on 2/9/24 at 11:18 a.m., emergency medical technician (EMT)-A stated the emergency medical services (EMS) report from the incident indicated on 2/6/24, at 7:30 a.m., when staff checked on R1, R1 was somnolent, not arousable, completed daily cares, and then began escalating the concern. EMT-A stated, per the EMS report, around 11:30 a.m. staff was advised to call EMS, and EMS staff felt there was a delay in care to R1. Additionally,	F 684			

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F 684	Continued From page 17 EMT-A stated upon arrival to the hospital, R1's lab work was abnormal and showed prolonged inadequate breathing during this event. R1's ambulance service run report dated 2/6/24 at 12:00 p.m., indicated emergency medical services (EMS) arrived to find R1 unresponsive with agonal breath sounds (when someone who is not getting enough oxygen is gasping for air), and staff reported R1 had been in that condition since 5:30 a.m. this was not able to be corroborated through interview nor record review. R1's Hospital record identified R1 was admitted to the ICU on 2/6/24 with very high C02 levels. R1 was transferred to a medical floor on 2/8/24, and then returned to facility on 2/9/24. Labs completed identified R1's C02 levels were greater than 100 milliequivalents per liter (mEq/L), with normal levels between 23 to 29 mEq/L. During an interview on 2/12/24 at 5:22 p.m., R1 stated, "My carbon dioxide in my body was building up. I imagine I could have died that way. That has happened three times. With my knee, it was a lot of pain when it happened. It was really bad. The pain that night was a 10/10. I was offered Tylenol and they put the cold pack on it. That helped a little bit. I had to distract myself after that." During an interview on 2/13/24 at 8:47 a.m., RN-A stated NA-A should have reported to the nurse when she found R1 unresponsive. RN-A further stated LPN-A notified her on 2/6/24 at about 9:30 a.m. that R1 was unresponsive, and then RN-A performed a sternal rub which R1 did not respond to and checked pedal pulses and found them to	F 684			

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F 684	Continued From page 18 be present and normal. RN-A reported to the director of nursing, and then a provider was called. The regular provider was not able to be reached, however RN-A did not call senior services until 11:00 a.m., after talking to the director of nursing (DON) to inquire about a covering provider. She then called the provider that was indicated as on-call. During an interview on 2/12/24 at 4:48 p.m., nurse practitioner (NP)-A stated the expectation when a resident was found unresponsive was call 911, then call the provider, and reiterated staff should not wait for a provider to respond. Additionally, NP-A stated staff should have checked R1's vital signs right away. During an interview on 2/12/24 at 3:35 p.m., medical director stated when a resident is found unresponsive, checking vital signs would be the first step to help triage the urgency of the situation, and if there was a true emergency, waiting for a provider was a delay in care. During an interview on 2/12/24 at 5:42 p.m., the hospital physician who discharged R1, MD-B, stated the duration of time would matter if R1 was found unresponsive at 7:30 a.m., and was not assessed until 9:00 a.m., and further stated R1's Intensive Care Unit (ICU) time and course of treatment may have been different and less, and R1 might not have needed the Bi-pap (positive airway pressure) if staff had not delayed care. MD-B further stated VS should have been checked right away when R1 was found unresponsive. During an interview on 2/13/24 at 9:27 a.m., the DON stated the expectation was for staff to report	F 684			

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F 684	Continued From page 19 change in condition right away, a nurse would perform an assessment as soon as the change in condition was noted, nursing staff would call 911 and family. The Change in Condition Policy dated 1/28/21, indicated nursing staff will notify the primary physician and/or the on-call MD and the resident/responsible party or family member immediately with any significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychological status in either life-threatening conditions or clinical complications (development of a stage 2 pressure sore, onset or recurrent periods of delirium, recurrent UTI [urinary tract infection], or onset of depression etc.). The immediate jeopardy that began on 2/6/24, was removed on 2/13/24, after it was verified the facility updated R1's care plan to include hypercapnia and related interventions, reviewed like residents' care plans and updated them as needed, provided education to licensed nurses about the signs and symptoms of hypercapnia, provided education to all staff about recognizing and reporting a resident change in condition, and posted information at nursing desks about how to reach on-call providers. The noncompliance remained at the lower scope and severity level of a D-isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm, that is not immediate jeopardy.	F 684			

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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 2/9/24, and 2/12/24 through 2/14/24, 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

02/29/24

Minnesota Department of Health

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2 000	Continued From page 1 when they will be completed. The following complaints were reviewed. H54829723C (MN 00100628) with a licensing orders issued at 0265 and 0830. 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	2 000			
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the	2 265			3/15/24

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2 265	Continued From page 3 resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide timely notification for change in condition to a provider and family for an unresponsive resident (R1) and for the same resident (R1) who, during a transfer between two surfaces, felt a pop sensation near her right knee, and afterwards reported severe pain, and could no longer bear weight. Findings include: R1 was admitted to the facility on 1/29/24 with diagnoses of pneumonia, chronic respiratory failure with hypercapnia, chronic obstructive pulmonary disease, acidosis, and neuropathy. R1's Minimum Data Set (MDS) dated 2/2/24, indicated mild cognitive impairment, assist of two staff for bed mobility, transfers, toileting, and set-up assistance for eating. R1's care plan dated 2/9/24, indicated R1 had shortness of breath with exertion, chronic obstructive pulmonary disease (COPD), pneumonia, and pulmonary hypertension, and required the assistance of two for most activities of daily living (ADLs). During an interview on 2/9/24 at 11:30 a.m., family member (FM)-A stated there were two events recently for R1 in which the family was not notified timely. FM-A stated the first incident was on 2/2/24, when a nursing assistant (NA)	2 265	Per state, the provider and family was not notified of the change in status fast enough for the knee and unresponsive episode. The change of condition policy and clinician services policy was updated and dispersed to all nursing staff. In addition this tag heavily focuses on the incident in F684 so i will post that response It was identified by a survey member, that compliance and protocol involving assessment and implementation of care and interventions including timely notification for change in condition for an unresponsive resident was delayed and may have contributed to the hospitalization or illness of a resident in our care. Specifically, nursing failed to promptly or properly assess a change in condition and this delayed notification to provider and EMS. To extinguish the possibility of a scenario like this happening again, Prairie Manor will complete review of policies regarding change in condition and monitoring/assessment of change in condition. Will ensure that the policy and procedure includes a system for WHO to identify, including if the primary provider is unavailable. Prairie Manor will begin training of all staff on 2/13/24 that are		

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2 265	Continued From page 4 transferred R1, R1's right leg twisted during the transfer, and R1 could no longer bear weight on the right leg because the pain was intolerable. FM-A stated he was not notified of the incident until R1 was transferred to the hospital on 2/3/23. FM-A stated the second incident was 2/6/24, when R1 was found unresponsive at around 7:30 a.m., but he was not notified of the change in condition until 11:58 a.m., and further stated, "She could have been gone in that amount of time. I wasn't told about it until after they sent her to the hospital. They should have called me. I would have asked them to send her right away." R1's progress note on 2/2/24 at 10:26 p.m., indicated R1 complained of right knee discomfort immediately following transfer from recliner to wheelchair, R1 stated she thought she injured it while pivoting, ice was applied but refused Tylenol, and the nurse would continue to monitor. The progress note lacked notification to family or a provider of the change in condition. R1's progress note on 2/3/24 at 10:18 a.m., indicated staff reported R1 was unable to stand the prior evening due to right knee pain, and was transferred to bed with a mechanical lift. The progress indicated R1's right knee was swollen and warm to touch, and R1 complained of pain rated as 10/10. Additionally, the note indicated R1 requested staff notify her son, and subsequently R1's son requested R1 transfer to the hospital. During an interview on 2/9/24 at 2:39 p.m., LPN-C stated R1 reported to LPN-C before supper on 2/2/24, around 3:00 p.m., R1 felt a pop in her right leg near the knee during a pivot transfer at around 3:00 p.m., that same day. LPN-C stated she assessed the leg and there was no bruising or swelling, "I just know it hurt her	2 265	involved with direct cares to residents (including LPN□s, RN□s, TMA□s and CNA□s). Specifically, each CNA/TMA (including pool aides) will be educated to inform the charge nurse immediately if there is any noted change to resident□s usual condition, including if any resident does not respond appropriately to spoken voice, cares, or usual methods of communication, and will be provided with written education on when and who to notify as well as copies of any policy changes. This information will be disbursed via smartlinx messaging system as well as the nursing communication book, and reviewed again at the nursing department meeting scheduled for 2/19/24. LPN□s and RN□s will be educated on assessment of change in condition including WHEN to contact provider, and WHO to call if usual provider is unavailable. RN and LPN staff will be provided with copies of any policy changes. A Change in Condition Clinical Competency module on Educare will be assigned to all RNs and LPNs on 2/13/24 to be completed prior to the start of their next shift, which includes a competency test with the module that will be completed to demonstrate their understanding of this assessment. DON or designee will keep a copy of these competencies on file to demonstrate proof of competency, and they will be reviewed and updated as needed. If a staff member□s training cannot be completed by the end of the day on		

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2 265	Continued From page 5 to move on it." LPN-C stated she did not ask R1 to rate her pain, but instead relied on facial expressions to determine it was not severe pain, and further stated, "I just used my judgement." LPN-C stated R1 did not ask for pain medication, but LPN-C offered Tylenol because R1 stated the leg bother her when she stood on it. LPN-C further acknowledged R1 did not normally have pain in her right leg when standing, the aide reported R1 had pain when R1 stood, and LPN-C stated, "I thought it was a possibility [R1] was injured, but thought at that time of night, I didn't think I needed to send her for an X-ray. I did not report it to the provider or family. I just put in a progress note, monitored it, and charted what I did." During an interview on 2/9/24 at 2:33 p.m., LPN-A stated she assessed R1's right knee on 2/3/24 between 9:30 a.m. and 10:00 a.m., and found the right knee was swollen and warm. LPN-A further stated the night nurse, registered nurse (RN)-C informed her in morning report RN-C iced the area on night shift, R1 complained of pain on evening shift, and was unable to bear weight on it, even though R1 was noted to be assist of one staff for transfers. LPN-A stated, "I don't know why she wasn't sent to the hospital on the 2nd. [February 2nd.]. It was warm to the touch and really big when I saw it, so I sent her in." R1's progress noted dated 2/3/24 at 7:54 p.m., indicated R1 returned from the hospital at 5:20 p.m., with a right fractured tibial plateau (a break of the larger lower leg bone below the knee that breaks into the knee joint itself.) During an interview on 2/9/24 at 2:15 p.m., nursing assistant (NA)-A stated on 2/6/24 NA-A entered R1's room between 7:30 and 8:00 a.m.,	2 265	2/13/2024 they will receive training prior to start their next shift. There is a scheduled all staff nursing meeting on 2/19/24 at 10:30am where this information will also be reviewed with the nursing department staff. Training will be conducted by DON, ADON, or designee. Additionally, the DON, ADON, MDS coordinator, or designee will complete an audit on 2/13/2024 of all current resident charts and care plans to identify the following: 1) Any resident at risk for hypercapnia or respiratory failure 2) Any resident with history or diagnosis of respiratory failure Care plans will be updated to include risk for and monitoring for respiratory failure. DON, ADON, MDS coordinator or designee will complete ongoing audits of care plans for NEW residents to ensure that any at risk for respiratory acidosis or hypercapnia are included in care plan including protocols for monitoring and interventions. All applicable internal policies relating to change in condition will be reviewed by ADON, DON, or designee before staff training begins, so that all staff can be informed of any changes. With this plan by the end of day 2/13/2024 the risk for immediate jeopardy will be mitigated as staff will have been (or will be before they work next) educated regarding assessment of and monitoring for change in condition. Additionally, all current residents care plans will have reviewed and updated for risk of hyercapnia and respiratory failure to include monitoring and interventions in place.		

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2 265	Continued From page 6 R1 was not responding and "was really out of it". NA-A stated she provided morning cares for approximately 30 minutes and even though R1 did not respond or react in any way she did not notify the nurse. NA-A stated LPN-A looked in the room around 8:00 a.m. and then left again. NA-A further stated it was not until after morning cares were complete around 8:30 a.m. NA-A reported to LPN-A R1 was unresponsive. During an interview on 2/12/24 at 12:28 p.m., LPN-A stated on 2/6/24, LPN-A entered R1's room for the first time that shift around 8:00 a.m., and found R1 snoring and sleeping, so LPN-A returned around 8:30 a.m., saw the NA changing R1's pad, and at that time NA-A reported R1 didn't respond at all during cares. LPN-A acknowledged she returned to R1's room at approximately 9:00 a.m., reported to RN-A around 9:30 a.m., and acknowledged she had not called a provider of the family. R1's progress noted on 2/6/24 at 11:55 a.m., indicated RN-A noted she was notified by LPN-A R1 was lethargic and did not awaken for morning medications, vital signs (VS) were taken by LPN-A and were normal, and R1 was not arousable with a sternal rub. RN-A notified the director of nursing (DON), who advised RN-A to call the on-call provider. RN-A called the medical service to inquire who was covering the facility as the regular provider was out ill. RN-A was advised at 11:00 a.m., about which provider to call, and left a voice mail for the provider at 11:08 a.m. The covering provider called back at 11:47 a.m., and advised RN-A to discontinue oxycodone, administer Narcan (medication used to reverse the effects of opioid overdose), and transport R1 to the hospital via ambulance if the Narcan was ineffective. The progress note lacked mention of	2 265			

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2 265	Continued From page 7 a call to a provider or family. R1's progress noted on 2/6/24 at 12:44 p.m., indicated emergency medical services (EMS) arrived around 12:06 p.m., two doses of Narcan were administered with no response from the resident except one moan after the first dose, R1's son was notified, and R1's son questioned if R1's carbon dioxide (CO2) levels were elevated as R1 had a history of elevated CO2 levels. During an interview on 2/13/24 at 8:47 a.m., RN-A stated NA-A should have reported to the nurse when she found R1 unresponsive. RN-A further stated LPN-A notified her on 2/6/24 at about 9:30 a.m. that R1 was unresponsive, and then RN-A performed a sternal rub which R1 did not respond to and checked pedal pulses and found them to be present and normal. RN-A reported to the director of nursing, and then a provider was called. The regular provider was not able to be reached, however RN-A did not call senior services until 11:00 a.m. to inquire about a covering provider. She then called the provider that was indicated as on-call. During an interview on 2/12/24 at 4:48 p.m., nurse practitioner (NP)-A stated the expectation when a resident was found unresponsive was call 911, then call the provider, and reiterated staff should not wait for a provider to respond. During an interview on 2/13/24 at 9:27 a.m., the director of nursing stated the expectation was for staff to report change in condition right away, a nurse would perform an assessment as soon as the change in condition was noted, and nursing staff would call 911 and family. The Change in Condition Policy dated 1/28/21,	2 265			

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2 265	Continued From page 8 indicated nursing staff will notify the primary physician and/or the on-call MD and the resident/ responsible party or family member immediately with any significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychological status in either life-threatening conditions or clinical complications (development of a stage 2 pressure sore, onset or recurrent periods of delirium, recurrent UTI [urinary tract infection], or onset of depression etc.). Suggested Method of Correction: The director of nursing (DON) or designee could work with the medical director to update policies and procedures for when to notify the physician of changes in the resident, and then could educate staff. The DON or designee could also perform audits of resident records to determine if the physician had been notified as appropriate. Time Period for Correction: twenty-one (21) days.	2 265			
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.	2 830			3/15/24

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2 830	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to assess, implement care and interventions, and provide timely notification for change in condition to a provider for an unresponsive resident (R1) that delayed care resulting in risk of seizure, coma, or death to 1 of 3 residents (R1). Additionally, the facility failed to assess, implement care and interventions, and provide timely notification for a change condition to a provider for a resident (R1) who, during a transfer between two surfaces, felt a pop sensation near her right knee, and afterwards reported severe pain, and could no longer bear weight. The immediate jeopardy began on 2/6/24 when R1 was unresponsive during morning cares at approximately 8:00 a.m., was not assessed by a nurse until 9:00 a.m., was not continuously monitored, and was transferred to the hospital at 12:14 p.m., and was identified on 2/13/24. The director nursing, with the administrator on the phone, was notified of the immediate jeopardy on 2/13/24 at 11:38 a.m. The immediate jeopardy was removed on 2/13/24, at 6:00 p.m., but noncompliance remained at the lower scope and severity level of a D-isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm, that is not immediate jeopardy. Findings include: R1 was admitted to the facility on 1/29/24, with diagnoses of pneumonia, chronic respiratory	2 830	Nurses will be educated on update to the change in condition policy, and received educational training including a quiz on change in condition by 03/15/2024 Additional courses have been assigned to the LPN and RN staff for the month of March regarding CHF and COPD to further their knowledge on respiratory risks. Nurses will also be educated that if a resident does not immediately respond to sternal rub, EMS to be contacted followed by notification to family and provider. (Nursing had incorrectly assessed that stupor may have been related to new medication. Nursing will be educated that regardless of reason, a lack of response to sternal rub is an emergent condition requiring immediate EMS notification). Additionally, nurses will be reeducated that if a resident is noted to have new injury or pain, family and clinician are to be informed promptly, along with completion of an incident report, even if the injury does not require immediate medical attention based on the nurse's assessment. All nurses will acknowledge, review educational materials provided, and sign understanding of this education by 03/15/2024 In addition this tag heavily focuses on the incident in F684 so i will post that response.		

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2 830	Continued From page 10 failure with hypercapnia (too much carbon dioxide in the blood),and chronic obstructive pulmonary disease. R1's Minimum Data Set (MDS) dated 2/2/24, indicated mild cognitive impairment, assist of two staff for bed mobility, transfers, toileting, and set-up assistance for eating. R1's care plan dated 2/9/24, indicated R1 had shortness of breath with exertion, chronic obstructive pulmonary disease (COPD), pneumonia, and pulmonary hypertension, but lacked indication of history of hypercapnia or interventions related to the diagnosis. R1's face sheet printed dated 2/14/24, identified, R1's code status was DNR/DNI (do not resuscitate/ do not intubate (a tube inserted in mouth to keep airway open), but did not have orders for limited treatments. During an interview on 2/9/24 at 11:30 a.m., family member (FM)-A stated there were two events recently for R1 in which care was delayed. FM-A stated the first incident was on 2/2/24, when a nursing assistant (NA) transferred R1, R1's right leg twisted during the transfer, and R1 could no longer bear weight on the right leg because the pain was intolerable. FM-A stated R1 was transferred to the hospital on 2/3/24 due to the pain and was diagnosed with a tibial fracture on the right leg. FM-A stated the second incident was 2/6/24, when R1 was found unresponsive at around 7:30 a.m., but not sent to the hospital until several hours later. FM-A further stated, "They should have called me. I would have asked them to send her right away. She had several episodes where her CO2 [carbon dioxide] was too high." Additionally, FM-A stated, "Now she is in the	2 830	It was identified by a survey member, that compliance and protocol involving assessment and implementation of care and interventions including timely notification for change in condition for an unresponsive resident was delayed and may have contributed to the hospitalization or illness of a resident in our care. Specifically, nursing failed to promptly or properly assess a change in condition and this delayed notification to provider and EMS. To extinguish the possibility of a scenario like this happening again, Prairie Manor will complete review of policies regarding change in condition and monitoring/assessment of change in condition. Will ensure that the policy and procedure includes a system for WHO to identify, including if the primary provider is unavailable. Prairie Manor will begin training of all staff on 2/13/24 that are involved with direct cares to residents (including LPN's, RN's, TMA's and CNA's). Specifically, each CNA/TMA (including pool aides) will be educated to inform the charge nurse immediately if there is any noted change to resident's usual condition, including if any resident does not respond appropriately to spoken voice, cares, or usual methods of communication, and will be provided with written education on when and who to notify as well as copies of any policy changes. This information will be disbursed via smartlinx messaging system as well as the nursing communication book, and reviewed again at the nursing		

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2 830	Continued From page 11 hospital taking pain meds, strong antibiotics, has a urinary infection, and maybe a blood infection." R1's progress note on 2/2/24 at 5:14 p.m., indicated R1 may transfer with assist of one per physical therapy recommendations. During an interview on 2/9/24 at 3:16 p.m., nursing assistant (NA)-D stated on 2/6/24 at about 3:00 p.m., during a pivot transfer to a chair, R1's knee made a pop sound, R1 yelped, and said her knee hurt. "The pop was loud. She [R1] hollered out, it was horrible. She was definitely in pain." NA-D stated he and other NA tried to assist R1 to a standing position later, but R1 could not stand up and bear weight on her right leg anymore. NA-D stated when he transferred R1 on previous work shift, R1 could bear weight on the right leg, and could transfer without an EZ Stand. NA-A acknowledged he did not inform licensed practical nurse (LPN)-C about the incident when it occurred. Additionally, NA-D stated when R1 went to bed around 9:00 p.m., R1 stated her pain was rated at a 9/10, and NA-D reported that finding to LPN-C. During an interview on 2/9/24 at 2:59 p.m., NA-C stated on 2/2/24 at bedtime, she and NA-D tried to help R1 stand to pivot transfer, and NA-C stated, "[R1] said she couldn't stand, she said, 'I can't, I can't.' [R1] sounded like she was in pain. [R1] was trying to get up with her lift chair and said, 'I'm trying, I'm trying. I can't.'" NA-C stated she reported the problem to LPN-C who instructed NA-C to use an EZ Stand (a transfer-assist unit which actively engages the patient in the standing process, thus reducing the need for caregiver assistance) and have R1 stand only on her non-injured leg for the transfer. NA-C stated she and NA-D put R1 to bed using the EZ	2 830	department meeting scheduled for 2/19/24. LPN's and RN's will be educated on assessment of change in condition including WHEN to contact provider, and WHO to call if usual provider is unavailable. RN and LPN staff will be provided with copies of any policy changes. A Change in Condition Clinical Competency module on Educare will be assigned to all RNs and LPNs on 2/13/24 to be completed prior to the start of their next shift, which includes a competency test with the module that will be completed to demonstrate their understanding of this assessment. DON or designee will keep a copy of these competencies on file to demonstrate proof of competency, and they will be reviewed and updated as needed. If a staff member's training cannot be completed by the end of the day on 2/13/2024 they will receive training prior to start their next shift. There is a scheduled all staff nursing meeting on 2/19/24 at 10:30am where this information will also be reviewed with the nursing department staff. Training will be conducted by DON, ADON, or designee. Additionally, the DON, ADON, MDS coordinator, or designee will complete an audit on 2/13/2024 of all current resident charts and care plans to identify the following: 1) Any resident at risk for hypercapnia or respiratory failure 2) Any resident with history or diagnosis of respiratory failure Care plans will be updated to include risk		

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2 830	Continued From page 12 Stand as instructed and noticed R1's right leg was slightly swollen at that time. During an interview on 2/9/24 at 2:39 p.m., LPN-C stated R1 reported to her before supper on 2/2/24, around 3:00 p.m., R1 felt a pop in her right leg near the knee during a pivot transfer at around 3:00 p.m., that same day. LPN-C stated she assessed the leg and there was no bruising or swelling, "I just know it hurt her to move on it." LPN-C explained she did not ask R1 to rate her pain, but instead relied on facial expressions to determine it was not severe pain, and further stated, "I just used my judgement." R1 did not ask for pain medication, but LPN-C offered Tylenol because R1 stated the leg bothered her when she stood on it. LPN-C further acknowledged R1 did not normally have pain in her right leg when standing, the aide reported R1 had pain when R1 stood. LPN-C further stated, "I thought it was a possibility [R1] was injured, but thought at that time of night, I didn't think I needed to send her for an X-ray. I did not report it to the provider or family. I just put in a progress note, monitored it, and charted what I did." R1's progress note dated 2/2/13 at 8:30 p.m., written by LPN-C indicated R1 complained of right knee discomfort immediately following a transfer from recliner to wheelchair earlier in the day and further indicated R1 thought she injured the knee while pivoting. Ice was applied, R1 refused Tylenol, and the note indicated the nurse would continue to monitor R1. R1's progress noted dated 2/2/24 at 10:52 p.m., indicated 1000 mg Tylenol was administered, but lacked a pain rating. In review of R1's record on 2/2/24 between 3:00	2 830	for and monitoring for respiratory failure. DON, ADON, MDS coordinator or designee will complete ongoing audits of care plans for NEW residents to ensure that any at risk for respiratory acidosis or hypercapnia are included in care plan including protocols for monitoring and interventions. All applicable internal policies relating to change in condition will be reviewed by ADON, DON, or designee before staff training begins, so that all staff can be informed of any changes. With this plan by the end of day 2/13/2024 the risk for immediate jeopardy will be mitigated as staff will have been (or will be before they work next) educated regarding assessment of and monitoring for change in condition. Additionally, all current residents care plans will have reviewed and updated for risk of hyercapnia and respiratory failure to include monitoring and interventions in place.		

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2 830	Continued From page 13 p.m. and 10:00 a.m. on 2/3/24, it was not evident a comprehensive assessment or monitoring of R1's injury was completed that would include observation of the lower extremity, range of motion, or comprehensive pain assessments. During an interview on 2/9/24 at 2:33 p.m., LPN-A stated she assessed R1's right knee on 2/3/24 between 9:30 a.m. and 10:00 a.m., and found the right knee was swollen and warm. LPN-A further stated the night nurse, registered nurse (RN)-C informed her in morning report RN-C iced the area on night shift, R1 complained of pain on evening shift, and was unable to bear weight on it, even though R1 was noted to be assist of one staff for transfers. LPN-A stated, "I don't know why she wasn't sent to the hospital on the 2nd. [February 2nd.]. It was warm to the touch and really big when I saw it, so I sent her in." R1's progress note written by LPN-D on 2/3/24 at 10:18 a.m., indicated staff reported R1 was unable to stand the prior evening (2/2/24) due to right knee pain, and was transferred to bed with a mechanical lift. The progress indicated R1's right knee was swollen and warm to touch, and R1 complained of pain rated as 10/10. Additionally, the note indicated R1 requested staff notify her family member (FM), and subsequently R1's FM requested R1 transfer to the hospital. R1's progress note dated 2/3/24 at 10:38 a.m., indicated R1 left the facility by ambulance. During an interview on 2/12/24 at 11:06 a.m., physical therapy assistant (PTA)-A stated R1, at baseline, had no pain in her knees. During an interview on 2/12/24 at 11:22 a.m.	2 830			

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2 830	Continued From page 14 occupation therapist (OT)-A stated if R1 had no pain, and then complained of pain up to a rating of 9/10, was a concern. During an interview on 12/12/24 at 12:57 p.m., LPN-D stated if R1 heard a pop, had subsequent pain, and couldn't bear weight, the change in condition should have been reported to a provider. R1's progress noted dated 2/3/24 at 7:54 p.m., indicated R1 returned from the hospital at 5:20 p.m., with a right fractured tibial plateau (a break of the larger lower leg bone below the knee that breaks into the knee joint itself.) During an interview on 2/12/24 at 11:59 a.m., NA-F stated if she heard a pop during a transfer and then the resident complained of pain, then there could be a problem and it should be reported to the nurse. Additionally, NA-F stated if a resident was found unresponsive, she would report it to a nurse immediately. R1's progress note dated 2/5/24 at 8:51 p.m., indicated R1 required assistance of one staff for bed mobility, dressing, and hygiene and R1 was able to communicate needs. R1's progress note 2/6/24 at 12:04 a.m., indicated R1 was alert and able to make her needs known. R1's progress note dated 2/6/24 at 12:05 a.m., indicated RN-C administered oxycodone HCl (opioid pain medication) 5 mg (milligrams). R1's progress noted dated 2/6/24 at 5:28 a.m., indicated RN-C rated R1's pain as 1/10 and indicated the dose of oxycodone was effective.	2 830			

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2 830	Continued From page 15 During an interview on 2/9/24 at 2:00 p.m., NA-B stated she assisted NA-A to boost R1 up in bed on 2/6/24, around 7:00 a.m., and noticed R1 was unresponsive. NA-B stated she didn't know R1 well, but didn't think that was normal for R1, inquired about it to licensed practical nurse (LPN)-A, who said she tried to awaken R1, but R1 did not wake up. NA-B stated, "I was surprised with the boost she didn't make any noise. I carried on caring for my people after that. When I worked with her before, she was already awake and already had her pills and breakfast by 8:00 a.m. " During an interview on 2/9/24 at 2:15 p.m., nursing assistant (NA)-A stated on 2/6/24 NA-A entered R1's room between 7:30 and 8:00 a.m., R1 was not responding and "was really out of it". NA-A stated she provided morning cares for approximately 30 minutes and even though R1 did not respond or react in any way she did not notify the nurse. NA-A stated LPN-A looked in the room around 8:00 a.m. and then left again. NA-A further stated it was not until after morning cares were complete around 8:30 a.m. she reported to LPN-A that R1 was unresponsive. During an interview on 2/12/24 at 12:28 p.m., LPN-A stated on 2/6/24 at approximately 8:00 a.m., NA-A was in R1's room providing morning care, and R1 was still asleep. LPN-A acknowledged she did not assess R1 at that time but acknowledged R1 was typically out of bed by 8:00 a.m. LPN-A further stated at approximately 8:30 a.m., during another check, LPN-A saw NA-A change R1's incontinent pad, and at that time NA-A reported R1 was unresponsive. LPN-A returned to R1's room at approximately 9:00 a.m. to assess vital signs and since the registered	2 830			

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2 830	Continued From page 16 nurses (RN) had gone to report, LPN-A did not alert RN-A to R1's condition until after report, around 9:30 a.m. R1's vital signs (VS) were stated to be within normal limits but were not recorded in the medical record until 2/9/24 as a late entry and were as follows: blood pressure 124/66, pulse 79 beats per minute, respirations 16/ min, temperature 97.6 F, and blood oxygen (O2) saturation 97%. LPN-A acknowledged she did not contact the provider or family. During an interview on 2/12/24 at 12:07 p.m., LPN-B stated R1 had a routine in the morning in which R1 turned on the call light between 7:00 a.m. and 7:30 a.m., wanted two of her medications, and then wanted to sit up in bed or in her wheelchair for breakfast. LPN-B further stated it would be odd for R1 to be asleep at 9:00 a.m. and had not ever refused medications. Additionally, LPN-B stated NA-A should not have continued cares for an unresponsive resident, and instead, should have notified a nurse immediately, and the nurse should have called 911 immediately upon knowing R1 was unresponsive. R1's progress noted dated 2/6/24 at 11:55 a.m., indicated RN-A noted she was notified by LPN-A R1 was lethargic and did not awaken for morning medications, vital signs (VS) were taken by LPN-A and were normal, and R1 was not arousable with a sternal rub. RN-A notified the director of nursing (DON), who advised RN-A to call the on-call provider. RN-A called the facility's medical service to inquire who was covering the facility as the regular provider was out ill. RN-A was advised at 11:00 a.m., about which provider to call, and left a voice mail for that provider at 11:08 a.m. The covering provider called back at 11:47 a.m., and advised RN-A to discontinue R1's	2 830			

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2 830	Continued From page 17 oxycodone, administer Narcan (medication used to reverse the effects of opioid overdose), and transport R1 to the hospital via ambulance if the Narcan was ineffective. R1's record lacked evidence R1 was continuously monitored or assessed between 8:00 a.m. and 12:00 p.m. when EMS (emergency medical services) arrived. A progress note dated 2/6/24 at 12:22 p.m., indicated emergency medical services (EMS) arrived around 12:06 p.m., administered two doses of Narcan with no response from R1, family was notified, and R1 left via ambulance at 12:14 p.m. R1's progress noted dated 2/6/24 at 12:44 p.m., indicated emergency medical services (EMS) arrived around 12:06 p.m., two doses of Narcan were administered with no response from the resident except one moan after the first dose, R1's son was then notified, and R1's son questioned if R1's carbon dioxide (CO2) levels were elevated as R1 had a history of elevated CO2 levels. R1 was transferred to the hospital via ambulance. During an interview on 2/9/24 at 11:18 a.m., emergency medical technician (EMT)-A stated the emergency medical services (EMS) report from the incident indicated on 2/6/24, at 7:30 a.m., when staff checked on R1, R1 was somnolent, not arousable, completed daily cares, and then began escalating the concern. EMT-A stated, per the EMS report, around 11:30 a.m. staff was advised to call EMS, and EMS staff felt there was a delay in care to R1. Additionally, EMT-A stated upon arrival to the hospital, R1's lab work was abnormal and showed prolonged	2 830			

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2 830	Continued From page 18 inadequate breathing during this event. R1's ambulance service run report dated 2/6/24 at 12:00 p.m., indicated emergency medical services (EMS) arrived to find R1 unresponsive with agonal breath sounds (when someone who is not getting enough oxygen is gasping for air), and staff reported R1 had been in that condition since 5:30 a.m. this was not able to be corroborated through interview nor record review. R1's Hospital record identified R1 was admitted to the ICU on 2/6/24 with very high C02 levels. R1 was transferred to a medical floor on 2/8/24, and then returned to facility on 2/9/24. Labs completed identified R1's C02 levels were greater than 100 milliequivalents per liter (mEq/L), with normal levels between 23 to 29 mEq/L. During an interview on 2/12/24 at 5:22 p.m., R1 stated, "My carbon dioxide in my body was building up. I imagine I could have died that way. That has happened three times. With my knee, it was a lot of pain when it happened. It was really bad. The pain that night was a 10/10. I was offered Tylenol and they put the cold pack on it. That helped a little bit. I had to distract myself after that." During an interview on 2/13/24 at 8:47 a.m., RN-A stated NA-A should have reported to the nurse when she found R1 unresponsive. RN-A further stated LPN-A notified her on 2/6/24 at about 9:30 a.m. that R1 was unresponsive, and then RN-A performed a sternal rub which R1 did not respond to and checked pedal pulses and found them to be present and normal. RN-A reported to the director of nursing, and then a provider was called. The regular provider was not able to be	2 830			

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2 830	Continued From page 19 reached, however RN-A did not call senior services until 11:00 a.m., after talking to the director of nursing (DON) to inquire about a covering provider. She then called the provider that was indicated as on-call. During an interview on 2/12/24 at 4:48 p.m., nurse practitioner (NP)-A stated the expectation when a resident was found unresponsive was call 911, then call the provider, and reiterated staff should not wait for a provider to respond. Additionally, NP-A stated staff should have checked R1's vital signs right away. During an interview on 2/12/24 at 3:35 p.m., medical director stated when a resident is found unresponsive, checking vital signs would be the first step to help triage the urgency of the situation, and if there was a true emergency, waiting for a provider was a delay in care. During an interview on 2/12/24 at 5:42 p.m., the hospital physician who discharged R1, MD-B, stated the duration of time would matter if R1 was found unresponsive at 7:30 a.m., and was not assessed until 9:00 a.m., and further stated R1's Intensive Care Unit (ICU) time and course of treatment may have been different and less, and R1 might not have needed the Bi-pap (positive airway pressure) if staff had not delayed care. MD-B further stated VS should have been checked right away when R1 was found unresponsive. During an interview on 2/13/24 at 9:27 a.m., the DON stated the expectation was for staff to report change in condition right away, a nurse would perform an assessment as soon as the change in condition was noted, nursing staff would call 911 and family.	2 830			

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2 830	Continued From page 20 The Change in Condition Policy dated 1/28/21, indicated nursing staff will notify the primary physician and/or the on-call MD and the resident/responsible party or family member immediately with any significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychological status in either life-threatening conditions or clinical complications (development of a stage 2 pressure sore, onset or recurrent periods of delirium, recurrent UTI [urinary tract infection], or onset of depression etc.). The immediate jeopardy that began on 2/6/24, was removed on 2/13/24, after it was verified the facility updated R1's care plan to include hypercapnia and related interventions, reviewed like residents' care plans and updated them as needed, provided education to licensed nurses about the signs and symptoms of hypercapnia, provided education to all staff about recognizing and reporting a resident change in condition, and posted information at nursing desks about how to reach on-call providers. The noncompliance remained at the lower scope and severity level of a D-isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm, that is not immediate jeopardy. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and update policies and procedures about change in condition, educate all staff about the new or updated polices, and perform audits to ensure change in condition is reported and addressed appropriately. TIME PERIOD FOR CORRECTION: Twenty One	2 830			

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2 830	Continued From page 21 (21) days.	2 830			