P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
April 21, 2022

Administrator
The Green Prairie Rehabilitation Center
800 Second Avenue Northwest
Plainview, MN 55964

RE: CCN: 245345
Cycle Start Date: March 31, 2022

Dear Administrator:

On March 31, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 5, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 5, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 5, 2022.

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.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

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 $11,292; 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.

If you have not achieved substantial compliance by June 5, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Green Prairie Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 5, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. 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 an "E" tag), i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 30, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245345	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 3/31/2022
NAME OF PROVIDER OR SUPPLIER **THE GREEN PRAIRIE REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **800 SECOND AVENUE NORTHWEST PLAINVIEW, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to ensure a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage, Form CMS-10055 (SNF ABN) was provided to 1 of 3 residents (R23) reviewed for liability notices. Findings include: During a document review 3/30/22, 10:30 a.m. it was noted that R23 began receiving Medicare Covered services in the facility on 10/15/21, and the last covered day of service was 11/19/21. R23 remained in the facility after discharge from Medicare Covered Services Facility provided a notice of the last covered day, but no evidence was found that a SNF ABN had been provided giving the expected cost of care after Medicare had stopped.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245345	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 3/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	**800 SECOND AVENUE NORTHWEST PLAINVIEW, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Continued From Page 1 On 3/30/22, 12:42 p.m. a registered nurse (RN)-C stated she was unsure of why R23 had not received an SNF ABN, and said, "yes, I should have given that." A policy was requested, but not provided by the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING ______ B. WING ______	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	**800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964**

(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
E 000	Initial Comments On 3/28/22 through 3/31/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/28/22 through 3/31/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H5345033C (MN74073). 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 880	Infection Prevention & Control	F 880		4/29/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/26/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING ______ B. WING ______	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	**800 SECOND AVENUE NORTHWEST** **PLAINVIEW, MN 55964**

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F 880 SS=E	Continued From page 1 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING ______ B. WING ______	C 03/31/2022

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F 880	Continued From page 2 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was completed by 3 of 12 staff (NA-A, RN-A, and NA-B) observed prior to providing cares for 6 residents (R14, R4, R30, R37, R36 and R26). The facility was having a gastro-intestinal illness outbreak at the time. Findings:	F 880	F880 DPOC Handwashing Immediate Corrective Action: All staff working received appropriate education on hand hygiene. Corrective Action as it applies to others: The handwashing/hand hygiene policy was reviewed and remains current. All residents were assessed for adverse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING ______ B. WING ______	C 03/31/2022

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F 880	Continued From page 3 On 3/28/22, 1:45 p.m. two carts with personal protective equipment (PPE) were observed on the 200 hallway with signage posted on the doors to R22's and R10's room and R32's room, indicating persons entering the room should use, "contact precautions" (use PPE of gown, gloves and mask). Shortly after this, an additional cart with supplies was brought to a nearby room and a sign posted on R238's door also indicating staff were to use, "contact precautions." On 3/28/22, 2:33 p.m. a nursing assistant (NA)-A stated the facility had, "stomach flu" going around and the residents had symptoms of vomiting and diarrhea. NA-A was already wearing eye protection and a mask, but was observed to put on a gown and gloves, enter R22's room with incontinence products, put them away, touching furniture in the room. Then NA-A removed gown and gloves, placed them in the refuse container inside R22's room, touching the lid which was contaminated, and then sanitized hands with alcohol sanitizer. NA-A stated facility had provided infection control education about two months prior, and said hand sanitizer does not always work well with gastro-intestinal illnesses and staff should wash hands with soap and warm water for at least 20 seconds when someone has a GI illness, but admitted she had not done so after removing PPE, or leaving R22's room. During an interview 3/29/22, 9:43 a.m. the director of nursing (DON) stated the first incident of GI illness had started on 3/26/22 when R22 developed loose stools and was placed on contact precautions. When the next resident became ill with nausea and loose stools on 3/27/22 they suspected possible Norovirus (a GI illness that is contagious and easily spread in a	F 880	effects to ensure they have had no adverse effects due to handwashing deficiency. All staff to include the DON/Infection Preventionist will receive re-education on the hand hygiene policy and procedure. The DON/Infection Preventionist and designees will conduct return demonstration competencies on proper hand hygiene with all staff and maintain a log with results. Date of Compliance 4/29/2022 Recurrence will be prevented by: The DON/Infection Preventionist and other leadership staff will conduct audits on all shifts, everyday for one week to assure proper hand hygiene during resident care. The results of the audits will be shared with the facility QAPI Committee and based on results, the audits will continue daily or decrease in number and be discontinued once 100% compliance is demonstrated. Corrections will be monitored by: DON/Infection Preventionist and Designees	

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F 880	Continued From page 4 community living setting such as a nursing home). DON stated the medical director and all primary physicians were notified, and they initiated their Norovirus protocol. DON stated hand washing instead of the use of alcohol sanitizer had to be initiated as alcohol was not effective against GI illnesses such as Norovirus. DON said she and a nurse manager had been meeting with staff as they came to work to review the proper precautions. DON defined these precautions as being contact precautions with the use of soap and water handwashing for any person suspected of GI illness. On 3/29/22, 10:12 a.m. a registered nurse (RN)-A was observed without gloves, carrying a bag of soiled incontinent products and other trash from R238's room. R238's room still had a sign indicating staff should use contact precautions. RN-A was observed to carry the trash out a nearby building exit and go to the trash container to dispose of the bag. RN-A then returned to the building, used alcohol based hand sanitizer and walked to a medication cart, signed into the computer, opened the cart, removed a wound dressing, opened the dressing, wrote the date on the dressing with a marker sitting on the cart, and then went to the room of R14. RN-A knocked and entered R14's room and proceeded to apply the dressing to R14's ankle stating it was for protection. RN-A then left R14's room and returned to the medication cart and used alcohol based hand sanitizer, but did not clean the marker, the computer or the cart. On 3/29/22, 10:20 a.m. RN-A stated she had used alcohol based hand sanitizer after disposing of the contaminated trash from R238's room, and said she had not been told to use a soap and	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5 water wash when residents showed symptoms of GI illness. RN-A stated they should clean with a bleach solution if a person had "a C-diff infection, but we think this is a virus, not C-diff." (C. difficile is a GI infection usually associated with antibiotic use.) At 3/29/22, 12:52 p.m. NA-B was observed while doing the task of picking up lunch trays after residents had finished eating. NA-B entered several rooms, picking up soiled trays and placing them on the cart for dirty trays. NA-B brought a soiled tray from R36 and placed it on the cart, then, without practicing hand hygiene picked up a clean drinking mug, went to the dining area and filled it, then returned with the cup and brought it to R4 in another room. NA-B was then observed to enter R7's room to retrieve a used lunch tray, placed it on the cart, entered R19's room and retrieved a used lunch tray and placed it on the cart. Then, NA-B was asked to assist with the care of R30. NA-B grabbed a transfer lift sitting in the hall and without practicing hand hygiene, entered R30's room. On 3/30/22, 8:30 a.m. NA-B was observed providing cares to R23, and when NA-B left R23, no hand hygiene was observed. NA-B was observed to get R37 to do a weight. NA-B did physically touch R37 during this process. Afterwards, NA-B was not observed to practice hand hygiene. NA-B then went get R36 for a morning weight, without doing hand hygiene before the task and even though R36 was touched during the process, NA-B did not practice hand hygiene after the task was complete. NA-B then proceeded to pass morning breakfast trays to R26 and R36 without performing hand hygiene first.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245345	A. BUILDING ______ B. WING ______	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964

(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 880	Continued From page 6 During an interview 3/30/22, 8:42 a.m. NA-B stated the facility had provided infection control training within the past few months, and said the previous month the training had been on hand hygiene and the use of PPE. NA-B stated one way to prevent the spread of infection within the facility was by using hand sanitizer and by washing one's hands. NA-B stated it was expected use hand sanitizer before entering a resident's room, and upon exit. NA-B stated she did not recall any lapse in hand hygiene on her part. A facility document titled Resident GI Illness log indicated the first case of GI illness started on 3/28/22, R22 on the 200 wing, then R32, across the hall on 3/29/22 and R238, next door on 3/28/22. The next case was R17 on the 100 wing on 3/29/22, as well as R3 on the same date. R9 on the 300 hall and R10 on the 200 hall were also stricken on 3/29/22. On 3/30/22, R7 and R21 on the 100 wing became ill with GI illness, and on 3/31/22, R16 and R35 on the 100 unit became ill; R25 and R18 on the 200 unit became ill, and R23, R34 and R36 on the 300 unit became ill with GI illness. A facility policy titled MHM-Norovirus Prevention and Control marked as updated 3/4/22 indicated "during outbreaks, residents with norovirus gastroenteritis will be placed on Contact Precautions for a minimum of 72 hours after the resolution of symptoms. Also, the policy indicated, "during outbreaks, use soap and water for hand hygiene after providing care of having contact with residents suspected or confirmed with norovirus gastroenteritis. To prevent food-related outbreaks of norovirus	F 880		

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	245345	A. BUILDING ______ B. WING ______	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 7 gastroenteritis in healthcare settings, food handlers must perform hand hygiene prior to contact with or the preparation of food items and beverages." A facility policy and procedure titled Monarch Healthcare Management Handwashing policy dated 11/2019 indicated "proper hand washing techniques should be used to protect [from] the spread of infection. Han washing shall be completed before, during and after preparing food, before eating, before and after caring for someone who is sick, before and after treating a cut or wound, after using the toilet, after changing incontinent products or cleaning up after someone who has used the toilet, after blowing nose, coughing or sneezing, touching an animal or animal waste, after handling pet food or pet treats, after touching garbage." The implementation portion indicated, "hand washing shall be performed by all employees, as necessary, between tasks and procedures, and after bathroom use to prevent cross contamination." According to the CDC, healthcare workers should use hand sanitizer immediately before touching a patient, before performing an aseptic task or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces and immediately after glove removal. The CDC recommends washing with soap and water when hands are visibly soiled, and after caring for a person with known or suspected infectious diarrhea, after known or suspected exposure to spores (e.g. B.antracis, C difficile	F 880		

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	245345	A. BUILDING ______ B. WING ______	C **03/31/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREEN PRAIRIE REHABILITATION CENTER	**800 SECOND AVENUE NORTHWEST PLAINVIEW, MN 55964**

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F 880	Continued From page 8 outbreaks).	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING MEADOWS AT LUTHER - MADELIA	**503 BENZEL AVENUE SW** **MADELIA, MN 56062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/30/2022. At the time of this survey, Living Meadows at Luther was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | | 04/21/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/30/2022**

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Living Meadows at Luther was constructed as follows:
The original building was constructed in 1958; it is one-story, has no basement, is fully fire sprinkler protected, and is of Type II(000) construction.
The 1st addition was constructed in 1973; it is one-story, has no basement, is fully fire sprinkler protected, and is of Type II(000) construction.
The 2nd addition was constructed in 1993; it is one-story, has no basement, is fully fire sprinkler protected, and is of Type II(000) construction.

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	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/30/2022**

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LIVING MEADOWS AT LUTHER - MADELIA	**503 BENZEL AVENUE SW** **MADELIA, MN 56062**

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K 000	Continued From page 2 The 3rd addition was constructed in 2001; it is one-story, has no basement, is fully fire sprinkler protected, and is of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification, and the building is fully sprinklered. The facility has a capacity of 40 beds and had a census of 36 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect fire door assemblies per NFPA 101 (2012	K 761	1. Facility maintenance staff tested and inspected all fire door assemblies per NFPA 101 (2012 edition),19.7.6 and	4/21/22

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

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	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/30/2022**

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K 761	Continued From page 3 edition),19.7.6 and 8.3.3.1 and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.2.1 and 5.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/30/2022, between 10:30 AM to 12:30 PM, during document review, it was revealed that documentation could not be provided to show that an annual fire door inspection and testing had occurred. An interview with the Maintenance Director verified this finding at the time of discovery.	K 761	8.3.3.1 and NFPA 80 (2010 edition). 2. The Environmental Services Director (EVS) has processes in place to ensure all fire door inspections will be completed on an annual basis, as required per NFPA 101 (2012 edition),19.7.6 and 8.3.3.1 and NFPA 80 (2010 edition) standards. 3. EVS Director will report and log findings, and will report to the administrator any findings that require attention to ensure solutions are sustained. 4. The administrator is responsible to ensure corrective actions are completed and to monitor completion and documentation in the log book.	