STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245371	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie View Senior Living	250 Fifth Street East Tracy, MN 56175

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and document review, the facility failed to facility failed to maintain surveillance of staff illness for preventing, monitoring and investigating illnesses to control infections for 1 of 1 infection control program. This had the potential to affect all 41 residents. The facility also failed to appropriately clean, rinse, and air-dry nebulizer apparatuses (mask, cup) after medication administration for 3 of 3 residents (R9, R14 and R21) and ensure 3 of 3 observed stand lifts, located in the 200 and 300 wing were appropriately cleaned between resident use. Findings include: SURVIELLANCE Review of the 2024-2025 Norovirus Information for Long-term Care Facilities, located at, https://www.health.state.mn.us/diseases/foodborne/outbreak/facility/ltcfnorotoolkit.pdf, identified Norovirus is transmitted through a fecal (stool)-oral route with symptoms of diarrhea, vomiting, nausea, abdominal pain, low grade fever, headache, and or body aches. Individuals generally become ill 12-48 hours after exposure (swallowing Norovirus). Infected individuals shed the virus in their stool and contaminate food, surfaces, and objects and can be shed in the stool for several weeks after recovery. Products used to clean Norovirus must say they are effective against Norovirus. Hand sanitizer does not work to kill the virus. Individuals should wash their hands for 20 seconds with soap and water. Individual cases of Norovirus are not reportable to the State, however, possible outbreaks or multiple cases with Norovirus-like symptoms must be reported. Documentation of possible outbreaks was to include: Use the RESIDENT ILLNESS LOG and STAFF ILLNESS LOG to document illnesses among staff and residents/patients: Contact managers of each unit, etc. as necessary to gather illness information. Send both ILLNESS LOGS back to MDH within 2 business days of reporting the suspected outbreak. Epidemiology staff will use this to assess A) which pathogen is causing the outbreak, B) the likely route of transmission, and C) whether additional prevention measures are needed. Gather additional information List activities, events, etc., held during the week prior to the first illness (especially if food was served). Determine when and where there were any vomiting incidents or diarrheal accidents in the facility. (continued on next page)

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.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	If requested by MDH, provide a dietary menu (breakfast, lunch, and dinner). If requested by MDH, provide names and phone numbers for staff and/or residents (in rare cases, MDH may want to conduct interviews). Collect a stool sample from three (3) residents and/or staff and send to MDH Laboratory for analysis (MDH will provide specimen collection kits; the testing is free of charge). If stools from residents or staff were sent to a clinical laboratory, notify MDH of any results. Send both completed ILLNESS LOGS back to MDH between 1 and 2 weeks after the last illness. IMPLEMENT OUTBREAK CONTROL MEASURES: Monitor for resident illness (record on RESIDENT ILLNESS LOG) and when possible, isolate residents while they are ill and for 72 hours after symptoms have stopped. Consider halting new admissions until the outbreak has ended. Exclude actively ill residents from games/activities where touching common items occurs (e.g., checkers, cards). Monitor for staff illness (record on STAFF ILLNESS LOG) and restrict ill staff/volunteers from patient care and food handling duties until 72 hours after their vomiting/diarrhea has ended. Review of the Attendance Slip forms identified columns of: Employee name Shift and date Excuse for calling in Time called in A check box if staff were late (approved with less than 12-hour notice), late (no notice), 2 plus hours late (without notice) and if checked, how late staff were, if they left work early without approval, were a no-show, and who it was completed by. The form had no column to document when symptoms started, when symptoms were resolved, when staff RTW, or if they were cleared using national/ state standards to return to work. Review of May 2026, Attendance Slips identified: NA-B had called in on 5/2/26, with symptoms of nausea and vomiting. Review of NA-B time punch identified NA-B had returned to work on 5/3/26 the next day. NA-A had called in on 5/18/26, with symptoms of vomiting and fever. Review of NA-A time punch identified NA-A had returned to work on 5/19/26 the next day. Interview on 5/19/26 at 4:15 p.m., with the infection preventionist (IP) identified she did not have surveillance for staff illnesses. If staff called in one day for a headache, vomiting, diarrhea, or fever they were allowed to return to work 24 hours after symptoms resolved. For norovirus, the facility just (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	kept track of symptoms and if they were symptomatic and more than one resident or staff was affected, that would constitute an outbreak then she would track that information and keep the resident in their room. She made no mention of how that would affect a staff's RTW. When a staff member called in, the person taking the call would fill out an attendance slip. The attendance slip typically went to the director of nursing (DON). She was unaware that staff should be out for 72 hours with symptoms of potential norovirus per State guidance. She acknowledged that she had not tracked staff illness since January of 2025. Interview on 5/19/26 at 4:28 p.m., with the administrator identified the facility could not require staff to disclose their symptoms or reason for calling in if the staff did not voluntarily provide that information. Interview on 5/20/26 at 11:32 a.m., with nursing assistant (NA)-A identified she had called-in for work on 5/18/26, she had vomited and had a fever Friday night on 5/15/26. She had called in because her stomach still did not feel good. She was unaware of any process for staff when they were ill. She had just called in ill and felt better the next day and assumed she should be able to RTW. She thought there should be some kind of process to ensure the residents do not become ill also. Interview on 5/20/26 at 11:52 a.m., with infection preventionist (IP) identified she reached out to her registered nurse (RN) consultant for the facility and was informed that there was no RTW policy. RTW was dependent on the staff symptoms. If staff had one day of vomiting but felt better the next day, staff would be allowed to RTW. The facility was to track symptoms on the absentee form the facility used. She did not receive the forms; however, she was notified of staff illnesses verbally. Staff are asked to report their symptoms when calling in for a shift, however they were not required to disclose their symptoms if they did not want to. Review of 4/20/26, General Infection Prevention and Control-Surveillance policy identified the infection preventionist would record infection data on the facilities monthly Infection Line Listing/Log in Infection Watch. Infection Control Records would be reviewed, presented, and evaluated by the QAPI Committee quarterly for residents and staff. Review of 4/20/26, Surveillance and Monitoring policy identified the facility would maintain routine surveillance and monitoring of the workplace. The infection preventionist or the director of nursing would be responsible for maintaining the surveillance records. The surveillance record would be evaluated for corrective measures to be taken to prevent a recurrence or similar exposure. The surveillance and monitoring would be reviewed at the QAPI meetings. Review of 4/20/26, Staff with Infections policy identified the facility would evaluate staff with infection to determine if staff may continue providing direct care or services to residents in the facility. Staff with infections would not be permitted to provide direct care until the facility conducted a review of the staff's medical record to determine if the staff may provide direct care in accordance with the established policies. NEBS Observations during initial tour on 5/18/26 beginning at 10:00 a.m., through 11:00 a.m., identified R9, R14, and R21's nebulizers were lying on their bedside tables/ nightstands and had not been disconnected, rinsed and air dried. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Additional observation and interview on 5/18/26 at 3:48 p.m. of registered nurse (RN)-A as she proceeded to give R9 her inhaled nebulizer treatment identified R9's medication apparatus was still intact from this morning's administration. RN-A proceeded to hold the nebulizer and pour the nebulizer medication from the ampule in through the mask and into the medication cup. RN-A stated the apparatus should have been disassembled, cleaned and rinsed after each nebulizer administration. She was unsure if this occurred and noted facility policy directs staff to disassemble, clean, and air dry after each medication observation. Review of the May 2026 Medication Administration/Treatment Administration Records (MAR/TAR) identified: R9 had received her 6:00 a.m., nebulizer treatment for formoterol furmate nebulizer treatment solution that morning. R21 had received her ipratropium-albuterol inhaler nebulizer treatment at 7:00 a.m. that morning. Review of the 4/20/26, Respiratory Equipment Cleaning Procedure policy identified after each use, staff were to rinse the mouthpiece and medication cup with water and allow to air dry. MECHANICAL LIFTS Random observations on 5/18/26 from 10:00 a.m., through 6:00 p.m., of the 200 and 300 wing stand lifts identified all 3 lifts were sitting in the hall waiting to be used and had dirt and food-like debris on the pedals. Interview on 5/20/26 at 2:02 p.m. with RN-A identified stand lifts were to be cleaned after each use. Review of the 4/20/26, Nursing Weekly Cleaning task policy identified multiple use items, such as a mechanical lift were to be cleaned and disinfected after each use.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident's (R36) room was maintained in a homelike manner and ensure preventative maintenance was provided to repair numerous chips and scratches in the pain on 2 of 4 walls.Findings include: R36's comprehensive Minimum Data Set (MDS), accepted on 9/5/25, identified R36 was re-admitted to the facility in November 2023, with diagnoses of heart failure, high blood pressure, and arthritis. R36 had intact cognition and had no behaviors noted. Observation on 5/18/25 at 10:25 a.m., of R36 ion her room identified R36 was seated in her chair. R36 was alert and oriented and stated she had been at the facility for a while. R36 had numerous chips on the walls directly behind her chair and on the right side of the bed, approximately 10 to 12 inches on the wall, above the mattress. When asked about the chips and scuffs in the paint, R36 stated they had always been there since she moved in. Interview on 5/20/26 at 1:00 p.m., with the administrator identified the maintenance director (M-D) was out at the moment, but he did use a TELS system that could generate, assign, and track work orders, and could be used to track preventative maintenance. He was unsure if the M-D had a preventative maintenance schedule that included resident rooms, but agreed at a minimum, rooms should be checked yearly for maintenance needs. He noted R36 did like to move her furniture around a lot. Interview on 5/20/26 at 1:38 p.m., with registered nurse (RN)-A identified R36 was known to move things around in her room. RN-A was unaware of the numerous scratches and chips in R36's pain behind her chair and beside her bed on the wall. She was not sure if staff had put in a work ticket but did think the M-D did do environmental rounds. Review of the QAPI meeting minutes from May 2025 through April 2026 identified M-D was present at the QAPI meetings and submitted data for environmental services that included painting as needed in the category of Building Improvements. The action plans were to touch up paint when rooms were empty or as needed. Review of the 4/26/26 Safety Meeting documentation identified facility staff did perform monthly safety rounds; however, there was no mention of specific preventative maintenance checks to ensure resident rooms were maintained in a homelike manner. There was no policy related to preventative maintenance provided by the end of survey.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and document review, the facility failed to have documented communication between the facility and hospice per their written agreement and ensure hospice notes were included in the medical record for 1 of 1 sampled hospice resident (R5). Findings include: R5's comprehensive Minimum Data Set (MDS) assessment, accepted on 9/24/25 identified R5 was re-admitted to the facility in September 2024, with diagnoses of dementia, anxiety disorder and had moderately impaired cognition. R5's current, undated care plan identified R5 has a terminal prognosis requiring hospice involvement/palliative care related to his end stage disease process. Comfort, dignity and autonomy was to be maintained at the highest level and was to demonstrate peacefulness and calmness through body language and/or verbalization. Review of R5's electronic medical record (EMR) hospice notes identified R5's R5 had hospice notes, schedules, and care plans captured in the EMR for the following months:February 2025, 9 times.March 2025, 6 times.April 2025, 5 times.May 2025, 1 time.June 2025 through August 2025, no notes were captured.September 2025, 6 times.October 2025 through February 2026, no notes were captured.March 2026, 5 times.April 2026, no notes were captured.May 2026, 7 times. Interview on 5/20/26 at 8:46 a.m., with the hospice nurse (HN)-A identified he or another nurse would come to the facility 2x per week on Tuesdays and Fridays. The facility was supposed to have all documentation form each hospice visit captured in their medical record. He noted very recently he had some issues faxing over the documents, but that had been resolved. Hospice staff always speak to facility staff and give report after each day they visit. He was unsure why the facility didn't have any notes and wasn't aware they were missing any. R5's 5/1/26 current hospice care plan identified he was admitted to hospice for senile degeneration of the brain. R5's hospice visit communication note from the facility identified there was 1 entry in January 2025, made by registered nurse (RN)-A that noted R5 continued to have an ulcer to his left rear calf. Improvement was noted. R5 also had a pressure ulcer to his right heel. Staff were to ask the physician to continue betadine and noted other interventions. There was no mention if this was a recommendation from hospice, or what the communication was that day between hospice and the facility staff. Interview and document review on 5/20/26 at 1:26 p.m., with RN-A identified she would expect the facility to follow the hospice contract made between R5's hospice and the facility. Staff do have verbal communication, but the facility doesn't document that communication. If the staff that received the verbal communication and did not pass along pertinent information, she agreed communication that may be urgent etc. could be lost. She was unaware the hospice notes were not being captured for several months. Hospice was to send the administrator the notes, and he would print them out and give them to staff. She was not aware of anyone else checking to see the facility had received that documentation and agreed they need to follow contract identifying both parties document communication. Review of the current hospice contract between R5's hospice provider and the facility identified hospice, and the facility, were to communicate with one another regularly and as needed. After every communication, each party was to document the communication in its respective clinical records to ensure the needs of hospice patients were met 24 hours per day.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interview and document review, the facility failed to ensure 2 of 8 sampled staff (director of nursing (DON) and nursing assistant (NA)-C) had initial or annual Alzheimer's and dementia training. Findings include: Review of the facility Employee Roster, Job and hire date document identified nursing assistant (NA)-C's had a hire date of 2/23/26. Review of her Alzheimer's Disease or Related Disorder Training identified she had not completed training for an explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, or communication skills. Review of the facility Employee Roster, Job and hire date document identified director of nursing (DON) had a hire date of 5/28/24. Review of her Alzheimer's Disease or Related Disorder Training identified she had not completed training for an explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, or communication skills. Interview on 5/19/26 at 4:25 p.m., with the administrator identified that 2 of the 8 staff had not completed their Alzheimer's training as required. He would expect the Alzheimer's training to be completed initially and annually as required. Review of the undated, New Hire Requirements for Relias orientation education included dementia care:Understanding the world of dementiaBeing with a person with dementia, listening and speakingBeing with a person with dementia, actions and reactionsAlzheimer's/Dementia verses normal ageingHelping friends and family with dementia carePreventing adverse reactions to dementia careDementia care, performing ADL'sDementia care, challenging behaviors and direct care staffCaregiver stress management Review of the 5/12/26, Facility Assessment identified staffing would be adequate for caring for residents with mental health conditions, history of trauma and dementia. The facilities training program for new and existing staff included dementia management and abuse prevention, effective communication, special needs of residents, and caring for residents who are cognitively impaired. A policy on the facilities Alzheimer's dementia training program for new hires and annual training was requested but not provided.