STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Manor Care Center	220 Third Street Northwest Blooming Prairie, MN 55917

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview, and document review the facility failed to ensure care plans, which the facility used to communicate Enhanced Barrier Precautions (EBP), were revised for 4 of 4 residents (R10, R16, R24, R31) who were reviewed for care plans and who had been placed on EBPs designed to reduce the spread of multidrug-resistant organisms (MDRO's). Findings include: The Centers for Medicare and Medicaid Services (CMS) Center for Clinical Standards and Quality/Quality, Safety and Oversight Group Ref: QSO-24-08-NH dated March 20, 2024, documented Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and glove use during high contact resident care activities. In addition, EBP are indicated for residents with any of the following: -Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or -Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Also, Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. Guidance also documented, EBP is employed when performing the following high-contact resident care activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care: any skin opening requiring a dressing. During facility entrance conference on 6/30/24 at 10:15 a.m., a list of residents on EBP was requested. The facility's infection control preventionist (ICP) provided surveyors with a list identifying R10, R16, R24, and R31 who were on EBP. R10's quarterly Minimum Data Set (MDS) dated [DATE], identified admission to facility on 10/26/20, dependence on staff for toileting hygiene, required substantial assistance with dressing and bathing, and had diagnoses of obstructive uropathy (impaired urine flow), urinary tract infection, and Parkinson's disease. Furthermore, R10 had an indwelling catheter (tube system used to drain urine from the bladder). (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R10's care plan (CP) and Kardex (nursing assistant care instructions) downloaded 6/30/24 failed to document EBP status. R16's annual MDS dated [DATE], identified admission to facility on 4/5/23, was dependent on staff for eating, toileting, personal hygiene, dressing and bathing, and had diagnoses of neurogenic bladder (impaired bladder control), Alzheimer's, and arthritis. Furthermore, R16 was on hospice and had an indwelling catheter. R16's CP and Kardex downloaded 6/30/24, failed to indicate EBP status. R24's significant change in status MDS dated [DATE], identified admission to facility on 11/12/20, was dependent on staff for toileting, bathing, and lower body dressing, and had diagnoses of neurogenic bladder, paraplegia (limb paralysis), and seizure disorder. Furthermore, R24 had an indwelling catheter. R24's CP and Kardex downloaded 6/30/24 failed to indicate EBP status. R31's quarterly MDS dated [DATE] identified admission to facility on 8/14/23, was dependent on staff for toileting hygiene, and lower body dressing, and had diagnoses of obstructive uropathy, renal failure, and anxiety. Furthermore, R31 had an indwelling catheter. R31's CP and Kardex downloaded 6/30/24 failed to indicate EBP status. During observation on 6/30/24 at 11:27 a.m., R10, R16, R24, and R31 had doors with posted signage indicating infection control precautions with instructions for staff to apply and remove personal protective equipment (PPE) for EBP. In addition, these rooms had PPE carts outside their doors. During observation and interview with LPN-A on 7/1/24 at 8:41 a.m., LPN-A stated she worked full time and was familiar with all the residents of the facility. LPN-A stated the expectation of staff was to find information on individual resident care needs, including assistance required for transfers, hygiene, diet, infections including EBP [status] or contact precautions, is in the report book (nursing communication book), [Kardex] and in the care plan. LPN-A reviewed in R10's electronic medical record (EMR) and reviewed R10's care plan and Kardex and verified they both lacked R10's EBP status. LPN-A walked to alcove near entrance of facility and pointed to a blue colored 3 ring binder labeled, Communication folder. LPN-A reviewed the nursing communication book and verified it lacked EBP status for R10, R16, R25, and R31. LPN-A stated updates to resident care plans, Kardex's, including information regarding EBP status are the responsibility of the director of nursing (DON), assistant director of nursing (ADON) who is also the ICP of facility or nurse manager. During interview with nursing assistant (NA)-A on 7/1/24 at 10:33 a.m., NA-A stated he had worked at facility full time for three years. NA-A stated the expectation of nursing staff was to receive verbal report at the beginning of every shift and, look in the communication folder. If there is changes it should be in the Kardex [also]. NA-A reviewed R10, R16, R25, and R31 care plans, Kardex's, and the nursing communication board and stated, Nope, I don't see anything about precautions for any of those residents [to receive verbal report at the beginning of every shift] .I don't know why they are on those precautions though so I would have to ask the nurse about that. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with NA-B on 7/1/24 at 9:18 a.m., NA-B stated she was full time and worked at facility for seven months. NA-B stated the expectation of nursing staff was to receive verbal report at the beginning of every shift and to look in the Kardex for each resident to determine the assistance needed. If there were changes in status I would look in the communication book every time I work. [If any resident is on] EBP or contact precautions, we are told in the morning meeting, and communication book. I expect [EBP status] to be in the Kardex. NA-B reviewed the EBP status for R10, R16, R25, and R31 and verified it was not in their care plans, Kardex's, and communication book. [It] should be though. During interview with ICP on 7/1/24 at 9:50 a.m., ICP verified she was also the facility's assistant director of nursing. ICP stated facility's method of communication to staff regarding EBP included updating individualized care plans, Kardex's, and the nursing communication book. ICP reviewed R10, R16, R25, and R31's care plans, Kardex's and the nursing communication book and verified all lacked information on EBP status. All of them [R10, R16, R25, and R31's care plans, Kardex's, and the nursing communication book] were updated today. [Updates] should have been put in the Kardex's, [care plans] and communication binder when they were put on precautions, but it wasn't. ICP stated unfamiliar staff such including agency staff would not be informed of resident care needs unless the care plan, Kardex's and communication book were accurate. ICP stated, It's important for all staff to know [resident EBP status]. Facility policy titled state, The care plan will be updated from a Registered Nurse, Social Services, Dietary, or Activities with any changes in resident care as needed. In addition, A Kardex will be completed with each care plan update to ensure staff are notified of a change in the care plan. Staff will also be notified of changes made to the care plan via the nursing communication book.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure routine hygiene cares (i.e. , nail care) was provided for 1 of 2 residents (R10) reviewed for activities of daily living (ADLs) and whom was dependent on staff to complete such cares. Findings include: R10's quarterly Minimum Data Set (MDS), dated [DATE], identified R10 had moderate cognitive impairment and demonstrated no delusional thinking. Further, the MDS outlined R10 required partial or moderate assistance with personal hygiene and did not have diabetes mellitus. R10's care plan, printed 6/30/24, identified R10 had Parkinson's Disease and required assistance with bathing due to impaired mobility. A series of goals were listed which included, To be neat[,] clean and odor free, along with multiple interventions such as bathing three times a week, physical assist of one for bathing, and foot care services for toenails as needed. The care plan lacked any guidance or direction on fingernail care including what, if any, preference for length R10 had or how often they should be checked or clipped. On 6/30/24 at 12:53 p.m., R10 was observed seated in his wheelchair while in his room. R10 had a visible tremor at times along with several long fingernails present on his left hand with the nail edge being multiple millimeters (mm) in length and some nails having a faint, dark coloration debris present under the nail bed. R10 stated he needed his nails clipped and added aloud, They [staff] come around to clip your toe nails but not your fingernails. R10 stated he was getting his scheduled bathing completed but only one staff member ever asks about clipping his fingernails adding, Most of the time, its one girl [staff]. R10 stated he hadn't seen the staff member lately but reiterated he would like the nails clipped. R10's POC (Point of Care) Response History, dated 6/3/24 to 6/28/24, identified the recorded support provided to R10 to complete bathing. This recorded a total of 12 episodes of bathing with R10 needing, at minimum, physical assistance in part of the task. However, R10's corresponding POC Response History, dated 6/3/24 to 6/28/24, listed a follow-up question to be completed which asked, Were fingernails cut[?], and staff could record a yes, no, refusal or unavailability. A total of 12 episodes were recorded with each response being marked, No. There were no recorded refusals of the care. R10's progress notes, dated 6/3/24 to 6/30/24, identified multiple notes labeled, Skin Wound Check, with sections to be completed by the nurse including, Fingernails & toenails trimmed: [answer recorded]. The most recent entries were recorded as: 6/12/24: Fingernails & toenails trimmed: no. 6/17/24: Fingernails & toenails trimmed: no refused. 6/19/24: Fingernails & toenails trimmed: no. 6/21/24: Fingernails & toenails trimmed: nails are clean and appropriate. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/24/24: Fingernails & toenails trimmed: no. 6/26/24: Fingernails & toenails trimmed: no. However, the completed notes lacked information on how long the nails were (including what parameters were used to determine 'appropriate') or what, if any, re-approach effort was made on 6/17/24 to clip R10's nails with a refusal of care. Further, the medical record was reviewed and lacked evidence R10 had his fingernails clipped or trimmed since early June 2024, despite having long nails readily visible (i.e., 6/30/24 when observed). On 7/1/24 at 10:16 a.m., nursing assistant (NA)-C stated they had worked at the campus for a couple years and were aware of R10's care needs. NA-C explained R10 received help with bathing three times a week and nail care was usually done by the bath aide, however, R10 seemed to only like certain staff members or someone he trusts. NA-C stated they did not think R10 was diabetic but expressed aloud, I think they nurse does them [clips nails] for him. NA-C then observed R10's fingernails at the surveyor request. R10's fingernails remained long as they had been observed prior (6/30/24) and NA-C stated aloud, I think they're pretty long and need some clipping. R10 reiterated he wanted them clipped just not too short. NA-C stated any nail care completed by the NA staff, including offers and refusals of such, would be charted in the POC. NA-C stated the nail length appeared like it had been one or two months I think since they had last been clipped. When interviewed on 7/1/24 at 10:23 a.m., licensed practical nurse (LPN)-A explained nail care for a non-diabetic resident would typically be completed by the NA who helped with bathing on their scheduled bath days. LPN-A stated the NA will complete a bath sheet which is then provided to the nurse working who enters the information into the progress notes (i.e., Skin Wound Check). LPN-A verified any refusals of offered nail care should also be recorded. LPN-A then went and observed R10's fingernails and, upon return, stated aloud, They are long. LPN-A stated R10 did just again say he wanted them clipped and expressed it looked like it had maybe [been] a couple weeks since they were last clipped or trimmed. LPN-A stated nail care should be completed routinely to reduce the risk of bacterial growth under the nails. On 7/1/24 at 11:43 a.m., registered nurse manager (RN)-A stated they had just updated R10's care plan to reflect nail length preference adding the NA did just file them after reviewing them. RN-A explained nail care was usually completed with scheduled bathing but could also be done as needed. RN-A stated they had spoken with some other staff members and voiced they decided maybe adding clarity to the bath sheets would help ensure nail care wasn't missed moving forward as the language may be confusing to the aides. RN-A verified R10 likely needed help to complete fingernail clipping due to his Parkinson's Disease and expressed nail care should be done to promote good hygiene, reduce the infection risk, and also reduce the risk of him scratching himself with long nails. A provided Nail Trimming Policy and Procedure, dated 1/2022, identified staff may complete basic nail care for residents which included trimming. A procedure was listed with a step-by-step process to complete the actual task of nail care, however, the policy lacked information on how nail care would be documented or how often such care was to be offered or provided. An additional ADL Policy, dated 11/2016, identified the facility must provide care and services in accordance with F310 (sun-setted regulation for ADL care). The policy outlined ADL(s) included hygiene care (i.e., bathing, grooming) and directed, Staff will complete documentation in POC every shift describing the amount of care needed to complete each ADL.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and document review the facility failed to comprehensively assess for and use the compatible mechanical lift with mechanical lift sling to ensure safe transfers for 1 of 1 residents (R18) observed and reviewed for safe transfers. This had the potential to affect five residents (R4, R8, R9, R18, R24) residing in the facility who used the same practice for mechanical lift transfers. Findings include: R18's quarterly Minimum Data Set (MDS), dated [DATE], indicated R18 had severe cognitive impairment, was dependent on staff for all activities of daily living (ADLs) and required a mechanical lift for transfers. R18's Weights, dated 7/2/24, in the electronic medical record (EMR) indicated R18 had lost 32 pounds in the past 6 months, approximately 15% of her body weight with a current weight of 187 pounds. R18's care plan, printed 7/2/24, indicated R18 required physical staff assist of two with VOLARO hoyer [mechanical] lift and size large (black trim cross leg sling) or the ARJO lift with (green trim) size large sling. R18's progress notes, dated 4/1/24 - 7/1/24, indicated R18 had two falls from a mechanical lift on 4/14/24 and 6/1/24. R18's progress note, dated 4/14/24, indicated R18 was transferring from her bed to wheelchair via a mechanical lift and two staff members when R18 got ahold of the leg straps and started viciously shaking them. R18 was up in the air when one of the leg straps came out of the hook holding it in place causing R18 to fall from the mechanical lift and was lowered to the ground. R18's progress note, dated 6/1/24, indicated R18 slid out of the hoyer [mechanical lift] sling and was lowered to the floor. During an interview on 7/1/24 at 9:45 a.m., nursing assistant (NA)-D stated R18 required assistance with two staff for transfers via a mechanical lift. NA-D stated R18 often had aggressive behaviors during transfers. NA-D stated she was present with R18 on 4/14/24, when R18 grabbed the sling straps and started shaking them. NA-D stated R18 was up in the mechanical lift and fell into the chair when the sling strap came lose. NA-D further stated the facility used multiple types of mechanical lifts and slings. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/1/24 at 9:50 a.m., the director of nursing (DON) stated the restorative nurses and the assistant director of nursing (ADON) were responsible to assess what mechanical lift and sling were appropriate for a resident to use. The DON stated a resident would be reassessed for proper sling size if a concern was noted or a change in condition but not necessarily from weight loss alone. The DON stated R18 was using the proper care planned mechanical lift and sling when she fell on [DATE], however the mechanical lift was found to have a broken clip that may have contributed to the sling coming loose, and after the second fall on 6/1/24 the sling was changed to a less slippery sling. The DON further stated the maintenance department provided routine maintenance of the mechanical lifts and nursing staff was educated on checking the clips on the mechanical lifts prior to use. During an interview on 7/1/24 at approximately 1:00 p.m., the ADON stated after R18's fall on 6/1/24, a different sling and mechanical lift was put in place to see if it would prevent R18 from wiggling out of the sling. The ADON further stated they had not had the mechanical lift or sling companies out to the facility to do education with the staff on how to properly use the mechanical lifts and slings to prevent further falls from a mechanical lift. The DON stated approximately 3 weeks ago she realized the facility was using three different types of slings and mechanical lifts, so each resident using a mechanical lift was assessed by the ADON for proper sling sizing. During interview on 7/1/24 at 3:10 p.m., (via email) the DON confirmed R18 was using a Volaro brand mechanical lift with Tollos brand sling when she fell from the mechanical lift on 4/14/24 and 6/1/24. The DON further confirmed while they had changed the mechanical lift and sling for R18, other residents in the facility were still using a combination of the Volaro brand mechanical lifts and Tollos brand slings. During an interview on 7/1/24 at 4:17 p.m., (via email) a Tollos (sling) Representative (TR) and the Tollos Clinical Educator (TCE) stated Tollos had not tested their slings to be used with the Volaro mechanical lifts and stated the most important aspect of using a Tollos sling with any other equipment would be if the facility received proper training for safe use. The TCE further stated Tollos does not make a recommendation in this regard because the possible combinations and uses would be numerous and could be unsafe in some situations. We would need to evaluate each individual use. During an interview on 7/2/24 at 8:55 a.m., a Volaro mechanical lift representative (VR) stated Volaro does not recommend, as a manufacturer, the use of other branded slings with their lifts. The VR stated he had seen other slings on the Volaro lifts that may have appeared to have a strong hold but created unsafe gaps in the sling where it should wrap the resident for safety to prevent a resident from slipping out. The VR further stated their slings were specifically designed to fit their mechanical lifts. During an interview on 7/2/24 at 10:27 a.m., the DON stated they had processes in place to review quarterly what slings and mechanical lifts a resident was using to ensure appropriateness, but have not had any facility wide education on what staff should look for to determine if a mechanical lift or sling was not appropriate for a resident. The ADON stated she determined the Volaro brand mechanical lifts and the Tollos sling were appropriate to use together by visual inspection but did not reach out to the mechanical lift and sling companies for education or to assess if they were appropriate and safe to use together. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An undated policy titled Lifts & Transfers indicated the facility used a variety of mechanical lifts and slings for both sit to stand and full lift purposes and each resident would be assessed for an appropriate lift and sling based on the resident's height, weight, and body circumference.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and document review the facility failed to comprehensively assess and reassess a resident's history of abuse and trauma, behavioral symptoms, triggers, and interventions to minimize physical and verbal aggression during cares for 1 of 1 resident (R18) reviewed for behavioral management. Findings include: R18's quarterly Minimum Data Set (MDS), dated [DATE], indicated R18 was admitted to the facility on [DATE] and had severe cognitive impairment. The MDS further indicated R18 was dependent on staff for all activities of daily (ADLs) and had verbal behavioral symptoms daily and physical behavioral symptoms 4-6 days of the 7 day look back period. R18's diagnoses list, printed 7/2/24, indicated R18 had multiple medical diagnoses including unspecified dementia with behavioral disturbances and other specified mental disorders due to known physiological condition. R18's medication administration record (MAR), dated 5/24/24, indicated R18 received several medications including Seroquel (an antipsychotic medication that treats several kinds of mental health conditions including schizophrenia [a serious mental illness that affects how a person thinks, feels, and behaves] and bipolar disorder [severe mood swings]) 50 milligrams (MG) by mouth every morning and bedtime related to unspecified dementia with behavioral disturbance, dated 6/4/24 and escitalopram oxalate (used to treat depression and generalized anxiety disorder) 10 mg by mouth one time a day related to dementia with behavioral disturbance, dated 3/26/24. The orders also contained an order to monitor mood and behaviors d/t [due to] increase Seroquel 6/5 - every shift for 4 weeks. R18's care plan, printed 7/2/24, with revisions since admission, indicated problematic manner in which resident acts characterized by ineffective coping in unfamiliar environment. Agitation as e/b calling out and yelling at staff with cares related to: Dementia, cognitive decline, history of physical and emotional abuse. Can become very anxious at times and call out/verbalize with phrases such as: You're hurting me You're going to drop me I'm slipping I'm not safe. Has swatted and pinched staff and makes threats to hurt staff. History of yelling, swearing, and showing unwanted hand gestures when being provoked by other residents. History of yelling, swearing, hitting and attempts to bite staff during cares. The care plan contained the following interventions, that had not been updated since R18's admission despite them being ineffective in decreasing R18's care planned behaviors; Be sure you have the resident's attention before speaking or touching. Staff to maintain calm approach, provide support listening, reassurance and verbal cues with transfers and cares, Keep schedules and routine predictable and inform resident ahead of time before attempting cares, Monitor for verbal/nonverbal indicators of pain and report to nurse for further assessment if noted, Refer to transferring/toileting care plans. Staff to provide verbal cues and use 2a [assistance] with mechanical lift to ensure safety, Remove resident from public area when behavior is disruptive/unacceptable. Talk to resident in low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity offer food/fluid, toilet, nurse to assess for pain, ask resident about her farm or horses. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's medication administration record (MAR) and treatment administration record (TAR), dated 6/24, lacked any documentation of non-pharmacological interventions or as needed medication to address R18's frequent and continued verbal and physical behaviors. R18's progress notes from 5/1/24 to 7/1/24, also lacked any non-pharmacological interventions but indicated R18 had behaviors on the following days and two falls from a mechanical lift; On 5/1/24 it was documented R18 was still very combative towards staff during cares. On 5/2/24 it was documented R18 was still very combative and using abusive language during cares. On 5/3/24 it was documented R18 was still very combative and using abusive language during cares. On 5/6/24 it was documented R18 continues to scream out at staff during cares. Swings out and hits at them, kicks, refuses cares, yells 'you're hurting me, ow that hurt!' Swears at staff and calls them names. Yells 'shut up' frequently when staff are providing cares. Behaviors do subside once cares are completed, after a bit. Is content when sitting in dining room or when lying in bed. Refuses care or yells during cares each time. R18's skilled nursing notes from 5/9/24 - 5/16/24 indicated R18 has continued to yell and strike out at staff during cares daily. On 5/14/24 it was documented under RN Behavior Note nursing continues to note (R18) has behaviors of screaming, yelling, use of abusive language and Hx (history) of being combative with ADLs and transfers. Primarily has almost daily behaviors of yelling and using abusive language with cares due to anxiety and fear. Explanation of task, calm approach, different staff, speaking in a calm voice is usually effective in allowing task to be fulfilled and behaviors do not continue once task is complete. On 5/18/24 it was documented R18 continues to yell and hit out with cares. On 5/23/24 it was documented in a Care Conference note R18 continues to have behaviors daily of yelling out, swearing and accusatory behaviors. At times does attempt to hit out at staff. Staff continues to try interventions, effectiveness varies. Resident is followed by Rural Psych Associates. On 5/24/24 it was documented R18 was yelling out and grabbing with am (morning) cares. On 5/28/24 it was documented yelling/screaming, grabbing, pinching/scratching/spitting, abusive language, threatening behaviors was documented by the nursing assistants. On 6/1/24 it was documented R18 fell out of the hoyer lift during transfer. (An additional fall from the hoyer lift was documented on 4/14/24.) On 6/4/24 it was documented R18 was seen by Rural Psych and Seroquel was increased to 50 mg twice a day. On 6/12/24 it was documented R18 was yelling at staff while cares are being completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245482	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Manor Care Center	220 Third Street Northwest Blooming Prairie, MN 55917

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/14/24 it was documented R18 continued to yell and is combative with cares. On 6/16/24 it was documented R18 was yelling and combative with am (morning) cares. On 6/29/24 it was documented R18 was yelling, pinching, and hitting the nursing assistants during cares. On 6/30/24 it was documented R18 was yelling during cares. On 7/1/24 it was documented R18 was yelling during care. R18'2 EMR had evidence of medication changes to attempt to help with behaviors but lacked a comprehensive reassessment of specific triggers and interventions that have been attempted and worked or attempted and not worked to control R18's anxiety surrounding personal cares due to a history of abuse, despite current interventions being ineffective. R18's Psychosocial History and Assessment, dated 9/1/22, indicated R18 had a history of abuse by her son and a family history of alcohol. The form indicated R18 did not have a history of mental health problems and lacked any initial observations of mood, personality, behavior, etc. R18's EMR indicated R18 was seen by Rural Psychiatry Associates three times on 5/2/24, 5/9/24 and 6/4/24. The notes indicated R18 continued to have aggressive behaviors but lacked any recommendations for staff on interactions with R18 or non-pharmacological interventions despite continued behaviors. R18's Rural Psych note, dated 5/2/24, indicated the chief complaint was aggressive behaviors and agitation during care. The note indicated R18 presented with behavioral issues during care activities, exhibiting aggressive behaviors, yelling, and screaming when touched or moved. The note indicated R18 had a history of trauma and abuse from her father and husband. R18's Rural Psych note, dated 5/9/24, indicated R18 had no changes in behavior. R18's Rural Psych note, dated 6/4/24, indicated R18's calling out seems to have improved minimally but she was more physically resistive. During observation on 7/1/24 at 9:03 a.m., R18 was sitting out at the breakfast table in the main dining area, resting calmly with her eyes closed. During an interview on 7/1/24 at 9:45 a.m., nursing assistant (NA)-D stated R18 had behaviors when being transferred or while staff were doing personal cares with her. NA-D stated she had been working with R18 since November 2023 and R18's aggressive behaviors seemed to be getting worse, stating R18 kicked, hit and punched at staff during cares and used foul language. During an interview on 7/2/24 at 10:43 a.m., NA-D stated she tried to treat all residents the same but she would be more understanding if she knew a resident had a history of abuse. NA-D she had heard that R18 may have had something in her past but nothing that she was certain of. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 7/1/24 at 10:10 a.m., NA-A, NA-B and NA-D were transferring R18 from her wheelchair to her hospital bed via hoyer lift. R18 was very agitated, yelling and screaming, I want to go home! Don't touch me! I don't like that guy! They broke my butt and it hurt! R18 was observed trying to reach out and grab staff. NA-A attempted to talk to R18 in a calm, reassuring voice which was ineffective in calming R18 down. No other non-pharmacological interventions were observed during cares. R18 was provided incontinent care and transferred back to her wheelchair via hoyer lift. NA-A stated they documented R18's behaviors in Tasks but it was limited to check boxes therefore limiting what they could document. During an interview on 7/1/24 at 1:05 p.m., licensed practical nurse (LPN)-B stated R18's behaviors mostly centered around cares. LPN-B stated documentation for mood and behavior was on R18's MAR but non-pharmacological interventions were not, stating usually for residents with behavior who were taking antipsychotic medications, non-pharmacological interventions would be on the MAR to allow staff to note which interventions were used and effective. LPN-B stated nothing really works for R18's behaviors, stating when she was first admitted to the facility, R18 talked more and LPN-B was aware of a history of some sort of abuse but she was unaware of specifics because nothing was care planned regarding the specifics of R18's history of abuse. During an interview on 7/1/24 at 1:12 p.m., social services director (SSD) stated she assisted with assessing care planning a residents' potential history of abuse or trauma. The SSD stated when R18 was first admitted she was more cognitively intact and reported physical abuse by her father and husband and the SSD believed there was some financial abuse by her son. The SSD stated they did not have a formal reassessment process to track what interventions effective or did not, stating interventions will work for one resident and not another. The SSD confirmed interventions had not been updated since R18's admission on how to help control R18's aggressive behaviors, stating she used to like to talk about the farm she grew up on and horses but she had declined cognitively to the point so no longer remembered and was living in the past where her abuse was current to her. The SSD further stated the intervention to provide R18 with her [NAME] doll was no longer working. The SSD stated they have been trying to find triggers but her aggression seems to be just during cares. During an interview on 7/2/24 at 10:16 a.m., the director of nursing (DON) stated social services was responsible for the initial psychosocial assessment and that quarterly the nurses would complete a Behavior Note in progress notes that assessed dose reduction of medications, oral intake, and cognitive status. (The assessment lacked a look at specific interventions and triggers for behaviors.) The DON stated she was aware of R18's aggressive behaviors as her office was across the hall from R18's room and she could hear her yelling with cares daily. The DON confirmed R18 lacked a comprehensive assessment and reassessment of her history of abuse and trauma and a reassessment of interventions despite care planned interventions being ineffective. A facility policy titled Behavioral Health Services Policy, dated 8/31/17, indicated behavioral health encompasses a resident's whole emotional and mental well-being: and it was the policy of the facility to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being and to ensure that a resident whose assessment did not reveal a mental/psychological disorder did not display decreased social interaction or increased withdrawn, angry or depressive behaviors unless the resident's clinical conditions demonstrated that this was unavoidable.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44656 Based on observation and interview the facility failed to ensure a container of oranges was stored off the floor to protect from contamination. This had the potential to affect all residents who consumed food served from the main kitchen. Findings include: During the initial kitchen tour of facility with cook (C-A) on 6/30/24 at 10:16 .m., a cardboard box of oranges was observed on the floor of the walk-in refrigerator next to wire racking containing refrigerated food. C-A stated, no it should not be on the floor. During interview with dietary director (DD) on 6/30/24 at 1:55 p.m., DD stated, the oranges should not have been on the floor of the fridge. We got a shipment on Friday [6/28/24] and . they should have been put up on a shelf in the fridge. During interview with C-C on 7/2/24 at 8:48 a.m., C-C stated, oranges should not be on the floor [sic] cause that is contamination [sic] and should be 6 inches off the floor. We go through a lot of oranges here too. That is not ok. Undated facility policy titled Perishable Food Storage Areas state, 1. All items must be stored at least 6 inches off the floor.