CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 6SQ3

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AGENCY	Fac	eility ID: 00113
1. MEDICARE/MEDICAID PROVIDER NO (L1) 245435 2.STATE VENDOR OR MEDICAID NO. (L2) 178540100		3. NAME AND ADI (L3) KNUTE NEL (L4) 420 12TH AV. (L5) ALEXANDR	SON ENUE EAST	TY	(L6) 56308	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNI (L9) 6. DATE OF SURVEY 05/01/2		7. PROVIDER/SUP 01 Hospital 02 SNF/NF/Dual	PLIER CATEGOR 05 HHA 06 PRTF	Y 09 ESRD 10 NF	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Com	9. Other plaint
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING D	ATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	108 (L18) 108 (L17)	B. Not in Comp	ce With quirements	n	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A	6. Scope of Service 7. Medical Director	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 108 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS See Attached Remarks 17. SURVEYOR SIGNATURE	(IF APPLICABLE S	HOW LTC CANCELL Date:	ATION DATE):		18. STATE SURVEY AGENCY API	PROVAL	Date:
Tammy Williams, HF	E NEII		05/16/2014	(L19)	Mark Meath, Enfo	rcement Specialis	<u>st</u> 05/16/2014 (L20)
	PART II - TO	BE COMPLETEI	D BY HCFA R	EGIONAI	OFFICE OR SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILITY X 1. Facility is Eligible to Partic 2. Facility is not Eligible	ipate (L21)		PLIANCE WITH C	CIVIL	1. Statement of Financi 2. Ownership/Control I: 3. Both of the Above :	al Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-	1513)
22. ORIGINAL DATE OF PARTICIPATION 02/01/1987 (L24)	23. LTC AGREEME BEGINNING I (L41)	DATE	4. LTC AGREEMI ENDING DAT (L25)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemer 03-Risk of Involuntary Termination	05-Fail to Meet 06-Fail to Meet	<u>RY</u> t Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE A. Suspension of B. Rescind Susp	of Admissions:	(L44) (L45)		04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider St 00-Active	atus Change
28. TERMINATION DATE:	29. (L28)	. INTERMEDIARY/Ca	ARRIER NO.	(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539	32. (L32)	DETERMINATION C 04/23/2014	DF APPROVAL DA	(L33)	DETERMINATION APPRO	VAL	

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00113

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5435

On May 1, 2014, a Post Certification Revisit (PCR) was completed to verify correction of deficiencies issued pursuant to the extended survey completed on February 14, 2014 and not corrected at the time of the April 2, 2014 PCR. Based on the May 1, 2014 PCR we have verified correction of the remaining deficiencies as of May 1, 2014. As a result of the May 1, 2014 PCR, this Department discontinued the Category 1 remedy of State monitoring, effective May 1, 2014. In addition, we recommended to the Region V office of CMS and they concurred with our recommendation and have authorized us to notify the facility of the following action:

- Mandatory Denial of Payment for new Medicare and Medicaid Admsissions, effective May 14, 2013, be rescinded.

The facility would still have a loss of NATCEP for a two year period, effective February 14, 2014.

Refer to the CMS 2567b for both health and life safety code for the results of the May 1, 2014 visit.

Effective May 1, 2014, the facility is certified for 108 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5435

May 16, 2014

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 May 1, 2014 the above facility is certified for:

108 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 108 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered May 16, 2014

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

RE: Project Number S5435024

Dear Ms. Urman:

On April 14, 2014, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective April 19, 2014. (42 CFR 488.422)

On April 23, 2014, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective May 14, 2014. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of April 23, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 14, 2014.

This was based on the deficiencies cited by this Department for an extended survey completed on February 14, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on April 2, 2014. The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 1, 2014, the Minnesota Department of Health completed a PCR and on May 2, 2014 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 PCR, completed on April 2, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 16, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on April 2, 2014, as of May 1, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state

Knute Nelson May 16, 2014 Page 2

monitoring effective May 1, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of April 14, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 14, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 14, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 14, 2014, is to be rescinded.

In our letters of March 7, 2014, April 14, 2014 and the CMS letter of April 23, 2014, you were advised that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 14, 2014.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245435	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/1/2014
Name	of Facility		Street Address, City, State, Zip Code	
K١	IUTE 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	C	Y5)	Date
		Correction			Correction					Correction
ID Prefix	E0225	Completed 05/01/2014	ID Prefix	E0226	Completed 05/01/2014		ID Profix			Completed
	-	_								_
Reg. # LSC	483.13(c)(1)(ii)-(iii), (c)(2) -	- (4) -		483.13(c)	-		Reg. # LSC			_
		_			-	+-				_
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		_								<u> </u>
Reg. # LSC		_	Reg. #		-		Reg. #			_
		_			-	+-				_
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		_	ID Prefix	-	_					
Reg. # LSC		_	Reg. #		-		Reg. #			_
		_	LSC		-	+-	LSC			_
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		_	ID Prefix		_		ID Prefix			_
Reg. #		_	Reg. #		-		Reg. #			_
			LSC		-		LSC			
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		_	ID Prefix		-		ID Prefix			_
Reg. #		_	Reg. # LSC		-		Reg. #			_
LSC			LSC		-	+-	LSC			_
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	eyor:	•			Date:	
State Agency	MM/C	GA 05/2	6/2014		3260	3			05/0	1/2014
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	eyor:				Date:	
CMS RO										
Followup to	Survey Completed on:				Uncorrected I			-		
	2/14/2014			Uncorrecte	d Deficiencies	(CMS	5-2567) Sent t	o the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245435	per A. Building		N BUILDING 01	(Y3) Date of Revisit 5/2/2014
Name	of Facility			Street Address, City, State, Zip Code	
ΚN	IUTE 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	()	′ 5)	Date	(Y	4) Item		(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			04/15/2014		ID Prefix			03/17/2014		ID Prefix			03/11/2014
Reg. #	NFPA 101				Reg. #	NFPA 101				Reg. #	NFPA 101		_
LSC	K0029				LSC	K0056				LSC	K0062		_
			Correction					Correction					Correction
ID Drofiv			Completed 03/20/2014		ID Drofiv			Completed		ID Drofiv			Completed
ID Prefix			03/20/2014		ID Prefix	-		=					_
-	NFPA 101				Reg. #					Reg. #			_
	K0067			ļ	LSC		_						
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg.#			-		Reg.#			-		Reg. #			_
LSC	·		='		LSC								_
				-		-			-				-
			Correction					Correction					Correction
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Reg. #					Reg. #					Reg. #			
LSC			-										_
										-			
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			-		ID Prefix					ID Prefix			_
Reg. #			-		Reg. #					Reg. #	·		_
LSC	-				LSC					LSC			_
Reviewed By	·	Reviewed B	Зу	Da	te:	Signature of Su	rve	yor:				Date:	
State Agency	/	MM/PS	5 05/1	6/2	2014			2720	0			05/02	2/2014
Reviewed By	,	Reviewed B	 Зу	Da	te:	Signature of Su	rve	yor:				Date:	
CMS RO													
Followup to	Survey Compl	leted on:				Check for a	nv	Uncorrected	Def	iciencies. Wa	a Summary of	1	
-	2/11/	/2014					-				to the Facility?	YES	NO
				1									

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 6SQ3

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PAR	T I - TO BE COMPLETED	BY THE STATE	E 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 F (L3) KNUTE NELSON (L4) 420 12TH AVENUE EA: (L5) ALEXANDRIA, MN		(L6) 56308	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CAT 01 Hospital 05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 04/02/20014 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/S	y 11 ICF/IID	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 108 (L18) 13. Total Certified Beds (L17)	10.THE FACILITY IS CERTIFII A. In Compliance With Program Requirements Compliance Based On:1. Acceptable PC X B. Not in Compliance with 1 Requirements and/or A	OC Program	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B*	Following Requirements:
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 108 (L37) (L38) (L39)	ICF (L42)	IID (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE See Attached Remarks 17. SURVEYOR SIGNATURE	SHOW LTC CANCELLATION DATED	ΓE):	18. STATE SURVEY AGENCY APP	PROVAL Date:
Tammy Williams, HFE NEII	04/14/2014	(L19)	Mark Meath, Enforce	cement Specialist 05/14/2014 (L20)
PART II - TO	BE COMPLETED BY HC	FA REGIONAL	OFFICE OR SINGLE STATI	E AGENCY
19. DETERMINATION OF ELIGIBILITY _X	20. COMPLIANCE V RIGHTS ACT:	WITH CIVIL	21. 1. Statement of Financia2. Ownership/Control In3. Both of the Above :	al Solvency (HCFA-2572) terest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREEM OF PARTICIPATION BEGINNING 02/01/1987 (L24) (L41)		REEMENT G DATE	26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: 27. ALTERNATIV A. Suspension (L27) B. Rescind Su	of Admissions: (L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE: 22 (L28)	0. INTERMEDIARY/CARRIER NO	O. (L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539 3. (L32)	2. DETERMINATION OF APPROV. 04/23/2014	AL DATE (L33)	DETERMINATION APPROV	/AL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00113

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5435

On April 2, 2014, a Post Certification Revisit (PCR) was completed at this facility to determine compliance with deficiencies issued pursuant to the extended survey completed on Febraury 14, 2014. Based on the PCR, it was deteremined the facility did not correct all deficiencies. In addition conditions in the facility continued to constitute Substandard Quality of Care (SQC) to resident health or safety. The most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for minimal harm that is not immediate jeopardy (Level F). As a result of finding the facility not in substantial compliance, this Department imposed State monitoring, effective April 19, 2014. The Region V office of CMS imposed the following enforcement remedy:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions, effective May 14, 2014

The facility is subject to a loss of NATCEP for a two year period beginning February 14, 2014 as a result of the extended survey that identified SQC.

Refer to the CMS 2567 along with the facility's plan of correction for this revisit.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered April 14, 2014

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

RE: Project Number S5435024

Dear Ms. Urman:

On March 7, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on February 14, 2014. Conditions in the facility at the time of the extended survey constituted Substandard Quality of Care SQC) to residents health or safety. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On April 2, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on February 14, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 15, 2014. Based on our visit, we have determined conditions in the facility continue to constitute SQC to residents health or safety, thus your facility has not achieved substantial compliance with the deficiencies issued pursuant to our extended survey, completed on February 14, 2014. The deficiencies not corrected are as follows:

- F0225 -- S/S: D -- 483.13(c)(1)(ii)-(iii), (c)(2) (4) -- Investigate/reportAllegations/individuals
- F0226 -- S/S: F -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective April 19, 2014. (42 CFR 488.422)

Knute Nelson April 14, 2014 Page 2

In addition, this Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 14, 2014. (42 CFR 488.417 (b))
- Per instance civil money penalty for the deficiency cited at F226, effective April 2, 2014. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of March 7, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 14, 2014.

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, Supervisor Fergus Falls Survey Team Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: gail.anderson@state.mn.us

Telephone: (218) 332-5140

Fax: (218) 332-5196

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 remedy be imposed:

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

Knute Nelson April 14, 2014 Page 4

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 May 14, 2014 (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 August 14, 2014 (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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 14, 2014 (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 Knute Nelson April 14, 2014 Page 5

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

5435r1_14.rtf

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245435	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/2/2014
Name	e of Facility		Street Address, City, State, Zip Code	
ΚN	IUTE 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
			Correction				Correction					Correction
ID Prefix	F0323		Completed 03/21/2014	ID Prefix	F0371		Completed 03/21/2014		ID Prefix	F0465		Completed 03/21/2014
	483.25(h)		=		483.35(i)		=			483.70(h)		
			- -	LSC			- -		LSC			_ _
			0 "				0 "					0 "
			Correction Completed				Correction Completed					Correction Completed
ID Prefix				ID Prefix			_		ID Prefix			
Reg. #			_	Reg. #			_		Reg. #			
LSC			=	LSC			=		LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			-	ID Prefix			_		ID Prefix			
Reg. #			-	Reg. #					Reg. #			_
			=	LSC			-	-	LSC			_
			Correction				Correction					Correction
ID D (Completed	10 D "			Completed		ID D "			Completed
			-				_					
Reg. # LSC	-		=	Reg. #			=		Reg. # LSC			
			-					+-				
			Correction				Correction					Correction
ID Profiv			Completed	ID Profix			Completed		ID Profix			Completed
				Reg. #	-				Reg. #			
Reg. # LSC			- -				- -					<u> </u>
Reviewed I	Зу	Reviewed	I Ву	Date:	Sign	ature of Su	rveyor:				Date:	
State Agen	су											
Reviewed I	Зу	Reviewed	I Ву	Date:	Sign	ature of Su	rveyor:				Date:	
CMS RO												
Followup t	o Survey Co	-	n:		Check fo	or any Unco	rrected Defi	cienc	ies. Was a	Summary of		
	2/14	/2014			Unco	rrected Defi	ciencies (CN	/IS-25	b/) Sent to	the Facility?	YES	NO

Form CMS - 2567B (9-92) Page 1 of 1 Event ID: 6SQ312

PRINTED: 06/11/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY IPLETED
		245435	B. WING				R 02/2014
	NUTE NELSON 420 12TH AVENUE EAST ALEXANDRIA, MN 56308				04/	02/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMEN	тѕ	{F 00	00}			
{F 225} SS=D	4/2/2014. During th	PORT	{F 2:	25}			4/16/14
	been found guilty o mistreating residen had a finding enter registry concerning of residents or misa and report any kno- court of law agains indicate unfitness for	ot employ individuals who have f abusing, neglecting, or a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a tran employee, which would or service as a nurse aide or or the State nurse aide registry ties.					
	involving mistreatm including injuries of misappropriation of immediately to the to other officials in through established	nsure that all alleged violations nent, neglect, or abuse, funknown source and fresident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency).					
	violations are thoro	ave evidence that all alleged ughly investigated, and must ential abuse while the rogress.					
	to the administrator representative and with State law (inclu	to other officials in accordance uding to the State survey and					
I ABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

Electronically Signed

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING			E SURVEY PLETED
		245435	B. WING				R 02/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 420 12TH AVENUE EAST ALEXANDRIA, MN 56308	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD	BE	(X5) COMPLETION DATE
{F 225}	incident, and if the a appropriate correction. This REQUIREMENT by: Based on interview facility failed to report in the sagency (SA) in a time residents (R15, R1). Findings include: R15 sustained a frather facility failed to to the SA. R15 was found lying 3/22/14, at 3:50 p.m recliner chair, which were no witnesses to have displacement left knee and large was sent to the emergence.	within 5 working days of the alleged violation is verified ve action must be taken. It is not met as evidenced and document review, the ort instances of potential icious injuries of unknown sed fall with injury to the state nely manner for 3 of 5 58, R56). Incture to left hip following a fall. immediately report the injury g on the floor of her room on and, in front of the electric and was in a high position. There to the fall. R15 was observed ant of the right hip, abrasion on bump on the right knee. R15 ergency room for evaluation of	{F 22	,			
	R15 was admitted t fracture. The facility with serious injury to was received by the a.m., nineteen hour	ints of pain in the left hip area. o the hospital with a left hip reported the unwitnessed fall o the SA. However, the report SA on 3/23/14, at 11:35 and forty five minutes after n unwitnessed fall with injury.					
		num Data Set (MDS), dated R15 had diagnoses which					

PRINTED: 06/11/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	` '	E SURVEY PLETED
		245435	B. WING				R 02/2014
NAME OF	PROVIDER OR SUPPLIER			4:	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST ALEXANDRIA, MN 56308	<u> </u>	V2/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 225}	further identified R1 impairment, require mobility, transferring ambulate. Further, functional limitation and lower body. R1 (CAA), dated 10/4/history of cerebroved dementia, kyphosis vertebrae) and dep CAA further identifier required a total lift thand back. R15's fall 3/5/14, identified R1 related to the inability extensive assistant of medications for hR15's care plan, dautilize a total body lifted from bed to chair and inability to ambulate revealed R15 utilized Review of the programmental R15 and hard revealed: On 3/22/14, at 3:50 the floor on her back door and her feet to calling out, "help, he chair was in a high looked displaced, ri and complained of abrasion on her left transferred per ambulated revealed R15 utilized."	ge 2 and depression. The MDS 15 had severe cognitive ad extensive assistance with g, toileting and did not the MDS identified R15 had s in both sides of her upper 5's Care Area Assessment 13, revealed R15 had a ascular accident (stroke), (overcurvature of the thoracic ression with behaviors. The ed R15 did not stand and to transfer from bed to chair risk assessment, dated 15 was at high risk for falls that to stand, the need for the with transfers and the use expertension and depression. Ited 3/12/14, directed staff to the date and electric recliner chair. The care plan further and an electric recliner chair. The ses notes from 3/19/14 to p.m., R15 was found lying on the with her head towards the towards the windows. R15 was the position. R15's right hip ght leg was facing outward pain in the left hip and had an the R15 was then to bulance to the local hospital at tress note indicated the and administrator had been	{F 2:	25}			

	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245435 B. WING					R 02/2014
NAME OF F	PROVIDER OR SUPPLIER	240400		9	STREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST ALEXANDRIA, MN 56308	04/	02/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 225}	that R15 had sustai fracture. Review of the facilit 3/22/14 revealed R floor, yelling "HELP lift chair was in high there were no witne R15 had recent cha an acute illness was the fall. Review of the repor 3/23/14, revealed th SA at 11:35 a.m., ni	ocal hospital notified the facility ned a displaced left hip y incident report, dated 15 had been found on the !! HELP!! Her power recliner a position. The report indicated asses for the fall, and indicated anges in cognitive status and as listed as a possible cause of the submitted to the SA, dated are report was received by the ineteen hours and forty five experienced serious injury	{F 2:	25}			
	forearm and leg, whinjury of unknown of immediately report in R158's annual MDS diagnoses which into The MDS identified impairment and requith mobility, transferand toileting. R158's nursing assistant in the MDS identified impairment and requirement and requirement and toileting.	ee large bruises on her nich was determined to be an rigin. The facility failed to the injuries to the SA. Serevealed R158 had cluded dementia and anxiety. R158 had severe cognitive quired extensive assistance er from bed to chair, dressing distant care plan, dated aff to transfer R158 with a fall lift for transfers.					

-	OF DEFICIENCIES OF CORRECTION	()		COMPLETED			
		245435	B. WING	i			R 02/2014
NAME OF I	PROVIDER OR SUPPLIER			42	REET ADDRESS, CITY, STATE, ZIP CODE 10 12TH AVENUE EAST LEXANDRIA, MN 56308	<u> </u>	02/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 225}	following: On 3/24/14, at 9:58 forearm was measured sured and purple in one measured 2.5 measured 4 x 3 cm. Review of R158's irrevealed three bruis R158's bath. Left for cm dark purple in c. Two bruises on the 2.5 cm x 3 cm and cm. The report indicate happened to cause identified R158 was memory and was of Further, the report i witnesses to R158 unknown origin. The facility submitted an injury of unknown bruises, on 3/25/14 and thirty three mindiscovered.	p.m., a bruise on R158's left ured at 4 x 2 centimeters (cm) color, and lighter in the middle. oted on R158's left lower leg. x 3 cm and the other, both were light blue in color. Incident report dated 3/24/14, ses were observed during orearm bruise measured 4 x 2 color and lighter in the middle. left lower leg, one measured another measuring 4 cm x 3 cated R158 did not know what the bruises. The report is confused, had impaired rientated to person only. dentified there had been no sustaining the bruises/injury of ed a report to the SA indicating in source, regarding R158's, at 4:35 p.m., eighteen hours utes after the bruises were		25}			
		ange MDS dated 3/14/14,					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245425					R
		245435	B. WING			04/0	02/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KNUTE I	NELSON				20 12TH AVENUE EAST		
				A	LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE .	(X5) COMPLETION DATE
{F 225}	extensive assistan report dated 3/23/1 identified bruises a incident report date identified one dark that measured 2.4 purple bruise on the cm x 2.5 cm. The unaware of how the The facility reporte unknown source to p.m., thirty five ho identifying R56's be During interview or director of nursing incident report was thirty five hours aft unknown origin, the immediately becaus She confirmed the sent to the SA for Fand R158's suspicithe reports were mpossible, then state get to it, its always The DON confirmed ensure timely report the facility policy dimmediately, within During interview or administrator state incident to the SA stated, "If we know suspicious area, or	age 5 npairment and received ce with all ADL's. R56's Bruise 14, indicated that staff first at 7:00 a.m. The facility ed 3/23/14, at 12:45 p.m. purple bruise on the right wrist cm x 3.8 cm, and one dark e right hand that measured 2.2 report indicated R56 was e bruises occurred. d R56's bruises, as injuries of othe SA on 3/24/14, at 5:16 urs and sixteen minutes after ruises of unknown origin. at 4/1/14, at 5:52 p.m. the (DON) confirmed R56's not reported to the SA until er identifying the injuries of en said it was not reported use "we knew it wasn't abuse." timing of the reports the facility R15's injury of unknown origin ious bruises. The DON stated hade to the SA as soon as ed, "Sometimes you just don't been reported that next day." ed that it is her responsibility to rting to the SA and also stated rected staff to report to the SA at twenty four hours. 14/2/14, at 11:50 a.m. the d the facility reports the initial within twenty four hours, then of it is abuse, a bruise is in a r neglect, the facility reports to mediately." The administrator	{F 2:	25}			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245435	B. WING			R 02/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308	<u>, </u>	V Z Z V · ·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 225}	on a resident and is report is made to the four hours." The accepted that report	ge 6 facility feels its a small bruise is not in a suspicious area, the se state agency within twenty dministrator confirmed that it is its are made to the SA within er the facility policy.	{F 22	5}		
{F 226} SS=F	Abuse/Neglect Presuspect violations of reported to the seven which included star agency responsible Protection Services and Law Enforcement telephone call to the acceptable to meet reporting. The policy notices to agencies of the occurrence of policy contains contiming of reporting the needs to be immed 483.13(c) DEVELO ABUSE/NEGLECT The facility must depolicies and proced mistreatment, negle and misappropriation	P/IMPLMENT , ETC POLICIES Evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.	{F 22	6}		4/16/14
	by: Based on interview	NT is not met as evidenced and document review, the day a systematic failure to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED	
		245435	B. WING _			R /02/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308	-	102/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH APPROVIDED TO THE APPROVIDENCY)	ULD BE	(X5) COMPLETION DATE
{F 226}	immediate reporting 3 of 5 residents (R1 abuse prohibition. potential to affect a resided in the facility Findings include: The undated facility Abuse/Neglect Presuspect violations or reported to the seven which included state agency responsible Protection Services and Law Enforcement telephone call to the acceptable to meet reporting. The policy notices to agencies of the occurrence opolicy contains control.	use prohibition policies for g to the state agency (SA) for 15, R158, R56) reviewed for This deficient practice had the II 92 of 92 residents who by. If policy titled, Vulnerable Adult wention Plan, directed that all or abuse would be immediately eral persons or agencies te licensing/certification of for surveying the facility, Adult of the hocal/state Ombudsman ent Officials. A fax or the state agency would be the requirement of immediate by identified verbal or written will be made within 24 hours of the incident. However, the flicting information about the to the state agency which	{F 22	6}		
		acture to left hip following a fall. immediately report the injury				
	3/22/14, at 3:50 p.n recliner chair, which were no witnesses to have displaceme left knee and large	g on the floor of her room on n., in front of the electric n was in a high position. There to the fall. R15 was observed ent of the right hip, abrasion on bump on the right knee. R15 ergency room for evaluation of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED	
		245435	B. WING			R /02/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 420 12TH AVENUE EAST ALEXANDRIA, MN 56308	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 226}	R15 was admitted the fracture. The facility with serious injury the was received by the a.m., nineteen houre R15 experienced at R15's annual Minimal 10/1/13, identified Fincluded demential afurther identified R1 impairment, require mobility, transferring ambulate. Further, functional limitation and lower body. R1 (CAA), dated 10/4/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	ge 8 ints of pain in the left hip area. o the hospital with a left hip oreported the unwitnessed fall of the SA. However, the report of SA on 3/23/14, at 11:35 of sand forty five minutes after of unwitnessed fall with injury. Intum Data Set (MDS), dated of Stand diagnoses which and depression. The MDS of had severe cognitive of extensive assistance with of to tileting and did not of the MDS identified R15 had of in both sides of her upper of Stand R15 had a of scular accident (stroke), overcurvature of the thoracic of ression with behaviors. The of R15 did not stand and of transfer from bed to chair of the MDS identified R15 had a of transfer from bed to chair of the WDS identified R15 had a of transfer from bed to chair of transfer from bed to chair of the WDS identified R15 had a of transfer from bed to chair of the R15 did not stand and of transfer from bed to chair of the R15 did not stand and of transfer from bed to chair of the R15 did not stand and of transfer from bed to chair of the R15 did not stand and of transfer from bed to chair of the R15 did not stand and of transfer from bed to chair of the R15 did not stand and of transfer from bed to chair of the R15 did not stand and of transfer from bed to chair of the R15 had a	{F 22	(6)		
	Review of the programmer 3/23/14 revealed:	ress notes from 3/19/14 to				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED	
		245435	B. WING _			R /02/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		702/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
{F 226}	the floor on her back door and her feet to calling out, "help, he chair was in a high looked displaced, ri and complained of abrasion on her left transferred per ambed 4:40 p.m. The proguirector of nursing a notified at that time. At 11:02 p.m., the left that R15 had sustain fracture. Review of the facility 3/22/14 revealed R floor, yelling "HELP lift chair was in high there were no witner R15 had recent chain acute illness was the fall. Review of the report 3/23/14, revealed the SA at 11:35 a.m., notice the same content of the report of t	p.m., R15 was found lying on the with her head towards the owards the windows. R15 was elp" and the power recliner lift position. R15's right hip light leg was facing outward pain in the left hip and had an the knee. R15 was then coulance to the local hospital at the local hospital at the local hospital at the local hospital notified the facility lined a displaced left hip left		6}		
	forearm and leg, whinjury of unknown o	ee large bruises on her nich was determined to be an origin. The facility failed to the injuries to the SA.				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		COMPLETED			
		245435	B. WING				R 02/2014
NAME OF I	PROVIDER OR SUPPLIER			42	REET ADDRESS, CITY, STATE, ZIP CODE 0 12TH AVENUE EAST LEXANDRIA, MN 56308	<u> </u>	02/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 226}	diagnoses which in The MDS identified impairment and receivith mobility, transfund toileting. R158's nursing ass 3/13/14, directed st standing mechanical Review of R158's pfollowing: On 3/24/14, at 9:58 forearm was measured as was dark purple in the Two bruises were none measured 2.5 measured 4 x 3 cm. Review of R158's ir revealed three bruis R158's bath. Left for cm dark purple in common Two bruises on the 2.5 cm x 3 cm and cm. The report indication that the report indication in the report indication in the report indication in the report indication in the report indication.	S revealed R158 had cluded dementia and anxiety. R158 had severe cognitive uired extensive assistance er from bed to chair, dressing istant care plan, dated aff to transfer R158 with a		26}			
	an injury of unknow bruises, on 3/25/14	ed a report to the SA indicating n source, regarding R158's , at 4:35 p.m., eighteen hours utes after the bruises were					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG	CON	(X3) DATE SURVEY COMPLETED	
		245435	B. WING _			R /02/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 420 12TH AVENUE EAST ALEXANDRIA, MN 56308	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 226}	Continued From pa	ge 11	{F 22	6}		
	wrist, which was de	bruises on her right hand and etermined to be an injury of e facility failed to immediately to the SA.				
	identified R56 had a severe cognitive im extensive assistant report dated 3/23/1 identified bruises a incident report date identified one dark that measured 2.4 purple bruise on the	range MDS dated 3/14/14, a diagnosis of dementia, had pairment and received be with all ADL's. R56's Bruise 4, indicated that staff first to 7:00 a.m. The facility and 3/23/14, at 12:45 p.m. purple bruise on the right wrist cm x 3.8 cm, and one dark to right hand that measured 2.2 report indicated R56 was a bruises occurred.				
	unknown source to p.m., thirty five hou	d R56's bruises, as injuries of the SA on 3/24/14, at 5:16 ars and sixteen minutes after uises of unknown origin.				
	During interview on 4/1/14, at 5:52 p.m. the director of nursing (DON) confirmed R56's incident report was not reported to the SA until thirty five hours after identifying the injuries of unknown origin, then said it was not reported immediately because "we knew it wasn't abuse." She confirmed the timing of the reports the facility sent to the SA for R15's injury of unknown origin and R158's suspicious bruises. The DON stated the reports were made to the SA as soon as possible, then stated, "Sometimes you just don't get to it, its always been reported that next day." The DON confirmed that it is her responsibility to					

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245435	B. WING				₹	
NAME OF F	PROVIDER OR SUPPLIER	240400	D. WIIIC	ST 42	REET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST LEXANDRIA, MN 56308	U4/0	02/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE	
{F 226}	the facility policy dir immediately, within During interview on administrator stated incident to the SA w stated, "If we know suspicious area, or the state agency im then stated, "If the fon a resident and is report is made to the four hours." The ac	ting to the SA and also stated ected staff to report to the SA twenty four hours. 4/2/14, at 11:50 a.m. the the facility reports the initial vithin twenty four hours, then it is abuse, a bruise is in a neglect, the facility reports to mediately." The administrator facility feels its a small bruise is not in a suspicious area, the e state agency within twenty dministrator confirmed that it is ts are made to the SA within	{F 2.	26}				

PRINTED: 05/16/2014 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245435	B. WING				R /02/2014	
NAME OF	PROVIDER OR SUPPLIER			42	REET ADDRESS, CITY, STATE, ZIP CODE 10 12TH AVENUE EAST LEXANDRIA, MN 56308	<u> </u>	02/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMEN	TS	{F 0	00}				
{F 225} SS=D	4/2/2014. During th	PORT	{F 2	25}			4/16/14	
	been found guilty of mistreating resident had a finding enter registry concerning of residents or mist and report any kno court of law agains indicate unfitness f	of employ individuals who have if abusing, neglecting, or also by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a tran employee, which would or service as a nurse aide or of the State nurse aide registry ties.						
	involving mistreatm including injuries of misappropriation of immediately to the to other officials in through established	nsure that all alleged violations nent, neglect, or abuse, funknown source and fresident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency).						
	violations are thoro	ave evidence that all alleged bughly investigated, and must ential abuse while the progress.						
	to the administrator representative and with State law (incl	to other officials in accordance uding to the State survey and						
I ABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE	

Electronically Signed

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION ((X3) DATE SURVEY COMPLETED		
		245435	B. WING		R 04/0 :	2/2014
NAME OF F	PROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 120 12TH AVENUE EAST ALEXANDRIA, MN 56308	0.70	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 225}	incident, and if the appropriate correct This REQUIREMED by: Based on interview facility failed to report mistreatment, susporigin and unwitness agency (SA) in a tirresidents (R15, R1). Findings include: R15 sustained a frather facility failed to the SA. R15 was found lying 3/22/14, at 3:50 p.r recliner chair, which were no witnesses to have displacement left knee and large was sent to the eminjuries and complex R15 was admitted in the surprise of the surprise includes the surprise of the surprise and complex R15 was admitted in the surprise of the surprise includes the surprise of	within 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced and document review, the ort instances of potential vicious injuries of unknown under the fall with injury to the state mely manner for 3 of 5 (158, R56). Acture to left hip following a fall. In immediately report the injury of the goal of the room on the injury of the fall. R15 was observed and of the right hip, abrasion on bump on the right knee. R15 ergency room for evaluation of aints of pain in the left hip area. The to the hospital with a left hip area.	{F 225}	F 225 a. For residents R56 and R158 the have injuries of unknown cause or infrom an accident/incident reported to state agencies immediately upon discovery of the injury. These injuries be reported to the Administrator and Director of Nursing immediately upon discovery. Resident R15 has expired b. All resident of Knute Nelson have potential to be affected by this practice reportable allegations will be reported facility policy. c. All licensed staff was trained on completing the initial report to state agencies on all injuries of unknown and injuries that result from an accidincident immediately when the injury been discovered. A step by step procedure has been given to license staff to follow to do a report. They have been instructed to notify the Administration.	njuries of the se will of the se wil	
	with serious injury to was received by the a.m., nineteen hou R15 experienced a	y reported the unwitnessed fall to the SA. However, the report to SA on 3/23/14, at 11:35 and forty five minutes after in unwitnessed fall with injury. Thum Data Set (MDS), dated R15 had diagnoses which		and/or Director of Nursing when a reportable injury has been discovered to immediately to report that injury of incident to the state agencies. Licer staff has received training that after immediate initial report of injury or into the state agencies they then start investigation of the injury or incident Facility Vulnerable Adult Abuse/Negl	r nsed the ncident their	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245435	B. WING				R 02/2014
NAME OF	PROVIDER OR SUPPLIER	240400			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/0	02/2014
					20 12TH AVENUE EAST		
KNUTE I	NELSON				ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 225}	included dementia a further identified R1 impairment, require mobility, transferring ambulate. Further, functional limitation and lower body. R1 (CAA), dated 10/4/history of cerebroved dementia, kyphosis vertebrae) and dep CAA further identified required a total lift thand back. R15's fall 3/5/14, identified R2 related to the inability extensive assistant of medications for head to chair an inability to ambulate revealed R15 utilized R2 Review of the programmental R23/14 revealed: On 3/22/14, at 3:50 the floor on her back door and her feet to calling out, "help, he chair was in a high looked displaced, ri and complained of abrasion on her left transferred per ambulated revealed R15 utilized."	ge 2 and depression. The MDS 5 had severe cognitive 6 d extensive assistance with g, toileting and did not the MDS identified R15 had s in both sides of her upper 5's Care Area Assessment 13, revealed R15 had a ascular accident (stroke), (overcurvature of the thoracic ression with behaviors. The ed R15 did not stand and to transfer from bed to chair I risk assessment, dated 15 was at high risk for falls tity to stand, the need for the with transfers and the use expertension and depression. Ited 3/12/14, directed staff to fif for transferring the resident and back related to R15's the care plan further and an electric recliner chair. The care plan further and an electric recliner chair. The ses notes from 3/19/14 to p.m., R15 was found lying on the with her head towards the towards the windows. R15 was the power recliner lift position. R15's right hip ght leg was facing outward pain in the left hip and had an knee. R15 was then to bulance to the local hospital at tress note indicated the and administrator had been	{F 2	25}	Prevention policy has been revised reflect that licensed nurses will rep immediately any injuries of unknow cause upon discovery of the injury agencies. d. On-going/ at least daily audits conducted of all injuries or incident Director of Nursing and/or designed ensure staff are following the facility Vulnerable Adult Reporting Policy, that all injuries of unknown causes injuries from an accident /incident been reported immediately upon discovery of the injury to the state agencies and that the Administrate been notified immediately of the in incident. These audits will be taken Quality Assurance Committee for and discussion. e. Completion date: 4/16/2014	will be to state will be to the to state will be to the term of term of term of the term of the term of term of term of term of term of te	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245435	B. WING _			R /02/2014	
NAME OF PROVIDER OR SUPPLIER KNUTE NELSON				STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308	-	02/2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIVE ACTION SHIP CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		
{F 225}	that R15 had sustain fracture. Review of the facility 3/22/14 revealed R floor, yelling "HELP lift chair was in high there were no witner R15 had recent chain acute illness was the fall. Review of the report 3/23/14, revealed the SA at 11:35 a.m., not see the fall.	ocal hospital notified the facility ned a displaced left hip y incident report, dated 15 had been found on the !! HELP!! Her power recliner in position. The report indicated eases for the fall, and indicated eases in cognitive status and is listed as a possible cause of the submitted to the SA, dated the report was received by the ineteen hours and forty five experienced serious injury	{F 22	5}			
	forearm and leg, whinjury of unknown of immediately report. R158's annual MDS diagnoses which into The MDS identified impairment and require with mobility, transfand toileting. R158's nursing ass	ee large bruises on her nich was determined to be an rigin. The facility failed to the injuries to the SA. Serevealed R158 had cluded dementia and anxiety. R158 had severe cognitive quired extensive assistance er from bed to chair, dressing distant care plan, dated aff to transfer R158 with a fall lift for transfers.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245435	B. WING				⋜ 02/2014
	NAME OF PROVIDER OR SUPPLIER KNUTE NELSON			420	EET ADDRESS, CITY, STATE, ZIP CODE 12TH AVENUE EAST EXANDRIA, MN 56308	1 04/	0212017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 225}	following: On 3/24/14, at 9:58 forearm was measured was dark purple in or Two bruises were in One measured 2.5 measured 4 x 3 cm. Review of R158's ir revealed three bruis R158's bath. Left for cm dark purple in c Two bruises on the 2.5 cm x 3 cm and cm. The report indichappened to cause identified R158 was memory and was o Further, the report i witnesses to R158 unknown origin. The facility submitted an injury of unknown bruises, on 3/25/14 and thirty three mindiscovered. R56 sustained two wrist, which was defund the injuries to R56's significant chem.	p.m., a bruise on R158's left ured at 4 x 2 centimeters (cm) color, and lighter in the middle. oted on R158's left lower leg. x 3 cm and the other, both were light blue in color. Incident report dated 3/24/14, ses were observed during rearm bruise measured 4 x 2 color and lighter in the middle. left lower leg, one measured another measuring 4 cm x 3 cated R158 did not know what the bruises. The report is confused, had impaired rientated to person only. dentified there had been no sustaining the bruises/injury of ed a report to the SA indicating in source, regarding R158's, at 4:35 p.m., eighteen hours utes after the bruises were	{F 2.	25}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245435	B. WING				R 02/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		04/	02/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	CROSS-REFERENCED	ACTION SHOULD	BE	(X5) COMPLETION DATE
{F 225}	extensive assistance report dated 3/23/1 identified bruises at incident report date identified one dark that measured 2.4 purple bruise on the cm x 2.5 cm. The runaware of how the The facility reported unknown source to p.m., thirty five hou identifying R56's bruing incident report was thirty five hours after unknown origin, the immediately because She confirmed the sent to the SA for Rand R158's suspicit the reports were may possible, then stated get to it, its always. The DON confirmed ensure timely report the facility policy direction incident to the SA with the same dately, within the During interview on administrator stated incident to the SA with stated, "If we know suspicious area, or	pairment and received be with all ADL's. R56's Bruise 4, indicated that staff first to 7:00 a.m. The facility and 3/23/14, at 12:45 p.m. purple bruise on the right wrist cm x 3.8 cm, and one dark eright hand that measured 2.2 report indicated R56 was bruises occurred. If R56's bruises, as injuries of the SA on 3/24/14, at 5:16 ars and sixteen minutes after uises of unknown origin. If A/1/14, at 5:52 p.m. the (DON) confirmed R56's not reported to the SA until er identifying the injuries of en said it was not reported se "we knew it wasn't abuse." timing of the reports the facility R15's injury of unknown origin ous bruises. The DON stated add to the SA as soon as ed, "Sometimes you just don't been reported that next day." dithat it is her responsibility to ting to the SA and also stated rected staff to report to the SA	{F 2:	25}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245435	B. WING			R 02/2014	
NAME OF PROVIDER OR SUPPLIER KNUTE NELSON				STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308	1 047	<i></i>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
{F 225}	on a resident and is report is made to th four hours." The ad	acility feels its a small bruise not in a suspicious area, the e state agency within twenty dministrator confirmed that it is ts are made to the SA within	{F 22	25}			
•	Abuse/Neglect Previous suspect violations or reported to the seven which included star agency responsible Protection Services and Law Enforcement telephone call to the acceptable to meet reporting. The policinotices to agencies of the occurrence occurrence of the occurrence occurrence of the occurrence occurr	P/IMPLMENT ETC POLICIES velop and implement written	{F 22	26}		4/16/14	
	by: Based on interview	NT is not met as evidenced and document review, the daystematic failure to		F 226 a. Knute Nelson will follow their			

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245435	B. WING			R 02/2014	
	NAME OF PROVIDER OR SUPPLIER KNUTE NELSON			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
{F 226}	immediate reporting 3 of 5 residents (Rabuse prohibition. potential to affect a resided in the facility Findings include: The undated facility Abuse/Neglect Presuspect violations or reported to the sew which included state agency responsible Protection Services and Law Enforcem telephone call to the acceptable to meet reporting. The policy contains contiming of reporting needs to be immediately as a sustained a frate The facility failed to the SA. R15 was found lying 3/22/14, at 3:50 p.m.	use prohibition policies for g to the state agency (SA) for 15, R158, R56) reviewed for This deficient practice had the III 92 of 92 residents who ty. If y policy titled, Vulnerable Adult vention Plan, directed that all or abuse would be immediately eral persons or agencies ate licensing/certification are for surveying the facility, Adult as, the local/state Ombudsman ent Officials. A fax or e state agency would be at the requirement of immediate by identified verbal or written as will be made within 24 hours of the incident. However, the afflicting information about the to the state agency which diately. Secture to left hip following a fall. In immediately report the injury on the floor of her room on the floor of the room on the floor of the electric	{F 226	Vulnerable Adult Reporting Polic reporting injuries of unknown care injuries from an accident/incider to the state agencies immediated discovery of injury. All reportable will be reported immediately to the Administrator and/or Director of Residents R56 and R158 will have of unknown cause and/or injuried accident/incident reported immediately to the Administrator and/or Director of Resident R15 has expired. b. All residents of Knute Nelson potential to be affected by this preportable allegations will be repfacility policy. c. All licensed staff was trained completing the initial report to stand and injuries that result from an accident/incident immediately winjury is discovered. A step by signification procedure has been given to the staff to follow to do a report. The been instructed to notify the Adrand /or Director of Nursing when reportable injury has been disconinform of the injury and the reportable staff received the training that after the immediate initial report to the state of the start their investigation of the incident. Licensed staff has been instructed to follow the facility of Vulnerable Adult Reporting Policies.	nuse and on reported ally upon the injuries he injuries he injuries as from adiately. In have the ractice. All ported per injuries at the injuries at the injuries at the injuries at the injury or in a injury or inju		
	were no witnesses to have displacement left knee and large	h was in a high position. There to the fall. R15 was observed ent of the right hip, abrasion on bump on the right knee. R15 ergency room for evaluation of		Vulnerable Adult Abuse/Neglect been revised to reflect the chan licensed nurse reporting injuries unknown cause immediately up discovery of the injury to the sta	ges of the of		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245435	B. WING				? 02/2014
NAME OF F	PROVIDER OR SUPPLIER	2-10-100			STREET ADDRESS, CITY, STATE, ZIP CODE	04/0	02/2014
NAIVIL OF F	- NOVIDEN ON SUFFEIEN				20 12TH AVENUE EAST		
KNUTE N	IELSON				ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
{F 226}	R15 was admitted t fracture. The facility	ints of pain in the left hip area. o the hospital with a left hip reported the unwitnessed fall	{F 22	26}	agencies. d. On-going/ at least daily audits conducted of all incidents by the Di	rector	
	fracture. The facility reported the unwitnessed fall with serious injury to the SA. However, the report was received by the SA on 3/23/14, at 11:35 a.m., nineteen hours and forty five minutes after R15 experienced an unwitnessed fall with injury.				of Nursing and/or designee to ensuare following the facility s Vulneral Adult Reporting Policy, and that all of unknown cause and injuries fron accident/incident have been report immediately upon discovery to the	ole injuries n ed	
	10/1/13, identified Fincluded dementia a further identified R1 impairment, require mobility, transferring ambulate. Further, functional limitations and lower body. R1 (CAA), dated 10/4/1 history of cerebrova	15's annual Minimum Data Set (MDS), dated D/1/13, identified R15 had diagnoses which cluded dementia and depression. The MDS arther identified R15 had severe cognitive apairment, required extensive assistance with ability, transferring, toileting and did not ambulate. Further, the MDS identified R15 had anctional limitations in both sides of her upper and lower body. R15's Care Area Assessment DAA), dated 10/4/13, revealed R15 had a sistory of cerebrovascular accident (stroke), ementia, kyphosis (overcurvature of the thoracic			agencies and that the Administrato been notified immediately of the injincident. These audits will be taken Quality Assurance Committee for rand discussion. e. Completion date: 4/16/2014	r has ury or to the	
	CAA further identified required a total lift to and back. R15's fall 3/5/14, identified R1 related to the inability extensive assistance.	ed R15 did not stand and or transfer from bed to chair risk assessment, dated 5 was at high risk for falls ty to stand, the need for e with transfers and the use hypertension and depression.					
	utilize a total body li from bed to chair ar inability to ambulate revealed R15 utilize	ted 3/12/14, directed staff to ft for transferring the resident and back related to R15's at The care plan further and an electric recliner chair.					
	3/23/14 revealed:	655 NOI65 NOIN 3/19/14 IO					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED		
		245435	B. WING _			R /02/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		702/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
{F 226}	the floor on her back door and her feet to calling out, "help, he chair was in a high looked displaced, ri and complained of abrasion on her left transferred per ambed 4:40 p.m. The proguirector of nursing a notified at that time. At 11:02 p.m., the left that R15 had sustain fracture. Review of the facility 3/22/14 revealed R floor, yelling "HELP lift chair was in high there were no witner R15 had recent chain acute illness was the fall. Review of the report 3/23/14, revealed the SA at 11:35 a.m., notice the same content of the same content of the report 3/23/14, revealed the SA at 11:35 a.m., notice the same content of the report 3/23/14, revealed the SA at 11:35 a.m., notice the same content of the report 3/23/14, revealed the SA at 11:35 a.m., notice the same content of the report 3/23/14, revealed the SA at 11:35 a.m., notice the same content of the report 3/23/14, revealed the SA at 11:35 a.m., notice the same content of the report 3/23/14, revealed the SA at 11:35 a.m., notice the same content of the report 3/23/14, revealed the SA at 11:35 a.m., notice the same content of the report 3/23/14, revealed the SA at 11:35 a.m., notice the same content of the same content of the report 3/23/14, revealed the SA at 11:35 a.m., notice the same content of the same content of the report 3/23/14, revealed the same content of th	p.m., R15 was found lying on the with her head towards the owards the windows. R15 was elp" and the power recliner lift position. R15's right hip light leg was facing outward pain in the left hip and had an the knee. R15 was then coulance to the local hospital at the local hospital at the local hospital at the local hospital notified the facility lined a displaced left hip left		6}			
	forearm and leg, whinjury of unknown o	ee large bruises on her nich was determined to be an origin. The facility failed to the injuries to the SA.					

PRINTED: 05/16/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245435	B. WING				R 02/2014
NAME OF I	PROVIDER OR SUPPLIER			4	STREET ADDRESS, CITY, STATE, ZIP CODE 120 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG				Χ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 226}	diagnoses which in The MDS identified impairment and rec with mobility, transf and toileting. R158's nursing ass 3/13/14, directed st standing mechanical Review of R158's p following: On 3/24/14, at 9:58 forearm was measured as was dark purple in Two bruises were none measured 2.5 measured 4 x 3 cm. Review of R158's in revealed three bruis R158's bath. Left form dark purple in compartment of Two bruises on the 2.5 cm x 3 cm and cm. The report indicated the period of the compartment of the period of the compartment of the period of the peri	S revealed R158 had cluded dementia and anxiety. R158 had severe cognitive quired extensive assistance er from bed to chair, dressing istant care plan, dated aff to transfer R158 with a	{F 2:	26}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245435	B. WING		04	R /02/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		702/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 226}		bruises on her right hand and	(F 22	26}		
	•	etermined to be an injury of e facility failed to immediately the SA.				
	identified R56 had a severe cognitive im extensive assistant report dated 3/23/1 identified bruises at incident report date identified one dark that measured 2.4 apurple bruise on the	ange MDS dated 3/14/14, a diagnosis of dementia, had pairment and received se with all ADL's. R56's Bruise 4, indicated that staff first 7:00 a.m. The facility d 3/23/14, at 12:45 p.m. purple bruise on the right wrist cm x 3.8 cm, and one dark a right hand that measured 2.2 report indicated R56 was a bruises occurred.				
	unknown source to p.m., thirty five hou	HR56's bruises, as injuries of the SA on 3/24/14, at 5:16 ars and sixteen minutes after uises of unknown origin.				
	director of nursing (incident report was thirty five hours after unknown origin, the immediately because She confirmed the sent to the SA for R and R158's suspicite the reports were may possible, then state get to it, its always incident and reports were may be suppossible.	4/1/14, at 5:52 p.m. the (DON) confirmed R56's not reported to the SA until er identifying the injuries of en said it was not reported se "we knew it wasn't abuse." timing of the reports the facility at 15's injury of unknown origin ous bruises. The DON stated ade to the SA as soon as id, "Sometimes you just don't been reported that next day." id that it is her responsibility to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245435	B. WING				₹
NAME OF F	PROVIDER OR SUPPLIER	240400	D. WIIIG	ST 42	REET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST LEXANDRIA, MN 56308	U4/0	02/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
{F 226}	the facility policy dir immediately, within During interview on administrator stated incident to the SA w stated, "If we know suspicious area, or the state agency im then stated, "If the fon a resident and is report is made to the four hours." The ac	ting to the SA and also stated ected staff to report to the SA twenty four hours. 4/2/14, at 11:50 a.m. the definition the facility reports the initial vithin twenty four hours, then it is abuse, a bruise is in a neglect, the facility reports to mediately." The administrator facility feels its a small bruise is not in a suspicious area, the e state agency within twenty dministrator confirmed that it is ts are made to the SA within	{F 2.	26}			

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

Y4) Item	(Y5)	Date	(Y4) Item	(YE	i) Date	(Y4)	Item	(Y5)	Date
		Correction			Correction					Correction
ID Prefix	21000	Completed 03/21/2014	ID Prefix	21665	Completed 03/21/2014		ID Prefix	21685		Completed 03/21/2014
	MN Rule 4658.0610 Subp.	=		MN Rule 4658.1400				MN Rule 4658.1	415 Qub	
LSC	Mile 4030.0010 Subp.	•	LSC	WIN Rule 4030.1400	_		LSC	Wild Rule 4030. It	+13 3ub	<u></u>
		•								
		Correction			Correction					Correction
ID Prefix	21000	Completed 03/21/2014	ID Prefix	22000	Completed 03/21/2014		ID Prefix			Completed
		-								_
LSC	MN St. Statute 626.557 Sul	pa. 4	_	MN St. Statute 626.557 S	- 		Reg. # LSC			
		Correction			Correction					Correction
ID Prefix		Completed	ID Profix		Completed		ID Prefix			Completed
		-								
Reg. # LSC			Reg. #		_		Reg. # LSC			
		•			_					_
		Correction			Correction					Correction
ID Profix		Completed	ID Profix		Completed		ID Profix			Completed
ID Prefix		-			_		ID Prefix			
Reg. # LSC		-	Reg. # LSC		_		Reg. # LSC			<u> </u>
		Correction			Correction					Correction
ID Deafin		Completed	ID Drefin		Completed		ID Deefis			Completed
ID Prefix		-			_		ID Prefix			
Reg. # LSC			Reg. # LSC				Reg. # LSC			
					<u> </u>					<u> </u>
Reviewed By	Reviewed I	Зу	Date:	Signature of Surv	veyor:				Date:	
State Agency	MM/C	GA	04/14/201	4	31593				04	/02/2014
Reviewed By CMS RO	Reviewed I	Зу	Date:	Signature of Surv	eyor:				Date:	
Followup to	Survey Completed on: 2/14/2014				•			a Summary of to the Facility?	YES	NO
TATE EODA		5/99)	1	Page 1 of 1				Event ID: 6	SQ312	

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 6SQ3

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	THE STAT	E STATE SURVEY AGENCY Facility ID: 00113						
MEDICARE/MEDICAID PROVIDER N (L1) 245435 2.STATE VENDOR OR MEDICAID NO. (L2) 178540100	0.	3. NAME AND ADI (L3) KNUTE NEI (L4) 420 12TH AV (L5) ALEXANDR	SON ENUE EAST	TY	(L6) 56308		4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUF	PPLIER CATEGOR	Y 09 ESRD	<u>02</u> (1	L7) 22 CLIA	7. On-Site Visit 8. Full Survey After (9. Other Complaint
6. DATE OF SURVEY 02/14 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/ 2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	2	FISCAL YEAR ENDING	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	108 (L18) 108 (L17)	X B. Not in Com	quirements Based On: cceptable POC	n	2. T 3. 2. 4. 7	oroved Waivers Of The echnical Personnel 4 Hour RN -Day RN (Rural SNF) ife Safety Code B*	e Following Requirements:	vices Limit
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 108	19 SNF	ICF	IID		15. FACILITY 1861 (e) (1)	MEETS or 1861 (j) (1):	(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMARK See Attached Remarks	(L39)	(L42) HOW LTC CANCELL	(L43) ATION DATE):					
17. SURVEYOR SIGNATURE Tammy Williams, H	FE NEII	Date :	03/20/2014	(L19)		JRVEY AGENCY AP		Date: 04/21/2014 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	OFFICE OF	R SINGLE STAT	TE AGENCY	(120)
DETERMINATION OF ELIGIBILITY			IPLIANCE WITH O	CIVIL	2		ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCI	FA-1513)
22. ORIGINAL DATE OF PARTICIPATION 02/01/1987 (L24)	23. LTC AGREEMI BEGINNING (L41)		4. LTC AGREEMI ENDING DAT (L25)		VOLUNTARY 01-Merger, Cl	-	O INVOLUM 05-Fail to I	(L30) FTARY Meet Health/Safety Meet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44) (L45)			oluntary Termination on for Withdrawal	OTHER 07-Provide 00-Active	er Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C		(L31)	30. REMARK	S		
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION (DF APPROVAL DA	(L33)	DETERMI	NATION APPRO	VAL	

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00113

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5435

On February 14, 2014 an extended survey was completed. The facility was not in substantial compliance at the time of the survey. Conditions in the facility constituted Substandard Quality of Care (SQC) to residents health or safety. The facility has been given an opportunity to correct befor remedies have been imposed. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered March 7, 2014

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

RE: Project Number S5435025

Dear Ms. Urman:

On February 14, 2014, an extended 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 widespread isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), 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>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>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less

than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

<u>Informal Dispute Resolution</u> - 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:

Fergus Falls Survey Team Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health gail.anderson@state.mn.us

Phone: (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 March 26, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 26, 2014 the following remedy will be imposed:

• Per instance civil money penalty (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Knute Nelson is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective February 14, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division

> Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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 electronic acknowledgement signature of provider and date.

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 May 14, 2014 (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 August 14, 2014 (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 an ePoC 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_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: 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 pat.sheehan@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5435s14.rtf

PRINTED: 04/21/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245435	B. WING			02/14/2014	
NAME OF F	PROVIDER OR SUPPLIER			420	EET ADDRESS, CITY, STATE, ZIP CODE 12TH AVENUE EAST EXANDRIA, MN 56308	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	гs	F0	00			
F 225 SS=E	as your allegation of Department's acceptottom of the first puill be used as verification. Upon receipt of an revisit of your facility validate that substate regulations has been your verification. An extended survey was found to be in F226, due to failure prohibition policies to state agency allegates of unknown 483.13(c)(1)(ii)-(iii), INVESTIGATE/REFALLEGATIONS/INTEGATE/REFALLEGATION	c(c)(2) - (4) PORT DIVIDUALS In the employ individuals who have of abusing, neglecting, or the state nurse aide abuse, neglect, mistreatment appropriation of their property; whedge it has of actions by a than employee, which would or service as a nurse aide or to the State nurse aide registry ties. Insure that all alleged violations arent, neglect, or abuse, funknown source and	F 2	25			3/21/14
LABORATOR	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

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

Electronically Signed

03/13/2014

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		245435	B. WING		02/14/2014			
NAME OF F	PROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 120 12TH AVENUE EAST ALEXANDRIA, MN 56308				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION			
F 225	reported immediate facility and to other State law through e (including to the Stagency). The facility must haviolations are thoroprevent further pote investigation is in p The results of all into the administrator representative and accordance with St survey and certificate days of the incident	resident property are sely to the administrator of the officials in accordance with established procedures at early and certification are evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 225					
	by: Based on interview facility failed to thor instances of potent suspicious injuries agency (SA) and the 4 residents (R24, For 4 resident (R24) the administrator with prohibition. Findings include:	NT is not met as evidenced and document review, the roughly investigate and report ial neglect, mistreatment and of unknown origin to the state e facility administrator, for 4 of R70, R50 and R103) and for 1 failed to immediately notify ho were reviewed for abuse		F 225 a. For R24, this resident has expir For R50, R70 and R103 all further i of unknown cause or suspected about neglect or mistreatment, or injury froincident or accident will have an increport and a thorough investigation complete by the charge nurse and immanager. The DON and Administration be notified immediately. If the investigation determined that the rehas injuries of unknown cause or if suspected that abuse, neglect or	njuries use, om an ident will be nurse tor will sident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245435	B. WING		02/14/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
F 225	staff-assisted trans complete an individual selection of, and prosheet during his trathe lift manufacture plan for sling place facility failed to reponeglect of care to the R24's annual Minim 8/29/13, identified has cognition, did not a extensive assistant of daily living (ADLs Area Assessment (risk for falls, was unstabilize with staff a mechanical lift for the plan of care revised including demential kyphoscoliosis and identified R24 was for all ADLs and was care plan noted R2 physical limitations care plan goals incitalls or injuries. The person transfers utimechanical lift) and amputee transfer/lift in place while he werequest. Intervention how to position his when transferring volift.	ol/14/13, at 6:50 p.m., during a fer. The facility failed to lualized assessment for oper positioning for the lift insfers, as was instructed by an and failed to follow the care ment while in the chair. The port this incident of potential	F 225	mistreatment has occurred, or an sustained from an incident or accir report will be made to OHFC and b. All residents who have any injaccident or incident have the poter be affected. c. All staff will attend a mandator training on recognizing that injuries unknown causes, injuries that are sustained during an incident or accident to be reported immediately to DON, Administrator and OHFC/CE Licensed staff will receive training include that after the initial report is complete a thorough investigation the injuries of unknown cause and injuries from accidents or incidents what interventions need to be put place to keep residents safe from neglect or mistreatment. Will receive training on using the new assessm to determine the correct size of mechanical lift transfer slings that resident should be using. Staff will trained on following the plan of call each resident. The staff will be inson following Knute Nelson is Policincident and accident investigation reporting. d. Audits will be conducted daily incidents by DON/designee on producted that investigation and putting interventing place. The information from the investigation will be reviewed by the team daily Monday through Friday.	dent, a CEP. ury, ntial to y s from cident o the EP. that will staff will of all any s, and into abuse, ive nent tool each I be re for structed cy on as and with all ompt ons into

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F 225	9/14/13, at 6:50 p.r his recliner to his be slipped out of the lift head on the floor, with lift sheet. R24 of his head, and colleft-lower rib area anoted as grimacing inhaled. The note the fall as "lift sheet note dated 9/14/13 the emergency roof for evaluation and the fall. Review of R24's Fadocumentation of Frevealed the follow. Nursing assistated in his reclin lift sheet around his being transferred to lift, he slipped out of floor. NA-H documentation and indicanything at the time. NA-I identified staff placed the lift transferred, he slip noted, "He fell becard documented no recand indicated R24 at the time of the factorized was being transfed using the full-bed documented the factorized was being transfed using the full-bed documented the factorized was being transfed using the full-bed documented the factorized was being transfed using the full-bed documented the full-bed documented the factorized was being transfed using the full-bed documented the full-bed documented the factorized was being transferred to the factorized was being transferred was being transferred to the factorized was being transferred was being transferred was being tra	R24 fell in his room on m. while being transferred from ed. The note indicated R24 ft sheet, which resulted in his with his legs still entwined in suffered a laceration to the top implained of pain in the and lower back. R24 was and indicated pain when he identified the root-cause for it to [sic] small." A progress, identified R24 was sent to im via ambulance at 7:40 p.m. treatment of his injuries from all forms (the follow-up R24's fall) dated 9/14/13, ing: ant (NA)-H identified R24 was ing chair when staff placed the in. While he was in the air, of the bed with the mechanical of the lift sheet and fell to the ented no recent change in his lated R24 was not trying to do so of the fall. R24 was in his chair when sheet under him. As R24 was ped out of the lift sheet. NA-lates the sheet slipped." NA-latent change in his condition was not trying to do anything	F 2	looking at the cause, investive what interventions have been place. On weekends and he supervisor will review the intervention that occur, after her initial at the injury and if an injury of cause or suspected abuse, mistreatment or injury from accident is found the RN sureport immediately to the DC Administrator and OHFC/CI be done randomly on sling at to determine that the appropriate sare being used. If audicompliance, further educatic conducted and if indicated caction will occur. These auditaken to the Quality Assurar Committee for review and defended in the completion date in the comp	en put into blidays RN cident reports ssessment of unknown neglect or incident or will be disciplinary lits will be ince iscussion.		

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F 225	9/14/13, identified performed cathetel unusual actives or the three hours pricissues identified withe transfer technic lift sheet is to [sic] (DON) identified Ron 9/14/13, resulte for staples due to a diagnosis of thorac identified NA-I and transferring R24 with NA-I and NA-H we to remain under R2 larger lift sheet with was to be used for nurse (RN)-A identified were re-educated correct lift sheet siz lift sheet to R24, and the lift sheet to the Review of email conto the administrato identified R24 was to remain under him been removed, so him prior to use of identified, an unspellift sheet wasn't platas it should have be left side, he fell out indicated a larger state.	all Investigation Form dated that prior to his fall staff had reare and changed him. No behaviors were present during or to the fall. Environmental ere lighting and a concern with que detailed as "possible that small." The director of nursing 24's fall from the full body lift d in an emergency room visit a head laceration and sic contusions. The DON NA-H were the staff ith the use of a mechanical lift. The instructed the lift sheet was 24 at all times while up, and a nothree hooks on each side resident safety. Registered iffied LPN-A, NA-I, and NA-H, on the importance of using the ace, the correct way to apply the not the correct application of	F 2	25			

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F 225	R24, and should hashe did not feel the a report to the SA was a sistant director or R24 fell out of the fan emergency room contusions, and a hasheet was "too smaconfirmed the staff were re-educated a stated this was a "reshould have been so During an interview administrator confire 9/14/13, and that all was provided. The was immediately not administrator was redid not have a lift sistent which was to transfer. The administrator was redid not have a lift sistent which was to transfer. The administrator was redid not have a lift sistent which was to transfer. The admininvestigated the incomposition of the extent of the R70 alleged she was multiple, large bruist However, facility fair R70's allegation of the allegation and part of the side of the side of the side of the allegation and part of the side	ave been used. DON noted staff were in error. Therefore, was not necessary. If on 2/13/14, at 1:30 p.m. the finursing (ADON) confirmed ull-body lift, which resulted in notice, it is investigation was determination was that the lift all." The ADON further involved with this incident after the fall. The ADON eportable" incident, and submitted to the SA. If on 2/14/14, at 10:02 a.m. the med R24's care plan, fall on all documentation of the fall administrator confirmed she of the reason R24 heet under him, or why a lift of small was used during the histrator confirmed the DON cident the following day and of our fault." Therefore, it was 1:26 a.m., the administrator tripling the retable to the SA, depending	F 22	25		

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	245435	B. WING _		02/	14/2014
NAME OF PROVIDER OR SUPPLIER KNUTE NELSON			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308	•	
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
wheelchair for mobility. Review of R70's medical following: An incident report or identified a bruise which centimeters (cm) by 7.5 (left hand, below her indereport described the bruidark-blue. R70 lacked th source of the bruise. The identified the facility's iminstruct R70 on the place going through doorways, keep her arm protectors were documented, with scause of the bruise. Progress notes from the at 5:31 p.m. analyzed the bruise and noted that R7 hands on her wheelchair The incident report confinadministrator was immed No further investigation verport of the large, bruise the SA.	ted 12/26/13, identified ading dementia, renal MDS revealed R24 was aired and required h bed mobility, dressing also noted R70 utilized a I record revealed the 1/25/14, at 5:12 p.m. measured 7.5 cm to the back of R70's ex finger and thumb. The ise as purple to be ability to report the exincident report mediate response was to ement of her arms when and encourage her to on. Interviews with NAs staff opinions of potential LPN-B, dated 1/25/14, the possible cause of the ror personal lift handles. The ror personal lift handles armed the facility diately notified. Was completed. No end area was submitted to 1/31/14, at 1:32 p.m.	F 22	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
245435 B. WING	02/14/2014	
NAME OF PROVIDER OR SUPPLIER KNUTE NELSON STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	BE COMPLÉTION	
F 225 Continued From page 7 cm by 4.5 cm on the back of R70's right hand, below her index finger and thumb. The bruise was purple to dark-blue and slightly swollen. The incident report identified R70 reported someone had grabbed her hands in the night. The report also noted the first bruise on R70's left had had increased to nine by three cm and had become slightly swollen. The incident report confirmed the facility administrator was immediately notified. A typed note signed by RN-A, dated 1/31/14, addressed the allegation of mistreatment. The note revealed interviews with NAs were conducted, with staff opinions of possible causes for the bruising. The note identified that upon re-interview, R70's report varied. R70 did not identify it was a staff member who caused the bruise and given R70's cognitive impairment, the conclusion was that R70 likely bumped her hand on the side rail of her bed. However, the notes did indicate R70 was consistent in her complaint that someone had grabbed her. RN-A and LPN-D returned to R70's room on 1/31/14, at 1:45 p.m. for further follow-up to the allegation, during which the notes identified R70 "did not mention" someone had grabbed her. The facility failed to notify the SA of R70's allegations of mistreatment and her injury of unknown origin. An incident report on 2/3/14, at 10:36 p.m. revealed two additional bruises to the front of R70's right elbow. One bruise measured 9.5 cm by 7 cm and was light, to dark-purple in color. The other bruise was two by two cm and light-purple in color. The incident report identified that R70 stated she must have bumped it on something. The immediate action taken was for		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y4) PROVIDER/SURBILIER/GUA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		DNSTRUCTION		E SURVEY IPLETED
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F 225	Progress notes date indicated R70's phy supervisor were not not indicate notificate administrator. Though these were identified on R70 in facility had no evide bruising to the SA. lacked evidence to administrator was in bruising discovered. During interview on administrator stated investigation complibruises were explain history of bruises, because investigation of substantiated, then not trust men, so we room." The administrator have gone into of the night, as they much as possible. Staff did not want to behaviors, because night. The administracility did not repormistreatment and in the SA. On 2/14/14, at 10:2	indicate the facility of these bruises. ed 2/3/14, at 10:34 p.m. visician, family and nursing tified. However, the notes did tion was made to the facility the third and fourth bruises a span of ten days, the ence of having reported the R70's medical record also indicate the facility mmediately notified of the 1 on 2/3/14.	F 2	25			

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F 225	R70, and R70's cor stated R70 was coo different stories reg bruising. RN-A furth considered the incidence of the investigate the bruibruising to the SA. R50's annual MDS diagnoses including disease and demer cognition. R50's C. R50 had a history of his ability to common memory problems An incident report of a.m. identified two noted on his right be and measured ten bruise was on R50'cm by 7 cm, and was R50 lacked the abilitheses bruises. Or days after the large and elbow were identified the incident report of how the bruising of indicated the bruise furniture or doorwal confirmed the facilitimmediately notified.	implaint of mistreatment. RN-A gnitively impaired and had parding the cause of the ner indicated the facility dents not reportable. very large bruises with no facility failed to thoroughly sing and failed to report the dated 11/27/13, identified grathritis, peripheral vascular natia, with severely impaired AA dated 11/27/13, identified of dementia which impacted unicate his needs and had do r R50, dated 9/10/13, at 6:15 bruises. One bruise was incep area, "black and blue," by nine cm. The second s right elbow, measured 15 as noted as the same color. Ity to report the cause of a 12/6/13 (two months and 25 as, bruised areas on R50's arm entified), a note was added to which indicated R50 knew courred. The revised report as were "possibly related to ys." The incident report ty administrator was	F 22			

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F 225	tree (part of R50's r hand-written note d "Unexplained bruist denies staff abuse. investigation no about The investigation in interviews with NAs possible cause of the unknown. No further investigation completed. There is bruising was report. R103's quarterly Minim with diagnoses of falls, and anemia R103 was severely CAA dated 1/29/14 with communication dementia. The CAA for facility staff to lo determine his need. An incident report of identified a "red-pur 14 by seven cm on A "blue-purple" bruisty 8 cm was also nextending to his up (one month and 11 areas were identified incident report and of self-transfers and staff. The incident	of unknown origin decision medical record) included a lated 9/11/13, which read, es, right upper arm and elbow, Upon review and use or neglect suspected." Included evidence of three involved with R50. The me bruising was identified as a lation of R50's bruising was was no evidence that R50's ed to the SA. DS dated 11/6/13, identified including dementia, a history in the MDS also identified cognitively impaired. The identified R103 had difficulty in due to the progression of his A instructed it was necessary ok for non-verbal cues to	F 22			

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NAME OF F	PROVIDER OR SUPPLIER			4	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST LEXANDRIA, MN 56308	, 32	
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F 225	Continued From pa	ge 11	F 2	25			
	LPN-B, indicated the bruises was R103's combativeness. The evidence of three in	e investigation included nterviews with NAs involved ssible causes for the bruising					
	provided for R103's	e of an investigation was bruising. There was no 's bruising was reported to the					
	aware of the bruise	11 a.m. RN-A verified she was s on R50 and R103. RN-A e facility considered the able.					
	bruising on R50 and	p.m. the ADON confirmed d R103. The ADON further cidents had not been reported					
	used by the facility) of Minnesota, unda an injury of unknow source could not be and the injury was sextent or location. I document, directed unknown origin be in SA. Review of the facility Abuse/Neglect Previdentified the purpo	of Unknown Source (a tool of prepared by Care Providers ted, identified the definition of the source, which included the explained by the resident, suspicious because of the The "decision tree" on the suspicious injuries of immediately reported to the ty's Vulnerable Adult vention Plan dated 11/11, se of the policy was to protect dependent on others for their					

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F 225	care and to provide policy included defi source such as the incidence of injuries defined suspicious significant size any unexplained.	a safe environment. The nitions of injuries of unknown extent of injury or the sover time. The policy further bruising included a bruise of place on the body that was	F 2			
	policies and proced mistreatment, negle	ETC POLICIES Evelop and implement written	F 2	26		3/21/14
	by: Based on interview facility demonstrate implement their abuimmediate reporting 4 of 4 residents (R2 reviewed for abuse potential to affect a resided in the facilitimplement their pol to the facility admin (R70) and thorough residents (R70, R50 of mistreatment and unknown origin. Findings Include: Review of the facility	and document review, the ed a systematic failure to use prohibition policies for to the state agency (SA), for 24, R70, R50 and R103) prohibition. This had the II 98 of 98 residents who by. The facility also failed to icies for immediate reporting istrator for 1 of 4 residents investigating for 3 of 4 of and R103) with allegations door suspicious injuries of		a. Knute Nelson will put into system to ensure that the facil following their abuse prohibition immediate reporting injuries of cause and injuries that are sust because of an incident or accissuch injuries will be immediated to the DON and Administrator, immediately reported to OHFO b. All the residents of Knute have the potential to be affected Knute Nelson staff will follow the prohibition policy for all the residents of the facility. c. All staff will attend a mand training on recognizing that injunknown causes, injuries that	ity is on policy for funknown stained dent. All ely reported and CEP. Nelson ed by this. heir abuse sidents of latory uries, from	

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F 226	suspected or potent neglect and suspiciorigin to the SA. R R70, R50 and R10. The facility's Vulner Prevention Plan Posuspected violation neglect, injuries of and all substantiate reported immediate policy included defisource such as the incidence of injuries defined suspicious significant size any unexplained. During interview or administrator describing allegation injuries of unknown administration determistreatment and into be reported to the facility's completed stated if the investig substantiating evide it to the SA. The acfacility decided to not the review of a contiming of the notification how quick the facility investigation. During interview or a contiming of the notification of the not	icy for immediate reporting of tial incidents of mistreatment, ous bruising of unknown eview of incidents for R24, 3 supported these findings. Table Adult Abuse/Neglect blicy dated 11/11, directed all so, including mistreatment, unknown source or abuse; and incidents of abuse be bely to the appropriate SA. The nitions of injuries of unknown extent of injury or the sover time, the policy further bruising included a bruise of place on the body that was a 2/13/14, at 11:40 a.m. the libed the facility's system for sof mistreatment, neglect and a origin. She stated that facility rmined whether allegations of injuries of unknown origin were e SA, after reviewing the internal investigation. She	F 226	sustained during an incident or acceded to be reported immediately to DON, Administrator and OHFC/C Training will include that after the report staff will complete a thorous investigation of all injuries of unknown cause and any injuries from incident/accidents and what intervenced to be put into place to keep residents safe from abuse, negled mistreatment. The information froinvestigation will be reviewed by the team daily Monday through Friday looking at the cause, investigation what interventions have been put place. All nursing staff will attend of proper transferring techniques resident handling and positioning decrease the potential of resident On weekends and holidays the R supervisor will review the incident that occur, after her initial assessing the injury or incident/accident and determined that it needs to be reposited that it needs to be reposited that the DON and Administrator and immediately report to OHFC and Following Knute Nelson is policy Federal and State Regulations, as suspected abuse and neglect will reported immediately to the DON Administrator and immediately to the DON Administrator and immediately to the DON Administrator and immediately to the DON reposition of the policies are being followed prohibits mistreatment, abuse and neglect. These audits will be taken the policies are under the taken the policies.	to the EP. initial ghown ventions at or m this he IDT v. and into training and safe to injury. Note that it is ported, by reports and OHFC / all ignee to it that it	

AND DLAN OF CORRECTION INDENTIFICATION NUMBER:				E SURVEY PLETED		
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308	. ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	the facility's system mistreatment, negle origin. She reported righ an allegation of rou unknown origin, the was started. The creviewed by the ad (DON) and ADON. decided whether it an investigation wa then reported the ir indicated they repowithin 24 to 48 hou it could have taken investigation to be the SA was not not determination of suring interview on licensed social wor facility's system for mistreatment, negle origin. She stated to "comprehensive involved mistreatment. A "comprehensive invadministrator decid substantiated or no allegation was substo the SA within 24 R24 experienced a mechanical lift on 9 staff-assisted transcomplete an individual selection of, and principles.	a for handling instances of ect and injuries of unknown of that if abuse was witnessed, it away to the SA. If there was gh treatment or an injury of en an internal investigation completed investigation was ministrator, director of nursing. After the investigation, they was substantiated or not. If it is substantiated, the facility incident to the SA. The ADON orted to the SA, "hopefully" in the ADON confirmed that several days for an completed and reviewed and iffied until after the investigation instances of ect and injuries of unknown the facility completed a vestigation" for all allegations are completion of the vestigation," the DON and the ed whether an allegation was it. LSW reported if the estantiated, it was then reported	F 22	Quality Assurance Committee f and discussion. Continual train occur for staff that provides dire All incident reports will be revie Administrator with the DON. e. Completion date: 3/21/14	ing will ect care.	

AND DI AN OF CORRECTION I DENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	E SURVEY MPLETED			
		245435	B. WING		02	/14/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 226	the lift manufacture this incident of pote R24's annual Minim 8/29/13, identified rimpairment, did not extensive assistance of daily living (ADLs Area Assessment (risk for falls, he was to stabilize with stat R24's plan of care rediagnoses including sclerosis, kyphosocon The care plan ident upon staff for all AD weight. The care putilizing a maxilift (findirected staff to use and to leave the shis recliner, per R2 included showing Review of progress identified R24 fell in p.m. while being trahis bed. The note in the lift sheet, which floor, with his legs so R24 suffered a lace and complained of and lower back. R2 and indicated pain identified the root-coto [sic] small." A profile R24 suffered a lace and complained of and lower back. R2 and indicated pain identified the root-coto [sic] small." A profile R24 suffered a lace and complained of and lower back. R2 and indicated pain identified the root-coto [sic] small." A profile R24 suffered a lace and complained of and lower back. R2 and indicated pain identified the root-coto [sic] small." A profile R24 suffered a lace and complained of and lower back. R2 and indicated pain identified the root-coto [sic] small." A profile R24 suffered a lace and complained of and lower back. R2 and indicated pain identified the root-coto [sic] small." A profile R24 suffered a lace and complained of and lower back. R2 and indicated pain identified the root-coto [sic] small." A profile R24 suffered a lace and complained of and lower back. R2 and indicated pain identified the root-coto [sic] small." A profile R24 suffered a lace and complained of and lower back. R2 and indicated pain identified the root-coto [sic] small." A profile R24 suffered a lace and complained of and lower back. R2 and indicated pain identified the root-coto [sic] small."	r. The facility failed to report ential neglect of care to the SA. num Data Set (MDS) dated moderate cognitive ambulate and required se of two staff for all activities s.). The corresponding Care CAA) identified R24 was at sunsteady and was "only able ff assistance." Review of revised 9/14/13, identified g dementia, arthritis, multiple bliosis and osteoarthrosis. ified he was totally dependent DLs, and was unable to bear lan directed 2 staff transfers ull body mechanical lift) and an amputee transfer/lift sheet eet in place while he was in 4's request. Interventions 824 how to position his body et when transferring with the	F 2	.26		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245435	B. WING _		02	/14/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	Review of R24's Fadocumentation of Revealed the following assistated in his reclinicities seated in his reclinicities anything at the time condition and indicated reclinicities anything at the time of the fall because of R24 was being transped out of the lift the floor. Review of R24's Fall from the fall because identified we the three hours pricing issues identified we the transfer techniquist sheet is to [sic] selection an emerical selection of the fall from th	40 p.m. for evaluation and uries from the fall. Ill forms (the follow-up (24's fall) dated 9/14/13, ng: ant (NA)-H identified R24 was ng chair when staff placed the n. While he was in the air, of the bed with the mechanical of the lift sheet and fell to the ented no recent change in his ated R24 was not trying to do to of the fall. R24 was in his chair when sheet under him. As R24 was ped out of the lift sheet. NA-lause the sheet slipped." NA-lent change in his condition was not trying to do anything	F 22	26		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y4) PROVIDER/SURBILIER/GUA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245435	B. WING _		02	/14/2014
NAME OF PROVIDER OR SUPPLIER KNUTE NELSON				STREET ADDRESS, CITY, STATE, ZIP COD 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	thoracic contusions NA-H were the staf of a mechanical lift instructed the lift shat all times while up three hooks on each resident safety. Residentified LPN-A, Note-educated on the correct lift sheet siz lift sheet to R24, and the lift sheet to the Review of email conto the administrator identified R24 was to remain under himbeen removed, so shim prior to use of identified, an unspellift sheet wasn't plat as it should have build left side, he fell out indicated a larger seach side, would have build left side, and should have build left sheet wasn't plat as it should have build left side, would have build left side, and should have build left side, an	is. The DON identified NA-I and if transferring R24 with the use. NA-I and NA-H were neet was to remain under R24 or, and a larger lift sheet with the side was to be used for registered nurse (RN)-A A-I, and NA-H, were importance of using the rest, the correct way to apply the rest of the correct application of full body lift. Trespondence from the DON redated 9/15/13, at 4:00 p.m. care planned for the lift sheet in. However, the sheet had staff placed a lift sheet under the lift. The e-mail further recified NA "felt that maybe the ced as evenly on both sides een, so when he leaned to the of the sheet." The NA also heet, one with three hooks on ave been "much safer" for ave been used. DON noted staff were in error. Therefore, was not necessary. To n 2/13/14, at 1:30 p.m. the reconstructions, and a head oles. The ADON stated an	F 2:	26		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X4) PROVIDER/SURPLIED/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER KNUTE NELSON				STREET ADDRESS, CITY, STATE, ZIP COE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	incident, and should SA. During an interview administrator confir 9/14/13, and that all was provided. The was immediately not administrator was redid not have a lift sistent which was to transfer. The adminitration investigated the incide emed it to be "not reported. At 11 indicated a resident care plan was repoupon the extent of the R70 alleged she was multiple, large bruis However, facility fa R70's allegation of the allegation and pand failed to consist	I stated this was a "reportable" d have been submitted to the on 2/14/14, at 10:02 a.m. the med R24's care plan, fall on I documentation of the fall administrator confirmed she of the fall administrator confirmed she of the reason R24 heet under him, or why a lift o small was used during the histrator confirmed the DON dident the following day and our fault." Therefore, it was :26 a.m., the administrator tinjury due to not following the rtable to the SA, depending	F 2.	· ·		
	she had diagnoses failure and anemia severely cognitively extensive assistant	S dated 12/26/13, identified including dementia, renal The MDS revealed she was a impaired and required se with bed mobility, dressing MDS also noted R70 utilized a ility.				
	Review of R70's motion following:	edical record revealed the				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X4) PROVIDER/SURPLIED/CLIA

	A. BUILDING	
245435 B. WING		02/14/2014
KNUTE NELSON	EET ADDRESS, CITY, STATE, ZIP CODE 12TH AVENUE EAST EXANDRIA, MN 56308	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 226 An incident report on 1/25/14, at 5:12 p.m. identified a bruise which measured 7.5 centimeters (cm) by 7.5 cm to the back of R70's left hand, below her index finger and thumb. The report described the bruise as purple to dark-blue. R70 lacked the ability to report the source of the bruise. The incident report identified the facility's immediate response was to instruct R70 on the placement of her arms when going through doorways, and encourage her to keep her arm protectors on. Interviews with NAs were documented, with staff opinions of potential cause of the bruise. Progress notes from the LPN-B, dated 1/25/14, at 5:31 p.m. analyzed the possible cause of the bruise and noted that R70 likely bumped her hands on her wheelchair or personal lift handles. The incident report confirmed the facility administrator was immediately notified. No further investigation was completed. No report of the large, bruised area was submitted to the SA. An incident report on 1/31/14, at 1:32 p.m. identified a second bruise which measured 4.5 cm by 4.5 cm on the back of R70's right hand, below her index finger and thumb. The bruise was purple to dark-blue and slightly swollen. The incident report identified R70 reported someone had grabbed her hands in the night. The report also noted the first bruise on R70's left had had increased to nine by three cm and had become slightly swollen. The incident report confirmed the facility administrator was immediately notified. A typed note signed by RN-A, dated 1/31/14,		

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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 420 12TH AVENUE EAST ALEXANDRIA, MN 56308			
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F 226	for the bruising. The re-interview, R70's identify it was a state bruise and given R conclusion was that on the side rail of hidd indicate R70 was that someone had LPN-D returned to 1:45 p.m. for furthed during which the normal mention someone. The facility failed to allegations of mistrunknown origin. An incident reprevealed two additical R70's right elbow. By 7 cm and was light-purple in color that R70 stated she something. The im R70's bed rails to be lacked evidence to administrator was in Progress notes datindicated R70's physupervisor were not indicate notifical administrator. Though these were identified on R70 in facility had no evidence in the state of the state	off opinions of possible causes a note identified that upon report varied. R70 did not ff member who caused the 70's cognitive impairment, the t R70 likely bumped her hand er bed. However, the notes as consistent in her complaint grabbed her. RN-A and R70's room on 1/31/14, at r follow-up to the allegation, otes identified R70 "did not had grabbed her. onotify the SA of R70's eatment and her injury of ort on 2/3/14, at 10:36 p.m. onal bruises to the front of One bruise measured 9.5 cm ght, to dark-purple in color. as two by two cm and the must have bumped it on mediate action taken was for the padded. The incident report identified the padded. The incident report	F 22	6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 226	During interview on ADON stated she withorough investigated bruising, but verified the SA. During interview on administrator stated investigation complibruises were explainistory of bruises, because the allegation of substantiated, then not trust men, so without rousing the night, as they much as possible. Staff did not want to behaviors, because night. The administration facility did not report into substantiated. On 2/14/14, at 10:2 aware of the repeat R70, and R70's constated R70 was cooldifferent stories regibruising. RN-A further states and the same a	indicate the facility mmediately notified of the l on 2/3/14. 2/12/14, at 2:30 p.m. the vas certain the DON did a ion of R70's allegation and d she did not report either to 2/13/14, at 11:40 a.m. the	F 23	26				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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F 226	R50 and R103 had known cause. The investigate the bruibruising to the SA. R50's annual MDS diagnoses including disease and demer cognition. R50's C. R50 had a history on his ability to common memory problems An incident report ff a.m. identified two noted on his right be and measured ten bruise was on R50'cm by 7 cm, and w. R50 lacked the abil theses bruises. The facility administ On 12/6/13 (two molarge, bruised areas were identified), a report which indicate bruising occurred. The bruises were "progress notes date identified the cause Review of an injury tree (part of R50's in hand-written note of the service	very large bruises with no facility failed to thoroughly sing and failed to report the dated 11/27/13, identified garthritis, peripheral vascular hia, with severely impaired AA dated 11/27/13, identified of dementia which impacted unicate his needs and had or R50, dated 9/10/13, at 6:15 bruises. One bruise was icep area, "black and blue," by nine cm. The second s right elbow, measured 15 as noted as the same color. ity to report the cause of e incident report confirmed rator was immediately notified. on this and 25 days after the son R50's arm and elbow note was added to the incident ted R50 knew how the The revised report indicated ossibly related to furniture or ed 9/10/13, at 6:23 a.m. of the bruises was unknown. of unknown origin decision medical record) included a lated 9/11/13, which read, es, right upper arm and elbow,				

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		245435	B. WING			02/	14/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT 420 12TH AVENUE EA ALEXANDRIA, MN	AST	•		
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F 226	investigation no about The investigation in interviews with NAs possible cause of the unknown. No further investigated completed. There is bruising was reported. The CAR dated 1/29/14 with communication dementia. The CAR for facility staff to lod determine his need. An incident report of identified a "red-purple" bruising was also nextending to his upple (one month and 11 areas were identified incident report and of self-transfers and staff. The incident administrator was in A progress note dat LPN-B, indicated the bruises was R103's combativeness. The	use or neglect suspected." Included evidence of three is involved with R50. The me bruising was identified as ation of R50's bruising was was no evidence that R50's ed to the SA. DS dated 11/6/13, identified including dementia, a history in the MDS also identified cognitively impaired. The identified R103 had difficulty indue to the progression of his A instructed it was necessary ok for non-verbal cues to see the back of R103's left hand. If the back of R1	F 2	26				

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F 226 F 323 SS=G	with R103, with posidentified as combained as combained as combained and combained are reported aware of the bruise further indicated the incidents not reported on 2/14/14, at 4:21 bruising on R50 and confirmed these indicated the SA. No further evidence provided for R103's evidence that R103's eviden	sible causes for the bruising ativeness. 11 a.m. RN-A verified she was son R50 and R103. RN-A e facility considered the able. p.m. the ADON confirmed d R103. The ADON further cidents had not been reported e of an investigation was a bruising. There was no as bruising was reported to the of Unknown Source (a tool of prepared by Care Providers ted, identified the definition of an source, which included the explained by the resident, suspicious because of the The "decision tree" on the suspicious injuries of immediately reported to the EACCIDENT	F 2			3/21/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245435	B. WING		02/1	4/2014
NAME OF I	PROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 25	F 323			
	by: Based on observar review, the facility findings and care followed to minimiz residents (R24) review addition the facility assessment had be resident (R223) who This practice result. Findings include: According to review (closed record) expendentical lift during a reclining chair to The facility had not instructions for indivisit sheet and care plan transfer for R24. R2 the head, which received the left chest wall, as Review of R24's mental diagnoses which multiple sclerosis (kyphoscoliosis (abroof the upper spine) annual Minimum Daidentified R24 had impairment, had imupper and lower be	tion, interview and document ailed to ensure manufacturer's plan interventions were e the risk of injury for 1 of 4 iewed for accidents. In failed to ensure a safety een completed for 1 of 1 or utilized an ill-fitting mattress, ed in actual harm for R24. If of nurses' notes, R24 perienced a fall from a full bodying staff assisted transfer from a bed on 9/14/13, at 6:50 p.m. followed the manufacturer's vidualized assessment of the proper positioning of the lift in interventions during the 24 sustained a laceration to quired staples, a contusion to and lower back pain. Redical record identified R24 ch included dementia, arthritis, degenerating nerve disease), normal curvature front to back and osteoarthrosis. The ata Set (MDS) dated 8/29/13, moderate cognitive pairments on both sides of ody and did not ambulate. The required extensive		F 323 a. For R24, resident has expired, resident has been discharged. b. All residents have the potential affected. c. All staff will receive education of ensuring that the resident is environ remains as free of accident hazard possible. Licensed nursing staff will trained on completing a new assess tool that has been developed for all residents who use full mechanical appropriate sling size. Resident caplans will be reviewed by the nursing assistants prior to providing care. Anursing staff will attend an in-service training on reading and following the forcare. All staff will be trained on a safety assessment tool that has be developed and will be completed be Environmental Services on each be when a resident discharges and the is being prepared for a new resident the staff will do a safety assessment is completed. d. Audits will be put into place to monitor that facility is kept free of a hazards. DON or designee will do a audits that mechanical sling assessare being completed and that approsize slings are being used for resident is serviced and that approsize slings are being used for resident is serviced and that approsize slings are being used for resident is serviced.	al to be on onment s as is I be esment I lifts for re ng All ce ne plan new en y ed that e bed nt that nt to e bed ess is accident random sments opriate	

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F 323	assistance of 2 star (ADL), including tratoileting. The Care dated 9/3/13, identitall and weighed 22 problems, required oxygen for episode Further, the MDS id assistance with AD transferred with AD transferred with assistance with AD transferred	ff for all activities of daily living insfers, bed mobility and Area Assessment (CAA), fied R24 was 5 feet 8 inches 20 pounds, had memory verbal reminders, and utilized s of shortness of breath. Identified R24 required Ls and mobility and was sist from two staff and a full lift. Vised 9/30/13, identified a transferring with a goal for sfers with no falls or injury. Ited two person transfers ull body mechanical lift), and transfer/lift sheet for transfers. If the trying to place lift in time to transfer to bed. Is notes from 9/14/13, to R24's fall in room on 9/14/13, to R24's fall in room on 9/14/13, peing transferred from recliner dicated R24 slipped out of the in his head landing on the floor ned in the lift sheet. R24 had a up of his head, complained of the interest of	F 32	that transfer with mechanic designee will do random a that the care plans are bein and followed prior to provide interviewing staff and obsest Environmental services will audits that each resident be mattress that matches the These audits will be taken Assurance Committee for discussion. e. Completion date: 3/21	udits to ensure ng reviewed ding cares, by erving cares. Il do random led has a bed length, to the Quality review and	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	documentation date slipped out of the li of his head on a drupper chest on the pain, and bilateral (new lower back paincluded x-rays of staples placed for tlaceration and a na ordered for R24's p. Review of the follow from the lift, comple personnel revealed - Nursing assistant seated in his reclinisheet around R24 abeing transferred to mechanical lift, he fell to the floor. Nachange in R24's contrying to do anythin - NA-I identified R2 placed the lift sheet transferred he slipped documented "he fence transferred he slipped documented "he fence transferred he slipped outpet to his bed using the when he slipped outpet	ed 9/14/13, identified R24 had ft, fallen, hitting the right side esser and hitting the right floor. R24 complained of head both sides) lower rib pain, and in. Emergency room treatment the head, spine, abdomen, he three centimeter (cm) head recotic pain medication was eain. W up documentation of the falleted by involved facility the following: (NA)-H identified R24 was ing chair, staff placed the lift and while R24 was in the air of the bed, with the use of the slipped out of the lift sheet and the documented no recent rediction, and R24 had not been	F 3.	23		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245435	B. WING _		02	/14/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	The form included a transfer technique I "possible that lift sharm included a transfer technique I "possible that lift sharm included a transfer technique I "possible that lift sharm included in staples placed for a diagnosis of thorac identified R24 did in him, so the lift sheet was in the recliner. R24 with the mechasome on the left sid down and continue noted to lean to the near the bed, R24 is sheet to the floor. Tafter the fall, NA-I a lift sheet was to remain up, and a largeach side was to be Registered Nurse documentation date NA-I, and NA-H, we importance of correway to apply the lift application of the lift However, the facilitiall nursing staff were selection and position of the facinursing (DON) to the 9/15/13, at 4:00 p.m. included the need for the state of the s	sent 3 hours prior to the fall. an identified concern with had been documented as seet is to small." Ising (DON) documentation of 24's fall from a full body lift on an emergency room visit for a head laceration and ic contusions. The DON so thave the lift sheet under at had to be placed while R24 NA-I and NA-H started to lift anical lift, his buttock was out the of the lift, they pulled it d with the transfer. R24 was a right and as he was moved moved and slid out of the lift. The documentation indicated and NA-H were instructed the main under R24 at all times ger lift sheet with 3 hooks on a used for resident safety. (RN)-A's fall follow up and 9/19/13, identified LPN-A, are re-educated on the ext lift sheet size use, correct a sheet to R24, and the correct as the to the full body lift. By lacked documentation that are educated on the proper size.	F 32			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X4) PROVIDER/SURPLIED/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	RIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245435	B. WING		02	/14/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	ifft. The e-mail furth maybe the lift shee both sides as it she leaned to the left si The e-mail indicate sheet, one with thre be used as it would Review of the mediarea assessment (R24 utilized a full b transfers, however documentation of a sizing or type for R proper sling use or medical record. During interview or assistant director or R24's care plan and while transferred w resulted in injury for investigation had be determined the lift of ADON further confit this incident were resulted in injury for investigation had be determined the lift of ADON further confit this incident were resulted in use of a lift of RN-A was not award was used during Right aware why a lift she been used. RN-A cassessments for lift She stated she was	inder him prior to use of the per identified the "NA felt that the wasn't placed as evenly on ould have been so when he de he fell out of the sheet." It wasn't placed as evenly on ould have been so when he de he fell out of the sheet." It was the waste of the NA stated a larger see hooks on each side should he "much safer" for R24. I cal record revealed the care CAA) dated 9/3/13, identified ody mechanical lift for the record lacked in assessment for lift sheet 24. No further assessments of sizing was found in the four assessment for lift sheet 24. No further assessments of sizing was found in the four mursing (ADON) confirmed do confirmed R24 had fallen with the full body lift, which it R24. The ADON stated an		23		

AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245435	B. WING _		02	/14/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	sheets used for transtaff member included once the lift sheet or room for use, the lift it needed launderin physical therapy we use of the mechanical thousever, therapy we specific size of lift some residents. RN-A stainvolved with R24's sheet for each residents apply a lift sheet. Sompleted an annumechanical lift use unaware of how the determined and stacoded." During interview on administrator confirming of the fall, and investigation of the not aware of the resident under him or small had been use administrator confirmed the manual stated the DON follow up of the fall. During interview on confirmed the manual and Positioning Application Guide, it is the state of the resident of the fall.	Indicated the individual lift insfers were chosen by any ding the nursing assistants. It is sheet remained there unless in the sheet remained there unless in the sheet for the individual atted she instructed staff is fall on the proper size lift indicated all nursing staff all competency review of a size of the lift sheets were inted, "I think they are color in 2/14/14, at 10:02 a.m. the sheet for the findings in the fall. The administrator was ason R24 did not have a lift why a lift sheet which was too and during the transfer. The sheet which was too and during the transfer. The sheet which was too and the current facility policy in was responsible for the and had done so. 1.2/14/14, at 11:03 a.m. LPN-E unfacturer's guidelines for lift in Instructions & Sling and stated these were in a him mechanical lift, to be	F 32	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(COMPLETED	
		245435	B. WING			02/14	/2014
	KNUTE NELSON (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 31 During interview on 2/14/14, at 12:23 p.m. the ADON confirmed she would expect the manufacturer's guidelines for mechanical lift us were to be followed by all staff. The ADON confirmed staff were expected to follow care plinterventions. Review of the product information provided by the facility revealed the manufacturer's guideling from T.H.E. Medical, professional patient care products titled Sling Models and Specifications listed various models for use with sizing and			STREET ADDRESS, CITY, STATE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308	, ZIP CODE		
PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFI TAG		ACTION SHOULD E O THE APPROPR	BE C	(X5) COMPLETION DATE
F 323	During interview on ADON confirmed sl manufacturer's guid were to be followed confirmed staff were interventions. Review of the produte from T.H.E. Medical products titled Sling listed various mode average weight guid identified weight guid identified weight guid only, and identified on patient body commedical condition, specifications direct performed on a cassafe sling sizing. Review of the literal mechanical lifts revenoperating Instruct 2500X/3500X dated instructions which is maintenance of the not include instruction glide, in Patient Positioning Application Guide, instructions for position of a sling and direct properly centered upper properly centered upper staff in the proper	2/14/14, at 12:23 p.m. the he would expect the delines for mechanical lift use I by all staff. The ADON expected to follow care plan act information provided by the manufacturer's guidelines II, professional patient care in Models and Specifications is for use with sizing and delines. However, the form idelines were approximate proper sizing depended more in mosition (muscle tone, if the delines were approximate proper sizing depended more in mosition (muscle tone, if the delines were approximate proper sizing depended more in the most in the facility ealed the following: it is a seen and if the most in the lift sheets using with device. In the lift sheets using with device. In the lift sheets using with device. In the lift sheets using with device in the lift sheets using with device in the lift sheets using with device. In the lift sheets using with device in the lift sheets using with the lift sheets using with device in the lift sheets using with device in the lift sheets using with the lift sheets using with device in the lift sheets using with device in the lift sheets using with lift sheets using with the lift sheets using with lift sheets using with the lift sheets using with lif	F3	323			
	The facility's policy	titled Safe Patient Handling					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X4) PROVIDER/SURPLIED/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	RIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED	
		245435	B. WING		02	/14/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 420 12TH AVENUE EAST ALEXANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	/Limited Lift Policy, initial screening was assess transfer star a registered nurse assessments with the therapy, and a chair was responsible for Review of the facility Checklist, Maxi Melisted Critical Element Lift during transfers checklist did not into proper sizing of the residents. R223 utilized one standard was not compared the seatypically in R223's hospital additionable and standard stan	review date 5/2013, indicated as required on all residents to tus. The policy also indicated should perform the he potential assist of physical rege nurse or nurse manager rehanges to the care plan. Ity form titled, Competency chanical Lifts, dated 6/27/12, ents for use of the mechanical However, the competency clude elements related to eslings to be used for dide rail and had a mattress atable with her bed frame, graps with the risk for transfers with the risk for transfers and cluded a fractured right arm, opporosis. The admission identified R223 was and required extensive with bed mobility and transfers. plan dated 1/24/14, indicated stance of one staff for on, and transfers. The care	F3	23			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X4) PROVIDED (SUPPLIED OF A

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245435	B. WING _		02	/14/2014
NAME OF	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COI 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	bed was observed of the bed. There whead of the bed to so	to be shorter than the length was a four inch gap from the the top of the mattress. In p.m. NA-A stated R223 with transfers and utilized a raiser on the walker due to NA-A added, R223 required in bed and was independent In p.m. the ADON confirmed the shed was too small for the bed are ADON indicated she was re she had an ill-fitting who verified no assessment had evaluate R223's safety with mattress. She added, she continued the shed to be used for the p.m. RN-B confirmed R223's compatible with the bed frame. The p.m. RN-B confirmed R223's compatible with the bed frame. The p.m. RN-B confirmed R223's compatible with the bed frame. The p.m. RN-B confirmed R223's compatible with the bed frame. The p.m. RN-B confirmed R223's compatible with the bed frame. The p.m. RN-B confirmed R223's compatible with the bed frame. The p.m. RN-B confirmed R223's compatible with the bed frame. The p.m. RN-B confirmed R223's compatible with the same at 7:46 a.m., the ADON ress had not yet been a.m., R223's mattress was attress that was appropriate for		23		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY PLETED
		245435	B. WING		02/ ⁻	14/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371 SS=D	indicated R223 requerbal cues from stassistance of one. The facility did not lamattress sizing but manufacturer guide instructions. The gMaxxum bed had brisk of entrapment atogether with the mexposed to during redirected it was up to whether a different minimizing entrapm 483.35(i) FOOD PESTORE/PREPARE. The facility must - (1) Procure food froconsidered satisfact authorities; and	uired a minimal amount of aff and required standby have a policy for correct used the undated, slines for bed assembly uidelines indicated the een designed to minimize the and the side rails worked attress to minimize the gaps normal use. In addition, it to the end user to determine mattress was suitable for nent risks. ROCURE, SERVE - SANITARY om sources approved or story by Federal, State or local distribute and serve food	F 32			3/21/14
	by: Based on observative review, the facility for hygiene practices to food borne illness, (R39,R45,R62,) when edining room, a	NT is not met as evidenced tion, interview and document ailed to implement hand or minimize the potential for for 3 of 59 residents o were served food from the and 3 of 12 residents oserved in the Maple's dining		F 371 a. All food prepared and served we done so under sanitary conditions. that is responsible for serving residential will not touch the resident a glove on or use of a utensil. Staff preparing food will not touch any	Staff lents vithout	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY PLETED
		245435	B. WING		02/1	4/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 371	failed to practice primeal service to R38 During observation 2/10/14, at 5:26 p.n gloves on both han refrigerator handle, picked up several of them on a table directing and prepared to masame gloves containandle and caniste the canisters contained the canisters on the hands. C-A then regloves at 5:28 p.m. At 5:34 p.m., C-A dicay contained a covered of canister of pears with andle and canister canister of pears with andful of pears and changing gloves, C salad, again reaching and handling lettucing cheese, and a harden canister of pears with and canister of pears and canister of pears with an an an and canister of pears with an analysis of the canister of pears with an analysis of th	e Pine dining room, cook (C)-A oper hand hygiene during 9, R45 and R62. In the Pines dining room on in. C-A donned vinyl-type ds. C-A grabbed the opened the refrigerator, covered canisters, and placed ectly across from the bened each covered canister ake a chef salad. Using the minated by the refrigerator rs, C-A reached into each of ining lettuce, ham, tomatoes, coiled eggs, handing these leds. C-A then arranged the plate with the same gloved emoved the contaminated	F 371	contaminated object while preparit with gloved hands. b. All residents in the facility have potential to be affected by this, as residents have their food prepared served by staff. c. Staff will attend training on how prepare and serve residents and resolved to touching the food with ungloved has use of a utensil. Staff that prepare will be trained on not touching any which may be contaminated including refrigerator handles and container food while preparing food with a gland which may cause cross contamination. Staff will receive inservice training on following pol proper hand washing techniques to between glove usages. Staff service will be trained on not touching the residents food without a gloved in not using a utensil. d. Audits will be conducted rand DON or designee and Dietary Marensure cross contamination in not occurring with food preparation with gloved hands and following policy hand washing, as well as audits we conducted on all staff that serve at assist with tray set up ensuring that food item is touched with ungloved. These audits will be taken to the CAssurance Committee for review a discussion. e. Completion date: 3/21/14	e the all I and I at no I and	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X4) PROVIDER/SURPLIED/GLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245435	B. WING _		02	/14/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 420 12TH AVENUE EAST ALEXANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 371	C-A used her glove grab a spatula, the slices of unwrappe hands contaminate used a spatula to n sandwich from the proceeded to place the entire sandwich the other gloved ha C-A, were then ser grilled cheese sand served to R62. During interview or reported that she n touching dirty items eat foods. C-A stat wrong because I to containers and fridand used the same the handle on the rand containers were added, "We use a I busy tonight." During observation nursing assistants bare hands to hand been served to R13. During observation evening meal serving the backicken sandwich is slices.	onned a clean pair of gloves. In the Maples dining room, (NA)-J and NA-K used their dier of gloves and no continued and not on the Maple's dining room, (NA)-J and NA-K used their dier on 2/10/14, at 5:32 p.m. of the Maple's dining room, or on 2/10/14, at 5:32 p.m. of the Maple's dining room, or on 2/10/14, at 5:32 p.m. of the Maple's dining room, or on 2/10/14, at 5:32 p.m. of the Maple's dining room, or on 2/10/14, at 5:32 p.m. or on 2/10/14, at		71			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245435	B. WING _		02	/14/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	chicken sandwich vit on R25's plate. Not the chicken sandwi with her bare hands. At 5:38 NA-J handle bun with bare hand onto the chicken papushed the quarter with her bare finger and continued to pure the puring interview on confirmed she had with bare hands who condiments for their confirmed touching hands was not a us stated that she sho move the bun and it should have been to were available in the During an interview confirmed she had bare hands during the NA-J stated, "It was the usual practice wand knife to touch the During interview on assistant director or staff were not to has their bare hands. In	removed the top bun of R25's with her bare hand, and placed A-K applied mayonnaise to ch, then reapplied the top bun st. ed R42's chicken sandwich and adjusted the top bun atty. NA-J touched and ed sandwich, multiple times is. NA-J then picked up a fork ush at the sandwich pieces. 1. 2/10/14, at 5:55 p.m. NA-K handled R131 and R42's food alle she offered and applied in chicken sandwiches. NA-K ready-to-eat foods with bare sual practice. She further all have asked the resident to food they could not, a glove used. NA-K confirmed gloves the kitchen for staff use. 1. 2/10/14, at 7:34 p.m. NA-J touched R42's foods with the evening meal service. It would have been to use a fork the ready-to-eat foods. 1. 2/12/14, at 12:27 p.m. the food food in the ADON confirmed andle ready-to-eat foods with an addition, the ADON reported to wear gloves if touching	F 37			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY PLETED
	245435	B. WING _		02/	14/2014
			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
During a follow-up is a.m. dietary manage expected staff to us handling ready-to-egloves as long as the DM confirmed that handles or any non or containers were she expected staff is handling ready-to-ereceived education ready-to-eat foods. Review of the facilith Handling policy dat was to be served we spoons, spatulas, os as to avoid manage as to avoid	nterview on 2/14/14, at 10:08 er (DM) reported that she se tongs if at all possible when sat foods, but they could use ney were not contaminated. refrigerator handles, drawer food items such as canisters considered contaminated and to change their gloves before sat foods. DM stated that staff regarding handling during their monthly meetings. By's Food Preparation and ed 3/21/06, indicated food ith clean tongs, scoops, forks, or other suitable implements ual contact of prepared foods. BL/SANITARY/COMFORTABL Dovide a safe, functional, ortable environment for the public. NT is not met as evidenced sion, interview and document ailed to ensure walls, room fixtures were maintained 4 of 40 resident rooms (R129, R70, R71, R58, R3, R22,		F 465 a. Maintenance staff will remove replace caulking on sink in room R repair and replace 2 feet of caulking top of base of room R123, replace	22, ig on	3/21/14
Findings include:			room R223, install 3 tile bases in		
	Continued From paragement of the paragement of t	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 During a follow-up interview on 2/14/14, at 10:08 a.m. dietary manager (DM) reported that she expected staff to use tongs if at all possible when handling ready-to-eat foods, but they could use gloves as long as they were not contaminated. DM confirmed that refrigerator handles, drawer handles or any non-food items such as canisters or containers were considered contaminated and she expected staff to change their gloves before handling ready-to-eat foods. DM stated that staff received education regarding handling ready-to-eat foods during their monthly meetings. Review of the facility's Food Preparation and Handling policy dated 3/21/06, indicated food was to be served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements so as to avoid manual contact of prepared foods. 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure walls, doorways and bathroom fixtures were maintained in good repair, for 14 of 40 resident rooms (R129, R146, R92, R153, R70, R71, R58, R3, R22, R123, R225, R6, R223 and R51) observed.	DEROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 During a follow-up interview on 2/14/14, at 10:08 a.m. dietary manager (DM) reported that she expected staff to use tongs if at all possible when handling ready-to-eat foods, but they could use gloves as long as they were not contaminated. DM confirmed that refrigerator handles, drawer handles or any non-food items such as canisters or containers were considered contaminated and she expected staff to change their gloves before handling ready-to-eat foods. DM stated that staff received education regarding handling ready-to-eat foods during their monthly meetings. Review of the facility's Food Preparation and Handling policy dated 3/21/06, indicated food was to be served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements so as to avoid manual contact of prepared foods. 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure walls, doorways and bathroom fixtures were maintained in good repair, for 14 of 40 resident rooms (R129, R146, R92, R153, R70, R71, R58, R3, R22, R123, R225, R6, R223 and R51) observed.	TECORRECTION DENTIFICATION NUMBER: 245435 245435 245435 3 3 3 3 3 3 3 3 3	A BUILDING 245435 B. WING 245435 B. WING 245435 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308 SUMMARY STATEMENT OF DEFICIENCIES (EACH OBERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 During a follow-up interview on 2/14/14, at 10:08 a.m. dietary manager (DM) reported that she expected staff to use tongs if at all possible when handling ready-to-eat foods, but they could use gloves as long as they were not contaminated. DM confirmed that refrigerator handles, drawer handles or any non-food items such as canisters or containers were considered contaminated and she expected staff to change their gloves before handling ready-to-eat foods. DM stated that staff received education regarding handling ready-to-eat foods uring their monthly meetings. Review of the facility's Food Preparation and Handling policy dated 3/21/06, indicated food was to be served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements so as to avoid manual contact of prepared foods. 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. F 465 F 465 F 465 A BUILDING PROVIDER ALD DEFICIENCISS, CORDECTION PRECVIDENCY PROVIDERS. F 465 F 465 F 465 A BUILDING PROVIDER ALD DEFICIENCISS. F 465 F 465 A BUILDING PROVIDER ALD DEFICIENCISS. F 465 F 465 A BUILDING PROVIDER ALD DEFICIENCISS. A BUILDING PROVIDER ALD DEFICIENCISS. F 465 F 465 A BUILDING PROVIDER ALD DEFICIENCISS. F 465 A BUILDING PROVIDER ALD DEFICIENCISS. F 465 A BUILDING PROVIDER ALD DEFICIENCISS. F 465 A BUILDING F 465 A BUILDING F 465 F 465 A BUILDING PROVIDER ALD DEFICIENCISS F 465 A BUILDING F 465 A BUILDING F 465 F 465 A BUILDING F 465 F 465 A BUILDING F 465 A BUILDING F 465 A BUILDING F 465 F 465 A BUILDING F 465 A BUILDING F 465 A BUILDING F 465 A BUILDING F 465 A BUILDI

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245435	B. WING			02/	14/2014
NAME OF I	PROVIDER OR SUPPLIER			42	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST ILEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	2/14/14, at 8:44 a.r director, the following resident bathroom have scratched and sides, for R129, R1 R71. Resident toilets had caulking around the R70's room had a rethe toilet seat that with missing paint. Resident bathroom discolored caulking the wall for R3 and R123's bathroom be have discolored glufeet along the top of Resident room and chipped and rough R225, R153, and R152's room. Loose and missing R6's room. Loose, chipped and medicine cabinet in R51's bathroom was missing paint and glower part of all the R92's resident room paint and gouged sime as uring one and resident's reclining.	mental tour of the facility on m. with the maintenance on concerns were identified: door frames were noted to do missing paint on one or both 46, R92, R153, R70, and do cracked and discolored etoilet base for R58 and R71. In the plate fastened behind was rough, discolored and discolored an	F 4	465	bathroom of room R6, repair walls paint touchup in bathroom of room repair holes and paint one wall of r R92, sand, stain and seal bathroom where rough edges are in bathroom room R129, R225, R153 and R3. b. All residents in the facility have potential to be affected by this. c. Maintenance will complete a mwalk through of resident rooms and bathrooms. First week will cover SI Term Rehab Center. Second week be the Maples. Third week will be the Pines and Evergreens. The forth wwill cover resident common areas. will check for paint scrapes on doo check for door scrapes, wall touch and environmental concerns in ger. Then complete the necessary repains it in the maintenance repair book each neighborhood station. All staff receive in-service training on when notice any immediate environmental concerns that they record in Maintenance and they record in Maintenance and they record in Maintenance staff and/or designee ensure that all necessary environmental concerns have been addressed in any concerns in Maintenance repains been addressed. These audits be taken to the Quality Assurance Committee for review and discussive. Completion date: 3/21/2014	R51, oom on door ms of the conthly donort ek will he eek They rways, ups heral. ir and ok at f will they all enance ly by to hental cluding ir book is will	
	paint and gouged s measuring one and resident's reclining Review of the three identified that staff	theet rock in an area I a half feet, directly behind the chair.			be taken to the Quality Assurance Committee for review and discussion		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245435	B. WING			02/	14/2014
NAME OF F	PROVIDER OR SUPPLIER		•	420	REET ADDRESS, CITY, STATE, ZIP CODE D 12TH AVENUE EAST EXANDRIA, MN 56308	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	maintenance perso was made for a req resident room during interview on maintenance direct resident room repaid document needs in maintenance staff r several times through maintenance direct follow-up for repairs out of their room. A inspected by maintenance direct findings and the lact maintenance logs for the several times through the several times the several times through the	n. However, only one entry uest of missing paint in a g the past two months. 2/14/14, at 9:14 a.m. the or stated the facility plan for irs was for floor staff to the log books, with eviewing the log books ghout the day. The or confirmed the only other is was when a resident moved at that time, the room was enance with all repairs being	F	165			

(X1) PROVIDER/SUPPLIER/CLIA

5435022

(X2) MULTIPLE CONSTRUCTION

PRINTED: 03/18/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 245435 02/11/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **420 12TH AVENUE EAST KNUTE NELSON ALEXANDRIA, MN 56308** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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 (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

Electronically Signed

03/13/2014

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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(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 101 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245435	B. WING	_		02/1	1/2014
NAME OF F	PROVIDER OR SUPPLIER			4	STREET ADDRESS, CITY, STATE, ZIP CODE 120 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa By e-mail to: Marian.Whitney@s	_	κo)00			
		RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION:					
	A description of voto correct the deficition	what has been, or will be, done ency.					
	2. The actual, or pr	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.			×		
(2)	building with a particonstructed at 5 diffully building was constructed at 5 diffully building was constructed and to be of 1961, an addition with determined to be of 1961, an addition with the second construction of 2-hour fire resistive administration purpiculated in this surfadded to the south Type II(000) constructions.	forial Home is a 1-story ial basement. The building was ferent times. The original ructed in 1958 and was for Type II(111) construction. In was added to the east was for Type II(111) construction. In the facility are separated by a construction and are used for coses only and were nowey. In 1970 and addition was that was determined to be uction. In 1976 an addition was that was determined to be					
	Type V(111) construadded to the east a to be Type V(111) coriginal building and construction type a the facility was surv	uction. In 1980 additions were and south that were determined construction. Because the d the additions meet the llowed for existing buildings, yeyed as one building.			V _C >		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION O1 - MAIN BUILDING 01 (X3) D C	ATE SURVEY OMPLETED
		245435	B. WING			2/11/2014
NAME OF F	PROVIDER OR SUPPLIER			42	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST LEXANDRIA, MN 56308	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 029 SS=D	sprinkler system. Talarm system with corridors and space monitored for automotification. The far 108 beds and had the survey. The requirement at NOT MET as eviden NFPA 101 LIFE SAME One hour fire rated fire-rated doors) or extinguishing system and/or 19.3.5.4 protine approved automoption is used, the other spaces by shadoors. Doors are stield-applied protects	The facility has a complete fire smoke detection in the es open to the corridor that is matic fire department cility has a licensed capacity of a census of 98 at the time of a census of 98 at the time of a t42 CFR Subpart 483.70(a) is enced by: AFETY CODE STANDARD I construction (with ¾ hour an approved automatic fire em in accordance with 8.4.1 at otects hazardous areas. When matic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or citive plates that do not exceed bottom of the door are		000		4/15/14
	Based on observation provide proper provide proper provide accordance with N (2000 edition) sect deficient practice coresidents, staff, and	is not met as evidenced by: tions, the facility has failed to tection from 1 of several ocated throughout the facility in FPA Life Safety Code 101 ion 19.3.2.1. The following ould negatively affect the d visitors as smoke and fire in inter the corridor making it			K 029 Maintenance staff have ordered a new door and frame for the 600 wing soiled utility room as the door did not close completely and latch into the door frame due to the door being warped. Maintenance staff will continue to monite all soiled and clean utility doors for proper fitting door and closure with positive late.	or er

Facility ID: 00113

CENTER	42 FOR MEDICARE	& MEDICAID SERVICES			Oly	ID NO.	0936-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		.E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245435	B. WING	_		02/	11/2014
NAME OF F	PROVIDER OR SUPPLIER			4	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 056 SS=F	Findings include: On facility tour betw 02/11/2014, observe the 600 wing soiled close and positively. This deficient pract Administrator (AU). NFPA 101 LIFE SA. If there is an autominstalled in accordator the Installation oprovide complete coulding. The system accordance with NFI Inspection, Testing, Water-Based Fire Fupervised. There supply for the systems are equipped to the systems are eq	veen 9:30 AM to 1:30 PM on ation revealed, that the door to utility room did not completely a latch into the frame. ice was verified by the Facility FETY CODE STANDARD ratic sprinkler system, it is unce with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the em is properly maintained in FPA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water em. Required sprinkler sed with water flow and tamper a electrically connected to the		056	into the door frames in accordance of NFPA Life Safety Code 101 section 19.3.2.1 protecting hazardous areas Completion Date: 04/15/2014 Responsible Person: Tom Storer, Director of Environmental Services		3/17/14
	Based on observation system is not install accordance with NF Installation of Sprinto maintain the spriwith NFPA 13 (99) out of service causi	s not met as evidenced by: tions, the automatic sprinkler led and maintained in FPA 13 the Standard for the kler Systems (99). The failure nkler system in compliance could allow system being place ing a decrease in the fire exapability in the event of an			K 056 4 sprinkler heads in the wheelchair washing room were replaced and insin accordance to NFPA 13, Standard the Installation of Sprinkler Systems remove the painted sprinkler heads. sprinkler gauges on the dry pipe spr	stalled d for to The	

PRINTED: 03/18/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING. 02/11/2014 245435 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **420 12TH AVENUE EAST KNUTE NELSON ALEXANDRIA, MN 56308** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 056 K 056 | Continued From page 4 riser in the Maples Wing were replaced. emergency that would affect all residents, visitors The spare sprinkler box is now equipped and staff of the facility. with 2 spares of every style and type of sprinkler heads located throughout the Findings include: facility including the missing high temp heads for the northwest boiler room. The On facility tour between 9:30 AM to 1:30 PM on sprinkler system will be maintained on a 02/11/2014, observations reveled the following quarterly basis in accordance with NFPA deficient conditions affecting the facility's fire sprinkler system: 25. Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. The Director of 1. the spare sprinkler head box was not Environmental Services and maintenance equipped with at least 2 of every type and style of department will be responsible for proper sprinkler heads that are being used in the facility. maintenance and inspection of sprinkler The observed missing spare sprinkler heads system and compliance with NFPA 13 and were the elevated temperature type of sprinkler heads that were located in the northwest boiler 25. room. Completion Date: 03/17/2014 2. It could not be verified when the sprinkler Responsible Person: Tom Storer, gauges located on the main fire sprinkler riser Director of Environmental Services have were last tested or recalibrating. 3. There are 4 sprinkler heads that are located in the wheelchair washing room that were painted and covered with ceiling spackling. This deficient practice was verified by the Facility Administrator (AU). 3/11/14 K 062 K 062 NFPA 101 LIFE SAFETY CODE STANDARD SS=F Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested 19.7.6, 4.6.12, NFPA 13, NFPA 25. periodically. 9.7.5

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 02/11/2014	
		245435				
NAME OF PROVIDER OR SUPPLIER KNUTE NELSON			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 062	Continued From pa	age 5	K 00	52		
×	This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00) section 19.7.6, 4.6.12. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all residents, staff and visitors. Findings include:			The facility has confirmed a sol date and time each quarter for quarterly fire sprinkler flow test sprinkler system. These tests on the 2nd Tuesday of each Ma September and December. Ou Simplex Grinnell, has confirmed missed our quarterly inspection September 2013 and the annual confirmed and the september 2013 and the annual confirmed and the september 2013 and the annual confirmed and the september 2013 and	er for our w test for our fire tests will occur ach March, June, er. Our vendor, ofirmed they section in annual	
-	02/11/2014, a revie interview with the F revealed the facility documentation for	1 out of the last 4 quarterly fire inspections required by NFPA		inspection for June 2013 was de August 2013. We are back on with the quarterly inspection for quarter of 2014 occurring on M 2014. The Director of Environt Services and maintenance dep will be responsible for proper maintenance and inspection of system and compliance with NI 25.	schedule the first arch 11, nental artment sprinkler	
	This deficient pract Administrator (AU)	ice was verified by the Facility		Completion Date: 03/11/2014 Responsible Person: Tom Stor	er,	
K 067 SS=F	Heating, ventilating with the provisions in accordance with	FETY CODE STANDARD a, and air conditioning comply of section 9.2 and are installed the manufacturer's 9.5.2.1, 9.2, NFPA 90A,	K 0	Director of Environmental Serv		3/20/14

Facility ID: 00113

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(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 245435 02/11/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **420 12TH AVENUE EAST KNUTE NELSON ALEXANDRIA, MN 56308** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 067 Continued From page 6 K 067 This STANDARD is not met as evidenced by: K 067 Based on documentation review, the fire/smoke damper system has not been maintained in Maintenance failed to complete the testing accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does and inspection of the fire and smoke dampers on a every four year basis. The not ensure the proper operation of the fire/smoke last inspection was in November 2009. dampers and could allow smoke migration to negatively affect all residents, staff and visitors in Maintenance will review our Life Safety code book every quarter to ensure all the event of a fire. inspections are completed when due and the reports are kept in the book for easy review. The director of environmental Findings include: services has created a recurring calendar reminder to ensure the fire and smoke On facility tour between 9:30 AM to 1:30 PM on damper testing and inspection is 02/11/2014, it was revealed during the review of completed every four years on time. The facility's fire and smoke damper test and Director of Environmental Services and inspection documentation and confirmed by interview with the Facility Administrator (AU), that maintenance department will be responsible for maintaining the fire/smoke the facility failed to provide documentation that damper system in accordance with NFPA the fire and smoke dampers had been tested/inspected within the last 4 years in 90(99) Section 3-4.7. accordance with NFPA 90(99) section 3-4.7. Completion Date: 03/20/2014 Responsible Person: Tom Storer, This deficient practice was verified by the Facility Director of Environmental Services Administrator (AU).

Facility ID: 00113