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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4NUZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00113

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245435**

2.STATE VENDOR OR MEDICAID NO.
(L2) **178540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **KNUTE NELSON**
(L4) **420 12TH AVENUE EAST**
(L5) **ALEXANDRIA, MN** (L6) **56308**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/04/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **124** (L18)

13.Total Certified Beds **124** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	124			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 03/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 03/20/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
__X__ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/13/2013
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed on January 17, 2013, the facility was not in substantial compliance and the most serious deficiencies were a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On March 4, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction, and on February 22, 2013 the Minnesota Department of Public Safety completed a PCR and determined that the facility had achieved substantial compliance pursuant to the standard survey completed on January 17, 2013, effective February 21, 2013. Therefore, the remedies outlined in our letter dated February 6, 2013 will not be imposed.

See attached CMS-2567B for the results of the March 4, 2013 and February 22, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5435

March 20, 2013

Ms. Angela Urman, Administrator
Knute Nelson
420 12th Avenue East
Alexandria, Minnesota 56308

Dear Ms. Urman:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 21, 2013 the above facility is recommended for:

124 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 124 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Nicole Steege

Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 20, 2013

Ms. Angela Urman, Administrator
Knute Nelson
420 12th Avenue East
Alexandria, Minnesota 56308

RE: Project Number S5435023

Dear Ms. Urman:

On February 6, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 17, 2013. This survey found the most serious deficiencies 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) whereby corrections were required.

On March 4, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction, and on February 22, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 17, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 21, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 17, 2013, effective February 21, 2013 and therefore remedies outlined in our letter to you dated February 6, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Gail Anderson

Gail Anderson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 332-5140 Fax: (218) 332-5196

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245435	A. Building B. Wing	3/4/2013

Name of Facility	Street Address, City, State, Zip Code
KNUTE NELSON	420 12TH AVENUE EAST ALEXANDRIA, MN 56308

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **02/21/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **02/21/2013**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **02/21/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **02/21/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **02/21/2013**	ID Prefix **F0373** Reg. # **483.35(h)** LSC	Correction Completed **02/21/2013**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **02/21/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/NCS	3/20/13	28034	3/4/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/17/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245435	A. Building B. Wing 01 - MAIN BUILDING 01	2/22/2013

Name of Facility	Street Address, City, State, Zip Code
KNUTE NELSON	420 12TH AVENUE EAST ALEXANDRIA, MN 56308

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0017	02/08/2013	ID Prefix Reg. # NFPA 101 LSC K0029	02/08/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/NCS	Date: 3/20/13	Signature of Surveyor: 27200	Date: 2/22/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/16/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4NUZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00113

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245435**
2.STATE VENDOR OR MEDICAID NO.
(L2) **178540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **KNUTE NELSON**
(L4) **420 12TH AVENUE EAST**
(L5) **ALEXANDRIA, MN** (L6) **56308**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/17/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **124** (L18)

13.Total Certified Beds **124** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	124			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE-NEII 02/19/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 03/08/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987 (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

At the time of the standard survey completed on January 17, 2013, the facility was not in substantial compliance and the most serious deficiencies were a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed.

See attached CMS-2567 for survey results. Post Certification Revisit after February 21, 2013.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9233

February 6, 2013

Ms. Angela Urman, Administrator
Knute Nelson
420 12th Avenue East
Alexandria, Minnesota 56308

RE: Project Number S5435023

Dear Ms. Urman:

On January 17, 2013, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gail Anderson
Minnesota Department of Health
1505 Pebble Lake Road, Suite #300
Fergus Falls, Minnesota 56537

Telephone: (218) 332-5140

Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 26, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by April 17., 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 July 17, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

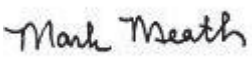
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Mark Meath, Program Specialist], Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5435s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	01/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNUTE NELSON	420 12TH AVENUE EAST ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	POC approved 2/15/2013 GA	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to respond to a resident's request in a dignified manner for 1 of 1 resident (R94) with a personal meal request. Findings include: During observations on 1/14/13, at 6:11 p.m., R94 was seated in the Sunset dining room for the evening meal. R94 had a plate in front of him with a tuna melt on a bun, scalloped corn and coleslaw. R94 stated to licensed practical nurse (LPN)-A the tuna melt was too sticky and difficult to cut with a knife. LPN-A responded to R94,	F 241	a. For resident R 94 facility will provide an environment that maintains or enhances each residents dignity. Resident personal meal requests will be responded to in a dignified manner. b. All residents in the facility have the potential to be affected by this practice. c. If the resident does not like the featured meal, or is unable to eat texture of meal, they are given the opportunity to order from the alternate menu. Staff will attend training on menu selection so that if a resident does not like the meal served or is unable to eat texture of meal served, they are offered the alternate menu to choose from. The training will also include promoting dignity and respect by honoring resident personal meal choices. d. Random Quality Assurance audits will be conducted by Director of Nursing/ designee interviewing residents whether they are given the opportunity to make personal meal choices. e. Completion date 2/21/2013	2/21/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	President and Chief Executive Officer	2/14/2013

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.

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	245435	A. BUILDING _____ B. WING _____	01/17/2013

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F 241	Continued From page 1	F 241		

"well, then just don't eat it." LPN-A abruptly reached over, removed the top of bun and placed it on the table next to R94 plate. LPN-A stated snacks were available on the station, before bedtime, however did not offer alternate food items and did not offer assistance to cut tuna melt for R94. R94 stated, "I can't eat this, it's too sticky" and stabbed the bottom part of the bun with a fork. R94 also stated "And this coleslaw, I can't eat this either because of my teeth. I could only eat the corn." LPN-A reminded R94 that snacks were available and stated R94 can have a snack tonight. R94 indicated he had not eaten most of his meal and stated "A snack can't do it. I'm hungry." LPN-A indicated there were no other food items from R94 to choose from and offered ice-cream. Resident refused the ice-cream and stated, "It's just all sugar. I don't want that." LPN-A again offered R94 snacks, including pudding, yogurt, ice-cream and snacks that were available at R94's nurse's station after the meal. Without asking R94's preference, LPN-A placed a cup of chocolate pudding in front of the resident. While eating a few bites of the pudding, R94 was observed to grimace. No other food items were offered R94 during the supper meal.

During interview with the dietary manager(DM) on 1/14/2013, at 6:37 p.m., she stated a main entree and an alternate food item was available to residents at all supper meals. She stated the facility also offered a "Dining Room Table Menu" which had an additional twelve various food choices, which included an egg salad sandwich, grilled cheese sandwich and two varieties of soup. The DM stated residents could choose any of the items during the supper meal. The DM stated she would expect staff to offer alternate

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F 241	Continued From page 2 food items to any resident who did not want to eat the main entree offered at the meal. The DM stated "We want to accommodate them." During interview on 1/14/2013, at 7:33 p.m., LPN-A confirmed she had not offered alternative food choices to R94 when he voiced dissatisfaction with the meal. She indicated there were no other alternatives available because the kitchen was closed "at 6:15 p.m." LPN-A stated snacks were available on the stations after meals and offered to residents if the resident does not like a food item they originally ordered. During interview with DM on 1/17/2013, at 9:28 a.m., DM stated R94 rarely complained about the food and usually eats almost everything at all meals. The DM confirmed R94 should have been offered any one of the numerous additional food items at the supper meal. The DM stated, "He could've had whatever he wanted. There's always alternatives. We want to accommodate them."	F 241		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315	a. For resident R 173 facility has completed an assessment and determined a medical justification for ongoing use of indwelling catheter. b. All residents that are admitted to facility with indwelling catheter and those who have an indwelling catheter placed have the potential to be affected by these practices. (F 315 continued on Page 4)	

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F 315	Continued From page 3 by: Based on observation, interview, and document review, the facility failed to comprehensively assess and determine medical justification for ongoing use of an indwelling catheter for 1 of 2 residents (R173) in the sample reviewed for use of indwelling catheters. Findings include: R173 was admitted 12/26/12 with diagnoses that included cerebrovascular accident, hypertension and chronic kidney disease. The admission Minimum Data Set (MDS) dated 1/5/13, indicated R173 was cognitively impaired, needed extensive assistance with toileting and had a indwelling catheter. R173's plan of care indicated she had a catheter and was continent of bladder. Review of the facility policy titled Urinary Catheter Protocol and Guidelines, revised 11/06/11, identified evidence was needed to support the ongoing use of an indwelling catheter. Further, the policy listed appropriate indication for continuing use of an indwelling catheter which included " medical justification such as terminal illness, severe impairment or diagnosis which makes positoning or clothing changes difficult, uncomfortable for the resident or which is associated with pain. " On 1/16/13, at 8:39 a.m. R173 was observed to be in bed with an indwelling catheter bag attached to the bottom of her bed. R173's discharge summary from the hospital dated 12/26/12, indicated discharge instructions for " Foley catheter care change every two weeks ." R173 ' s physician progress note dated 12/28/12, indicated that while in the hospital, prior to nursing home admission, an indwelling Foley catheter was placed.	F 315	(F 315 continued from Page 3) c. All residents with indwelling catheter will have an assessment completed and will have a medical justification for ongoing use of an indwelling catheter. Licensed Nursing staff will receive training on the need to complete an assessment and determine a medical justification for ongoing use of indwelling catheter. d. Random Quality Assurance audits will be completed by Director of Nursing/ designee of residents with indwelling catheters to determine that an assessment and a medical justification has been determined. e. Completion date 2/21/2013	2/21/2013

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F 315	Continued From page 4 Review of bladder assessment, dated 12/31/12, identified R173 had diagnoses of CVA (stroke), diabetes, and was dependent on staff for transferring. The bladder assessment identified R173 had indwelling catheter in place, directed staff to empty bag and provide cath cares every shift, and R173 to assist with repositioning and transferring. The assessment form listed conditions for the use of an indwelling catheter as follow: terminal illness or severe impairment and movement caused, Stage 2, Stage 3, Stage 4 pressure ulcers in an area affected by incontinence that prevents ulcer healing, urinary retention with appropriate diagnosis and need for exact measurement of urine output. Further, the form identified if none the conditions present, initiate a voiding trial. The form identified R173 had an indwelling catheter, however, lacked documentation of an evaluation of health status for justification for the use of the catheter. On 1/16/13, at 12:16 p.m., registered nurse (RN) -A confirmed R173 had an indwelling catheter in place. She stated R173 had improved in the recent past and she thought R173 had a catheter because of her stroke and decreased mobility. On 1/17/13 at 2:30 p.m., the director of nursing (DON) stated she thought the reason R173 had a catheter was because of a neurogenic bladder, but after review of the medical record, she could not find medical justification for the catheter.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further	F 318	a. For resident R 111 facility will provide range of motion services to prevent further decrease in range of motion of upper extremities. Staff has been educated to follow resident care plan in reference to range of motion services. (F 318 continued on Page 6)	

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F 318	Continued From page 5 decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide range of motion services to prevent further decrease in range of motion for 1 of 3 residents (R111) in the sample who had limitations in range of motion. Findings include: R111 had diagnoses which included late effects of cerebrovascular disease, hemiplegia, spasm of muscle, and osteoarthritis. The quarterly Minimum Data Set (MDS), dated 10/2/12, identified R 111 had no cognitive impairment. The MDS identified R111 had functional limitation in range of motion (ROM) one sided, on both upper and lower extremity. The Care Area Assessment (CAA), dated 7/24/12, identified R111 required assistance with acitviites of daily living and mobility. The CAA further identified R111 refused ambulation, however lacked documentation of the limited range of motion in upper and lower extremity and lacked documentation of interventions to maintain or prevent decrease in the limited range of motion. R111's care plan revised 3/11/13, identified R111 had hemiplegia with interventions which included range of motion (active or passive) with morning and evening care daily. During observation on 1/14/13, at 7:04 p.m. R111 used her right hand to pull the fingers of the left	F 318	(F318 continued from Page 5) b. All residents in the facility with limited range of motion have the potential to be affected by this practice. c. All residents who are assessed to receive range of motion exercises will receive their exercises. Nursing staff will identify this need on CAA and care plan. Nursing staff will be in-serviced on following residents care plan regarding range of motion exercises and the need to document these exercises when completed. d. Random Quality Assurance audits will be completed by Director of Nursing / designee to determine that nursing staff is completing range of motion exercises by resident's plan of care. e. Completion date 2/21/2013	2/21/2013

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hand away from the palm, partially extending the fingers. R111's left hand had no independent function.

During observation on 1/16/13, from 7:15 a.m. to 7:42 a.m., R111 maneuvered her electric wheel chair into the unit television area, sat at the table to drink coffee and read the newspaper. R111 used her right hand to operate the electric wheel chair joy stick, pick up her coffee mug and to handle the news paper. R111 did not use her left hand during the observation. The left hand lay in R11's lap with the fingers and thumb curled into the palm of her left hand.

During observation on 1/17/12, at 9:53 a.m. R11 lay in a recliner in her room with left hand propped on a pillow that rested on the recliner arm rest. The fingers and thumb of the left hand were curled into the palm of the left hand forming a fist.

During observation on 1/17/13, at 2:20 p.m. R11 participated in a wellness program using right arm only for arm exercises while riding a stationary exercise bike.

During interview on 1/14/13, at 7:04 p.m., R111 indicated she ambulated in the hall, utilized the stationary bike and stated that she did not receive ROM services to her left arm and hand since therapy had been discontinued in the past.

On 1/17/13, at 9:24 a.m., nursing assistant (NA) -F confirmed that she routinely assisted R111 with a.m. cares and had assisted her this a.m. NA-F stated ROM to left arm and hand were not part of R111's daily routine and she had not

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F 318	Continued From page 7 assisted R111 with range of motion during or after cares. NA-F stated ROM exercises would be done by the restorative NA (restorative/wellness coordinator), and further explained that the nursing assistants do not do anything more than dressing. During interview on 1/17/13, at 9:46 a.m., restorative/wellness coordinator confirmed R111 did not receive ROM services to her the left arm and hand. During interview on 1/17/13 at 11:12 p.m., the assistant director of nursing (ADON) confirmed R111 was not on an exercise/restorative program for range of motion for the left arm and hand. During interview on 1/17/13, at 2:22 p.m., RN- B confirmed R111's current care plan and need for ROM services. RN-B stated that ROM meant structured repetitions of exercises were to be done, and assisting with moving a limb was not part of ROM exercises. During interview on 1/17/12, at 3:31 p.m., the director of nursing (DON) confirmed R111's care plan and stated she would expect ROM to be done consistently as directed by the resident care plan. The facility policy titled Range of Motion, revised 4/2012, read the purpose of this procedure is to exercise the resident's joints and muscles. The policy identified structured range of motion exercises would include moving each joint through range of motion three times, providing support to the joint as it is exercised and to move the joint smoothly and slowly.	F 318		

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively asses and implement adequate interventions to ensure resident safety for 1 of 1 resident (R11) reviewed for elopement. Findings include: R11 had diagnoses that included dementia, delirium with delusions and a history of falls. R11's significant change minimum data set (MDS), dated 11/21/2012, identified severe cognitive impairment. The MDS further identified R11 required extensive assistance for dressing, personal hygiene, transfer and was wheelchair dependant for mobility. Review of the Progress notes revealed as follows: 12/29/12 increase in confusion noted, residents statements made of need to go to another town, with resident unable to be redirected; 12/30/12 statements of need to take sons bones to the the doctor; 12/30/12 wandering hallways and asking about taxi that is needed to leave and go home; 1/13/13 resident attempted to	F 323	a. For resident R 11 facility has put interventions into place to minimize the risk of wandering off of the neighborhood. Resident has been moved to a neighborhood with door alarms in place and resident has a wander guard bracelet placed on her wheelchair. Care plan and kardex have been updated to reflect these changes. b. All residents have the potential to be affected by this due to potential for accident hazards. c. Licensed staff will be in-serviced on all residents who are at risk for elopement will have a current elopement assessment completed. All staff will attend in-service on accident hazards and the requirement to keep our environment and residents safe. This will include making sure residents have adequate supervision and have measures in place to prevent elopements. d. Random Quality Assurance audits will be completed by Director of Nursing / designee to ensure that nursing staff has put new interventions in place with each incident that occurs. e. Completion date 2/21/2013	2/21/2013

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get out of the exit door, activated the handicapped door button, staff eventually able to redirect. 1/14/13 resident attempted to get out of building.

Progress notes titled Weekly Behavior Review from 12/29/12 to 1/5/13 identified behaviors as follows: On 12/29/12 wandering, very confused; waiting in front of door waiting for her husband. Resident making statements of staying at a motel today but wants a taxi to pick her up. On 1/5/13 resident confused, wandering up and down hallways with her purse, wandering in and out of her room, kept saying she was going home. On 1/11/13, wandering in the halls in wheel chair, keeps thinking she is going home, trying to open doors to the outside.

During observation on 1/17/13, at 2:53 p.m., R11 was seated in her wheelchair in an area of the facility that had 2 outside exit doors. R11 was approximatley 3 feet from one exit door with no other residents or staff in the area. At 3:05 p.m. the environmental director passed through the area once, stopped to assist R11 by pushing her in the wheel chair to her room.

R11's care plan revised on 4/8/2012, did not identify the problem of wandering or potential elopement and lacked direction for staff to ensure R11's safety.

During interview on 1/16/13, at 2:34p.m., nursing assistant (NA)- E confirmed R11's care plan and stated she was not aware of R11's behaviors of wandering or attempts to leave the building.

During interview on 1/17/13, at 3:10 p.m.,

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F 323	Continued From page 10 registered nurse (RN)-B confirmed R11's current care plan did not address elopement interventions. RN-B stated she was unaware of R11's attempts to leave the building. RN-B confirmed that the facility protocol for elopement risk would be reassessed quarterly, with significant change, and with resident attempts to leave the building. RN-B stated if a resident attempted to go out of the facility an assesment would be done to see if the resident met the criteria to be moved to a secure or locked unit in the facility. RN-B verified R11 did not have an elopement risk assesment at the time of significant change or after attempts to elope, and had not been assessed for a move to a secured unit. RN-B confirmed R11 should have been reassessed and interventions implemented to ensure her safety. On 1/17/13, at 3:13 p.m. RN-A confirmed that R11 had a recent decline in health status, with a significant change MDS completed 11/ 21/12. RN-A confirmed no further elopement risk assessment had been done since the admission assesment on 9/25/12. During interview on 1/17/13, at 3:30 p.m., the director of nursing (DON) confirmed R11's current plan of care, elopement risk assesment completed 9/25/12, and the current facility policy for elopement. She stated she did not consider R11 an elopement risk as she had not gotten out of the facility to the parking lot. During interview on 1/17/13, at 4:00 p.m., the maintenance staff (M)-A confirmed the facility did not have alarms on all exit doors in the facility, only in the secured unit.	F 323		

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F 323	Continued From page 11 The facility elopement policy, revised 10/2012, read Definitions: "elopement" refers to the ability if a resident-who is not capable of protecting himself from harm-to successfully leave Knute Nelson unsupervised and unnoticed and enter into harm's way.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329	a. For residents R 2, R 157, R 51 and R 72 facility will adequately indentify individualized target behaviors and monitor the effectiveness of the antipsychotic medications. Facility has implemented new target behavior sheets that have individualized target behaviors listed for each antipsychotic medication that resident is receiving; including individualized non-pharmacological interventions to use. b. All residents who receive antipsychotic medications have the potential to be affected by this practice. c. Licensed nursing staff will be in-serviced on the need for all residents who require target behavior monitoring will have their individualized target behaviors listed on target behavior sheets. These target behavior sheets also include non-pharmacological interventions to use, and space to address the effectiveness of the antipsychotic medication. (F 329 continued on Page 13)	

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F 329	Continued From page 12 Based on interview and record review the facility failed to adequately identify individualized target behaviors and monitor clinical indications to evaluate the effectiveness for the continued use of antipsychotic medication for 5 of 11 residents (R2, R157, R51, R72) in the sample who received psychotropic medications. Findings include: R2 had received Seroquel (antipsychotic medication) 25 milligrams (mg.) daily since 9/10/12 and lacked specific target behaviors and monitoring to ensure R2 was benefiting from the medication. R2 had diagnoses that included hallucinations, delusions and psychosis. The admission Minimum Data Set (MDS), dated 6/8/12, identified R2 had severe cognitive impairment, hallucinations and delusions with no overall presence of behavioral symptoms. The care plan dated 9/12/12 indicated mood/behavior related to hallucinations, both visual and auditory and also paranoia. The care plan directed staff not to argue with the resident and remove from public area when behavior is disruptive/unacceptable. Review of the behavior record charting from 8/12 to 1/16/13 revealed R2 had various behaviors documented by nursing assistants of yelling, screaming, refusal of cares. The behavior documentation collected data, however, lacked clinical indications to evaluate the effectiveness for the continued use of the Seroquel.	F 329	(F329 continued from Page 12) d. Random Quality Assurance audits will be completed by Director of Nursing/ designee to assure that target behaviors are being monitored for each resident who receives antipsychotic medication. e. Completion date 2/21/2013	2/21/2013

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F 329	Continued From page 13 The physician's orders dated 1/13 indicated Seroquel 25 mg. every evening for hallucinations and delusions. During interview on 1/17/12 at 11:15 a.m. nursing assistant (NA)-D stated she was unaware of target behaviors for R2 and non pharmacological interventions to utilize when the behaviors occurred. On 1/17/12 at 11:00 a.m. registered nurse (RN)-A stated the nursing assistants charted on the behavior sheet using a generic numbered list of behaviors, noted on each resident's behavior charting. The nurses would write a line or more on the opposite side of the form. RN-A stated behavior charting could also be found in the weekly nursing progress notes. RN-A was unable to identify what behavior was specifically monitored for administering daily Seroquel. RN-A verified there was no individualized target behavior for Seroquel. On 1/17/13 at 4:50 p.m. the pharmacy consultant verified the documentation on the facility's behavior form lacked an actual, individual target behavior for Seroquel. R157 received Zyprexa (a psychotropic medication) 2.5 milligrams (mg.) daily and lacked specific target behaviors and monitoring to ensure R57 was benefiting from the medication. R157 had diagnoses which included unspecified	F 329		

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psychosis. The admission MDS, dated 12/26/12, indicated severely impaired cognition, hallucinations and delusions with no overall presence of behavioral symptoms.

The Care Area assessment (CAA), dated 12/28/12, triggered psychotropic drug (zyprexa) use to be further analyzed for effectiveness. Also the CAA triggered for analysis for three anti anxiety medications R157 received. On 1/17/12 at 11:00 a.m. RN-A was unable to identify which behavior/behaviors were specifically documented to evaluate Zyprexa.

The care plan dated 6/2/11 indicated mood/behavior related to hallucinations, both visual and auditory and also paranoia. Interventions included behavior monitoring, however, the antipsychotic medication lacked individualized, specific interventions for zyprexa. Interventions were only related to side effects of the medication. The care plan did reference monitoring behavior on the behavior record.

Review of the behavior record charting revealed no individualized documentation related to R157 and the daily use of Zyprexa.The behavior documentation collected data, however, lacked clinical indications to evaluate the effectiveness for the continued use of zyprexa.
R157 was also receiving three daily medications for anxiety.

On 1/17/12 at 11:00 a.m. RN-A was unable to identify which behavior/behaviors were specifically documented to evaluate Zyprexa.

The physician's orders dated 1/13 indicated

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F 329	Continued From page 15 Zyprexa 2.5 mg. every evening for unspecified psychosis. During interview on 1/17/12 at 11:15 a.m. nursing assistant (NA)-D was unable to determine a specific target behavior listed on the behavior form for R157's use of Zyprexa. On 1/17/12 at 11:00 a.m. registered nurse (RN)-A stated the nursing assistants charted on the behavior sheet using a generic numbered list of behaviors, noted on each resident's behavior charting. The nurses would write a line or more on the opposite side of the form. RN-A stated behavior charting could also be found in the weekly nursing progress notes. RN-A was unable to identify what behavior was specifically monitored for administering daily Zyprexa. RN-A verified there was no individualized target behavior for Zyprexa. On 1/17/13 at 4:50 p.m. the pharmacy consultant verified the documentation on the facility's behavior form lacked an actual, individual target behavior for Zyprexa.	F 329		

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F 329	Continued From page 16 R51 received olanzapine, (antipsychotic medication) 5 milligrams every day since 4/23/12, for a diagnosis of psychosis. There were no individualized target behaviors identified, nor individualized non-pharmacological interventions identified for staff to monitor for the effectiveness or for continued use of the antipsychotic medication. R51 had diagnoses which included psychosis, senile dementia with depressive features, and neuro-psychiatric symptoms of aggressive behavior following a brain injury. The quarterly MDS, dated 11/14/12, identified R51 had delusions (misconceptions that were contrary to reality) and exhibited physical and verbal behaviors directed toward others. R51's Care Area Assessment (CAA), dated 8/24/12, identified R51 had a diagnosis of psychosis with paranoia, resisted care, and was verbally and physically combative with staff. The MDS further identified that the brief interview for mental status was not completed due to severe cognitive impairment. Review of R51's medication administration records from 11/1/12 to 1/17/13 revealed that R51 received a daily dose of the antipsychotic medication olanzapine, (Zyprexa) 5 milligrams. Review of the care plan, dated 11/21/12, identified R51 had hallucinations and paranoia, however lacked individualized non-pharmacological interventions for staff to utilize in an attempt to minimize or eliminate the behavior. Review of the current nursing assistant care plan for R51 directed staff to remove sharp objects	F 329		

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F 329	Continued From page 17 from the room as R51 had previous suicide attempts and to remove R51 from crowded areas when anxious, however, lacked identification of individualized target behaviors or individualized non-pharmacological interventions for staff to use, in an attempt to minimize or eliminate the behavior. Review of the daily facility behavior logs for R51 from 8/1/12 to 1/11/13, revealed the facility utilized a printed form with a general list of possible behaviors and possible non-pharmacological interventions from which to choose. However, this list did not identify individualized behaviors or individualized non-pharmacological interventions for R51, related to the ongoing use of antipsychotic medications. On 1/17/13, at 9:14 a.m., nursing assistant (NA) -C stated she was unaware of any individualized target behaviors identified for R51. On 1/17/13, at 10:38 a.m., NA-B stated that resident behavior was charted using the general list on the behavior log forms, however, NA-B was unaware of any individualized target behaviors identified for R51. On 1/17/13, at 10:55 a.m., NA-A stated she was unaware of any individualized target behaviors identified for R51. On 1/17/13 at 4:35 p.m., clinical manager (CM)-A stated that the nursing assistants utilized the nursing assistant care plans and facility behavior logs for the documenting of resident behaviors, and the nurses summarize the logs to perform	F 329		

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F 329	Continued From page 18 weekly resident behavior charting. CM-A confirmed R51's current nursing and nursing assistant care plans did not identify individualized behaviors nor individualized interventions for R51's behaviors. R72 received Risperdal, (an antipsychotic medication) 1 milligram daily, since 8/29/10, for psychosis with uncontrolled verbal and physical outbreaks potentially harmful to self or others, and wandering behavior. There were no individualized behaviors identified nor individualized non-pharmacological interventions identified for staff to monitor for the effectiveness or continued use of antipsychotic medication. Review of R72's medication administration records from 11/1/12 to 1/17/13 revealed that R72 had received a daily dose of Risperdal 1 milligram. R72 had diagnoses which included psychosis, dementia, and anxiety. The quarterly MDS, dated 11/21/12, identified R72 wandered, and exhibited physical and verbal behaviors directed toward others. The MDS further identified the brief interview for mental status was not completed due to severe cognitive impairment. R72's CAA dated 3/12/12, identified R72 received Risperdal, had delusions, wandered, rejected care and would hit. The CAA identified interventions to be implemented that included to reapproach if R72 refused care or hit, redirect, and directed staff to use a calm tone of voice and approach at eye level while speaking slowly.	F 329		

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F 329	Continued From page 19 Review of R72's care plan updated 11/29/12, identified that R72 wandered and had behaviors of physical and verbal abuse directed at staff and anger with self or others. The care plan lacked identification of the problem of delusions for R72. The care plan listed various interventions for behavior that included, food, rest, and a stuffed animal. Review of the facility behavior logs for R72 from 8/1/12 to 1/16/13 revealed the facility utlized a printed form with a general list of possible behaviors and a list of possible non-pharmacological interventions from which to choose. However, the form did not identify individualized behaviors or individualized nonpharmacological interventions for R72, related to the ongoing use of antipsychotic medications. On 1/17/13 at 9:14 a.m., NA-C stated she was unaware of any individualized target behaviors identified for R72. On 1/17/13 at 10:38 a.m., NA-B stated that resident behavior was charted using the general list on the behavior log forms, however, NA-B was unaware of any individualized target behaviors identified for R72. On 1/17/13 at 10:55 a.m., NA-A stated she was unaware of any individualized target behaviors identified for R72. On 1/17/13 at 4:35 p.m., clinical manager (CM)-A stated that the nursing assistants use the nursing assistant care plans and facility behavior logs for the monitoring of resident behaviors, and the	F 329		

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F 329	Continued From page 20 nurses then use the logs to perform weekly resident behavior charting. CM-A confirmed R72's current nursing and nursing assistant care plans for R72. She confirmed the behavior monitoring logs were not individulaized for for each resident's individualized target behaviors and non pharmacological interventions. Review of the facility policy titled Psychotropic Medication: Effectiveness Monitoring-Informed Choice/Consent, revised August 2012, directed that all psychotropic medications and effectiveness of the medication would be monitored, assessed and documented with individualized care plan approaches, including drug and non-drug approaches. The policy directed that individualized behaviors would be identified to monitor for the continued use of antipsychotic medications. During interview on 1/17/13, at 4:48 p.m., the facility consultant pharmacist (CP)-F stated that it would be expected that the facility would identify individualized target behaviors for each resident. The CP-F stated recommendations for behavior documentation had been discussed with the facility in the past. He indicated the facility needed to identify individulaized target behaviors and individualized nonpharmacological interventions to use for each resident.	F 329		
F 373 SS=E	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding	F 373	a. For residents R 72, R122 and R51 facility has re-assessed these residents by RN managers to determine if resident has a swallowing difficulty. R 57 has expired. (F 373 continued on Page 22)	

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F 373	Continued From page 21 residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control.	F 373	(F373 continued from Page 21) b. All residents who require assistance with feeding have the potential to be affected by this practice. c. Licensed staff will be educated on new assessment to be completed by the RN on each resident who requires assistance with feeding for any swallowing issues. After assessment completed residents who have no swallowing difficulties will be able to be assisted by feeding assistant. These assessments will be completed quarterly. Facility is planning on having all feeding assistants become Certified Nursing Assistants. d. Random Quality Assurance audits will be completed by Director of Nursing/ designee monitoring residents who receive assistance from feeding assistants for swallowing difficulties. e. Completion date 2/21/2013	2/21/2013

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F 373	Continued From page 22 Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to follow its own policy and ensure that 4 of 4 residents (R72, R122, R57 and R51)) in the sample identified with swallowing problems received safe and appropriate assistance with eating. Findings include: R72 had been identified with chewing and swallowing problems. However, the facility failed to follow their own policy and identified a paid feeding assistant (PFA) was safe to assist R72 with eating. R72 had a diagnosis of dysphagia. R72 ' s quarterly Minimum Data Set (MDS) dated 11/23/12 indicated she was cognitively impaired, required extensive assistance with eating. The MDS also identified R72 held food or residuals in	F 373		

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her mouth after meals and that she was on a mechanically altered and therapeutic diet. The current plan of care dated 11/20/12 indicated R72 required extensive assistance of one at meals and received a pureed diet. The current physician orders, dated 12/10/12, identified R72 received a pureed diet.

A speech therapy (ST) evaluation completed on 7/18/11 indicated R72 had a diagnosis of dysphagia. The referral also indicated she was seen for a diet downgrade. The evaluation also indicated that " patient presents with increased strength in swallowing influencing ability to consume a thin liquid diet as per prior level of function. Patient's diet textures to remain as pureed " . The evaluation further indicated that the staff and daughter had been educated on the diet changes and safety precautions to use with the patient.

R122 had been identified with chewing and swallowing problems. However, the facility failed to follow their own policy and identified a PFA was appropriate to assist R122 with eating.

R122 had a diagnosis of dysphagia. The annual MDS dated 11/07/12 indicated R122 was cognitively impaired, needed extensive assist of one to be fed and received a mechanically altered and therapeutic diet. The (MDS) further identified R122 required assistance from staff with feeding and received a mechanical soft/ground meat diet. The current physician orders dated 11/27/12 indicated R122 was to receive a mechanical soft diet with ground meat.

On 1/16/13 at 12:34 p.m., the life enhancement

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F 373	Continued From page 24 assistant (LEA) was observed in the Evergreens dining room feeding R122. R122 exhibited no swallowing or eating difficulties. A (ST) assessment was completed on 4/23/12 which indicated R122 had a diagnosis of dysphagia. The assessment further indicated R122 had modified independence with lingual function, delayed swallowing and mild pocketing of food and she was to be seen for treatment of swallowing dysfunction and oral function for feeding. The assessment recommended mechanical soft/ground meats and continue thin liquids. R57had been identified with chewing and swallowing problems. However, the facility failed to follow their own policy and identifed a PFA was safe to assist R57 with eating. R57 had a diagnosis of dysphagia, oropharyngeal phase. The annual MDS dated 12/27/12 indicated R57 was cognitively impaired and needed extensive assist of one with feeding. The MDS also indicated R57 required a mechanically altered diet. The current plan of care dated 1/1/13 indicated R57 received a regular, pureed diet, nectar thick liquids and no dairy. The physician orders dated 11/20/12 indicated, R57 received a pureed diet and nectar thick liquids. R57 was seen by (ST) on 12/01/11 and identified she had a diagnosis of dysphagia, oropharyngeal. The assessment also indicated " swallow initiation is delayed and effortful at times. Swallow appeared poorly coordinated. Residue noted throughout oral cavity with soft-solid	F 373		

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F 373	Continued From page 25 textures. .. " . The assessment also identified she is coughing/choking with mechanical soft diet and thin liquids. The (ST) discharge summary dated 12/12/11 indicated she is at risk for aspiration due to impairment in swallowing function and is to receive pureed textures and nectar-thick liquids. R51 had been identified with chewing and swallowing problems. However, the facility failed to follow their own policy and identified a PFA was safe to assist R51 with eating. R51 had diagnosis of esophageal reflux. The quarterly (MDS) dated 11/19/12 identified she was cognitively impaired, needed extensive assist of one with eating and received a therapeutic diet. The current plan of care dated 11/22/12 indicated R51 diagnosis of dysphasia and has a history of chewing difficulty. The current physician orders dated 12/12/12 indicated she received a two gram sodium diet. Although the facility identified R51 had a history of swallowing difficulty the facility failed to comprehensively assess her to be fed by a (PFA). Review of the facility policy Paid Feeding Assistance reviewed 6/12, indicated "paid feeding assistance will not feed residents with complex feeding problems or other residents precluded by the RN, RD, or Speech Language Pathologist. The policy also indicated residents will be assessed on admission and as necessary thereafter to determine the type of assistance needed. Any problems identified should be noted	F 373		

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	245435	A. BUILDING _____ B. WING _____	01/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 373	Continued From page 26 in the residents care plan along with specific corrective approaches. On 1/16/13 at 12:34 p.m., the (LEA) stated that she had taken the facility course for paid feeding assistants and would check with the nurses on the unit prior to a meal regarding which residents she would be allowed to assist. The (LEA) then stated she assists R72, R122, R57 &R51 and while feeding these residents none of them had any swallowing difficulty or chewing problems. On 1/16/13 at 2:00 p.m. , interview with the Director of Nursing (DON) stated the facility interdisciplinary team decide if the residents are safe to be feed by a PFA . The DON stated that if a resident has thickened liquids the PFA are not to be feeding those residents. On 1/17/13 at 9:04 a.m., nursing assistant (NA)-C stated that she was not aware of any residents in the Evergreens unit who had swallowing or choking problems. On 1/17/13 at 9:28 a.m., licensed practical nurse (LPN)-B, charge nurse on the evergreen unit, stated she was not aware of any swallowing or choking problems with R51, R72, & R122. On 1/17/13 at 10:25 a.m., nursing assistant (NA) -B stated the (LEA) had been assisting R122 to eat lunch on 1/16/13 and there was no difficulties. NA-B stated that the (LEA) assists residents on the evergreens unit to eat the lunch meal every day except weekends. NA-B further stated that R51, R72, & R122 required assistance to eat. She also stated R72 was routinely served pureed food for meals and would spit out any food that	F 373		

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F 373	Continued From page 27 was in chunks. NA-B stated she was not aware of any swallowing or choking problems regarding R52, R72, & R122. On 1/17/13 at 1:15 p.m., interview with the Speech Language Pathologist (SLP) stated she was aware the facility used (PFA) however was not aware of which residents were being fed by the PFA. On 1/17/13 at 1:30 p.m., reviewed the above information with the Director of Nursing (DON) and no further information was provided.	F 373		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 428	a. For residents R 51, R2 and R 72 facility has ensured that the consulting pharmacists irregularities found related to individualized target behavior monitoring for antipsychotic medications have been followed thru, each resident has individualized target behavior sheets for each antipsychotic medication, non-pharmacological interventions and addresses medication effectiveness. (F 428 continued on Page 29)	

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F 428	Continued From page 28 facility failed to ensure the consulting pharmacist identify irregularities related to individualized behavior monitoring for antipsychotic medications for 3 of 5 residents (R2, R51, and R72) in the sample reviewed for unnecessary medications. Findings include: R2 had received a daily dose of Seroquel (a antipsychotic medication) 25 milligrams (mg.) since 9/10/12. The consulting pharmacist had not identified the lack of individualized behavior monitoring to ensure R2 was benefiting from the medication. Review of the behavior record charting for R2 revealed no individualized target behaviors, and non pharmacological interventions related to the daily use of Seroquel. The behavior documentation collected data, however, lacked clinical indications to evaluate the effectiveness for the continued use of Seroquel. The physician's orders dated 1/13 indicated Seroquel 25 mg. every evening for hallucinations and delusions. Review of the monthly Consultant Pharmacist Drug Regimen reviews conducted on 9/25/12, 10/22/12, 11/27/12 and 12/27/12 revealed the pharmacist had not identified the lack of individualized target behaviors and individualized non pharmacological interventions. On 1/17/13 at 4:50 p.m. the pharmacy consultant stated, when a resident was administered antipsychotic medication, expectations would include behavior monitoring with identified target	F 428	(F 428 continued from Page 28) b. All residents who receive pharmacist recommendations will have irregularities addressed. c. Licensed nursing staff will be in-serviced that all pharmacy recommendations will be addressed and followed thru by RN mangers. Including initiating target behavior monitoring on all residents who receive antipsychotic medications. d. Random Quality Assurance audits will be completed by Director of Nursing/ designee to assure that all residents who receive antipsychotic medications for behaviors will have target behaviors listed for each antipsychotic medication along with non-pharmacological interventions and documentation is addressing medication effectiveness. e. Completion date 2/21/2013	2/21/2013

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F 428	Continued From page 29 behaviors. The pharmacy consultant stated recommendations for behavior documentation had been discussed with the facility in the past. Although the behavior charting form the facility used had a list of numbered behaviors to choose from, the pharmacy consultant emphasized antipsychotic medication must be related to an actual target behavior and should be clearly documented. R51 had received onlazapine, (antipsychotic medication) 5 milligrams every day since 4/23/12, for a diagnosis of psychosis. There were no individualized target behaviors identified, or individualized non-pharmacological interventions identified for staff to monitor for the effectiveness for continued use of the antipsychotic medication. The consulting pharmacist had not identified the irregularity. Review of facility form titled, Consultant Pharmacist Drug Regimen Review. revealed the consulting pharmacist had reviewed R51's record on 7/17/12, 8/20/12, 9/18/12, 10/18/12, 11/21/12, and 12/19/12. On 11/21/12, the consulting pharmacist (CP)-F noted that the onlazapine medication decreased R51's aggressive behavior, however the documentation did not address the lack of individualized target behaviors and individualized non-pharmacological interventions to minimize behaviors related to the use of antipsychotic medication. On 1/17/13, at 4:48 p.m., CP-F confirmed the regimen reviews for R51. He stated that it would	F 428		

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F 428	Continued From page 30 be expected that the facility would identify individualized target behaviors for each resident, to monitor for the continued use of antipsychotic medications. CP-F confirmed that the facility used preprinted forms with lists of behaviors and interventions from which to choose, with various behaviors charted in narrative form by the nursing assistants. The PC-F confirmed that there were no individualized behaviors identified for the continued use of antipsychotic medications for R51. R72 had received Risperdal, (an antipsychotic medication) 1 milligram, daily since 8/29/10, for psychosis with uncontrolled verbal and physical outbreaks potentially harmful to self or others, and wandering behavior. There were no individualized behaviors identified nor individualized non-pharmacological interventions identified for staff to monitor for the effectiveness or continued use of antipsychotic medication. Review of R72's drug regimen reviews revealed the consulting pharmacist had reviewed R72's record on 8/20/12, 9/18/12, 10/18/12, and 11/21/12. The consulting pharmacist documentation did not address the lack of individualized target behaviors and individualized non-pharmacological interventions to minimize behaviors related to the use of antipsychotic medication. On 1/17/13, at 4:48 p.m., CP-F confirmed the regimen reviews for R72. He stated that it would be expected that the facility would identify individualized target behaviors for each resident, to monitor for the continued use of antipsychotic	F 428		

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F 428	Continued From page 31 medications. CP-F confirmed that the facility used preprinted forms with lists of behaviors and interventions from which to choose, with various behaviors charted in narrative form by the nursing assistants. The PC-F confirmed that there were no individualized behaviors identified for the continued use of antipsychotic medications for R72.	F 428		

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

PRINTED: 02/06/2013
FORM APPROVED
OMB NO. 0938-0391

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Knute Nelson Memorial Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	RECEIVED FEB 14 2013 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok 2-19-13	

DC: 02.26.2013

EXIT: 01.17.2013

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

TITLE: President and Chief Executive Officer

(X6) DATE: 2/14/2013

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.

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K 000	Continued From page 1 By e-mail to: Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Knute Nelson Memorial Home is a 1-story building with a partial basement. The building was constructed at 5 different times. The original building was constructed in 1958 and was determined to be of Type II(111) construction. In 1961, an addition was added to the east was determined to be of Type II(111)construction. These 2 sections of the facility are separated by 2-hour fire resistive construction and are used for administration purposes only and were no included in this survey. In 1970 and addition was added to the south that was determined to be Type II(000) construction. In 1976 an addition was added to to the south that was determined to be Type V(111) construction. In 1980 additions were added to the east and south that were determined to be Type V(111) construction. Because the original building and the additions meet the construction type allowed for existing	K 000		

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K 000	Continued From page 2 buildings, the facility was surveyed as one building. The entire facility is protected by a complete fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 124 beds and had a census of 106 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by:	K 017	Maintenance staff have re-cut and realigned the metal grid that was damaged causing the suspended ceiling tiles to not seat properly in the grid causing penetrations and openings along the edges of the ceiling tiles. Maintenance staff will observe the corridors and penetrations when making rounds throughout the building. We have also incorporated a quarterly walkthrough audit of the entire facility which includes inspecting ceiling tiles as a requirement from the Safety Committee. This inspection will be performed by two members of the safety committee. If the audit has areas of corrections, they will be given to Tom Storer, Director of Environmental Services, for completion. Copies of the quarterly audits will be maintained by the Safety Committee. (K 017 continued on Page 4)	

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K 017	Continued From page 3 Based on observations, the facility had multiple penetrations in the corridors that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient practice could affect the exiting of 8 of 106 residents, staff and visitors. In the event of a fire in this space, smoke and fire could spread into the corridor making it untenable. Findings include: On facility tour between 10:30 AM to 12:30 PM on 01/16/2013, it was observed that the metal grid work that supports the suspended ceiling tiles was damaged and was not allowing the ceiling tiles not to seat properly in the supports. This condition has caused the misalignment of 4 ceiling tiles resulting in several penetrations and openings along the edges of the ceiling tiles that are affected by the damaged grid work. This deficient practice was verified by the Facility Administrator (AU).	K 017	(K 017 continued from Page 3) The Director of Environmental Services will be responsible for compliance with NFPA life safety code 101 sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. Completion Date: 02/08/2013 Responsible Person: Tom Storer, Director of Environmental Services	2/8/2013
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	Maintenance staff have applied fire rated caulking to the multiple vertical penetrations around the piping that passed through the ceiling that are located in the lower level hot water utility room. Maintenance staff will continue to monitor penetrations and will provide instructions for all outside contractors to make sure fire caulking is used at all times. (K 029 continued on Page 5)	

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K 029	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practices could affect residents, staff and visitors as smoke and fire in this rooms could enter the corridor making it untenable. Findings include: On facility tour between 10:30 AM to 12:30 PM on 01/16/2013, observations revealed that there were multiple vertical penetrations around the piping that passed through the ceiling that are located in the lower level hot water utility room. This deficient practice was verified by the Facility Administrator (AU).	K 029	(K 029 continued from Page 4) Maintenance staff will confirm the areas where contractors have been working in to ensure all penetrations have fire caulking applied as necessary. Completion Date: 02/08/2013 Responsible Person: Tom Storer, Director of Environmental Services	2/8/2013