MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 6SQ3
Facility ID: 00113

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/01/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **108** (L18)

13.Total Certified Beds **108** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	108			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 05/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/23/2014
(L33)

DETERMINATION APPROVAL

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 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

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

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, 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

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

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245435	A. Building B. Wing	5/1/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	05/01/2014	ID Prefix F0226 Reg. # 483.13(c) LSC	05/01/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/GA	05/16/2014	32603	05/01/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/14/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245435	A. Building B. Wing 01 - MAIN BUILDING 01	5/2/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	04/15/2014	ID Prefix Reg. # NFPA 101 LSC K0056	03/17/2014	ID Prefix Reg. # NFPA 101 LSC K0062	03/11/2014
ID Prefix Reg. # NFPA 101 LSC K0067	03/20/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	05/16/2014	27200	05/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/11/2014

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

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

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

ID: 6SQ3
Facility ID: 00113

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/02/20014** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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 **108** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	108			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 04/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/14/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **04/23/2014** (L33)

DETERMINATION APPROVAL

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 poten tial 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)

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.

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

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/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 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

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

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245435	A. Building B. Wing	4/2/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0323 Reg. # 483.25(h) LSC	03/21/2014	ID Prefix F0371 Reg. # 483.35(i) LSC	03/21/2014	ID Prefix F0465 Reg. # 483.70(h) LSC	03/21/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/14/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING ______ B. WING ______	R 04/02/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite revisit was conducted by the MDH on 4/2/2014. During this visit the following regulations were determined not to be corrected.	{F 000}		
{F 225} SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	{F 225}		4/16/14

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

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{F 225}	Continued From page 1	{F 225}		

certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to report instances of potential mistreatment, suspicious injuries of unknown origin and unwitnessed fall with injury to the state agency (SA) in a timely manner for 3 of 5 residents (R15, R158, R56).

Findings include:

R15 sustained a fracture to left hip following a fall. The facility failed to immediately report the injury to the SA.

R15 was found lying on the floor of her room on 3/22/14, at 3:50 p.m., in front of the electric recliner chair, which was in a high position. There were no witnesses to the fall. R15 was observed to have displacement of the right hip, abrasion on left knee and large bump on the right knee. R15 was sent to the emergency room for evaluation of injuries and complaints of pain in the left hip area. R15 was admitted to the hospital with a left hip 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.

R15's annual Minimum Data Set (MDS), dated 10/1/13, identified R15 had diagnoses which

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{F 225}	Continued From page 2	{F 225}		

Continued From page 2

included dementia and depression. The MDS further identified R15 had severe cognitive impairment, required extensive assistance with mobility, transferring, toileting and did not ambulate. Further, the MDS identified R15 had functional limitations in both sides of her upper and lower body. R15's Care Area Assessment (CAA), dated 10/4/13, revealed R15 had a history of cerebrovascular accident (stroke), dementia, kyphosis (overcurvature of the thoracic vertebrae) and depression with behaviors. The CAA further identified R15 did not stand and required a total lift to transfer from bed to chair and back. R15's fall risk assessment, dated 3/5/14, identified R15 was at high risk for falls related to the inability to stand, the need for extensive assistance with transfers and the use of medications for hypertension and depression.

R15's care plan, dated 3/12/14, directed staff to utilize a total body lift for transferring the resident from bed to chair and back related to R15's inability to ambulate. The care plan further revealed R15 utilized an electric recliner chair.

Review of the progress notes from 3/19/14 to 3/23/14 revealed:

On 3/22/14, at 3:50 p.m., R15 was found lying on the floor on her back with her head towards the door and her feet towards the windows. R15 was calling out, "help, help" and the power recliner lift chair was in a high position. R15's right hip looked displaced, right leg was facing outward and complained of pain in the left hip and had an abrasion on her left knee. R15 was then transferred per ambulance to the local hospital at 4:40 p.m. The progress note indicated the director of nursing and administrator had been

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notified at that time.

At 11:02 p.m., the local hospital notified the facility that R15 had sustained a displaced left hip fracture.

Review of the facility incident report, dated 3/22/14 revealed R15 had been found on the floor, yelling "HELP!! HELP!! Her power recliner lift chair was in high position. The report indicated there were no witnesses for the fall, and indicated R15 had recent changes in cognitive status and an acute illness was listed as a possible cause of the fall.

Review of the report submitted to the SA, dated 3/23/14, revealed the report was received by the SA at 11:35 a.m., nineteen hours and forty five minutes after R15 experienced serious injury from R15's unwitnessed fall.

R158 sustained three large bruises on her forearm and leg, which was determined to be an injury of unknown origin. The facility failed to immediately report the injuries to the SA.

R158's annual MDS revealed R158 had diagnoses which included dementia and anxiety. The MDS identified R158 had severe cognitive impairment and required extensive assistance with mobility, transfer from bed to chair, dressing and toileting.

R158's nursing assistant care plan, dated 3/13/14, directed staff to transfer R158 with a standing mechanical lift for transfers.

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{F 225}	Continued From page 4	{F 225}		

Review of R158's progress notes revealed the following:

On 3/24/14, at 9:58 p.m., a bruise on R158's left forearm was measured at 4 x 2 centimeters (cm) was dark purple in color, and lighter in the middle. Two bruises were noted on R158's left lower leg. One measured 2.5 x 3 cm and the other measured 4 x 3 cm, both were light blue in color.

Review of R158's incident report dated 3/24/14, revealed three bruises were observed during R158's bath. Left forearm bruise measured 4 x 2 cm dark purple in color and lighter in the middle. Two bruises on the left lower leg, one measured 2.5 cm x 3 cm and another measuring 4 cm x 3 cm. The report indicated R158 did not know what happened to cause the bruises. The report identified R158 was confused, had impaired memory and was orientated to person only. Further, the report identified there had been no witnesses to R158 sustaining the bruises/injury of unknown origin.

The facility submitted a report to the SA indicating an injury of unknown source, regarding R158's bruises, on 3/25/14, at 4:35 p.m., eighteen hours and thirty three minutes after the bruises were discovered.

R56 sustained two bruises on her right hand and wrist, which was determined to be an injury of unknown origin. The facility failed to immediately report the injuries to the SA.

R56's significant change MDS dated 3/14/14, identified R56 had a diagnosis of dementia, had

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{F 225}	Continued From page 5	{F 225}		

severe cognitive impairment and received extensive assistance with all ADL's. R56's Bruise report dated 3/23/14, indicated that staff first identified bruises at 7:00 a.m. The facility incident report dated 3/23/14, at 12:45 p.m. identified one dark purple bruise on the right wrist that measured 2.4 cm x 3.8 cm, and one dark purple bruise on the right hand that measured 2.2 cm x 2.5 cm. The report indicated R56 was unaware of how the bruises occurred.

The facility reported R56's bruises, as injuries of unknown source to the SA on 3/24/14, at 5:16 p.m., thirty five hours and sixteen minutes after identifying R56's bruises 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 ensure timely reporting to the SA and also stated the facility policy directed staff to report to the SA immediately, within twenty four hours.

During interview on 4/2/14, at 11:50 a.m. the administrator stated the facility reports the initial incident to the SA within twenty four hours, then stated, "If we know it is abuse, a bruise is in a suspicious area, or neglect, the facility reports to the state agency immediately." The administrator

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{F 225}	Continued From page 6 then stated, "If the facility feels its a small bruise on a resident and is not in a suspicious area, the report is made to the state agency within twenty four hours." The administrator confirmed that it is expected that reports are made to the SA within twenty four hours per the facility policy. The undated facility policy titled, Vulnerable Adult Abuse/Neglect Prevention Plan, directed that all suspect violations or abuse would be immediately reported to the several persons or agencies which included state licensing/certification agency responsible for surveying the facility, Adult Protection Services, the local/state Ombudsman and Law Enforcement Officials. A fax or telephone call to the state agency would be acceptable to meet the requirement of immediate reporting. The policy identified verbal or written notices to agencies will be made within 24 hours of the occurrence of the incident. However, the policy contains conflicting information about the timing of reporting to the state agency which needs to be immediately.	{F 225}		
{F 226} SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility demonstrated a systematic failure to	{F 226}		4/16/14

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{F 226}	Continued From page 7	{F 226}		

implement their abuse prohibition policies for immediate reporting to the state agency (SA) for 3 of 5 residents (R15, R158, R56) reviewed for abuse prohibition. This deficient practice had the potential to affect all 92 of 92 residents who resided in the facility.

Findings include:

The undated facility policy titled, Vulnerable Adult Abuse/Neglect Prevention Plan, directed that all suspect violations or abuse would be immediately reported to the several persons or agencies which included state licensing/certification agency responsible for surveying the facility, Adult Protection Services, the local/state Ombudsman and Law Enforcement Officials. A fax or telephone call to the state agency would be acceptable to meet the requirement of immediate reporting. The policy identified verbal or written notices to agencies will be made within 24 hours of the occurrence of the incident. However, the policy contains conflicting information about the timing of reporting to the state agency which needs to be immediately.

R15 sustained a fracture to left hip following a fall. The facility failed to immediately report the injury to the SA.

R15 was found lying on the floor of her room on 3/22/14, at 3:50 p.m., in front of the electric recliner chair, which was in a high position. There were no witnesses to the fall. R15 was observed to have displacement of the right hip, abrasion on left knee and large bump on the right knee. R15 was sent to the emergency room for evaluation of

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{F 226}	Continued From page 8	{F 226}		

injuries and complaints of pain in the left hip area. R15 was admitted to the hospital with a left hip 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.

R15's annual Minimum Data Set (MDS), dated 10/1/13, identified R15 had diagnoses which included dementia and depression. The MDS further identified R15 had severe cognitive impairment, required extensive assistance with mobility, transferring, toileting and did not ambulate. Further, the MDS identified R15 had functional limitations in both sides of her upper and lower body. R15's Care Area Assessment (CAA), dated 10/4/13, revealed R15 had a history of cerebrovascular accident (stroke), dementia, kyphosis (overcurvature of the thoracic vertebrae) and depression with behaviors. The CAA further identified R15 did not stand and required a total lift to transfer from bed to chair and back. R15's fall risk assessment, dated 3/5/14, identified R15 was at high risk for falls related to the inability to stand, the need for extensive assistance with transfers and the use of medications for hypertension and depression.

R15's care plan, dated 3/12/14, directed staff to utilize a total body lift for transferring the resident from bed to chair and back related to R15's inability to ambulate. The care plan further revealed R15 utilized an electric recliner chair.

Review of the progress notes from 3/19/14 to 3/23/14 revealed:

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On 3/22/14, at 3:50 p.m., R15 was found lying on the floor on her back with her head towards the door and her feet towards the windows. R15 was calling out, "help, help" and the power recliner lift chair was in a high position. R15's right hip looked displaced, right leg was facing outward and complained of pain in the left hip and had an abrasion on her left knee. R15 was then transferred per ambulance to the local hospital at 4:40 p.m. The progress note indicated the director of nursing and administrator had been notified at that time.

At 11:02 p.m., the local hospital notified the facility that R15 had sustained a displaced left hip fracture.

Review of the facility incident report, dated 3/22/14 revealed R15 had been found on the floor, yelling "HELP!! HELP!! Her power recliner lift chair was in high position. The report indicated there were no witnesses for the fall, and indicated R15 had recent changes in cognitive status and an acute illness was listed as a possible cause of the fall.

Review of the report submitted to the SA, dated 3/23/14, revealed the report was received by the SA at 11:35 a.m., nineteen hours and forty five minutes after R15 experienced serious injury from R15's unwitnessed fall.

R158 sustained three large bruises on her forearm and leg, which was determined to be an injury of unknown origin. The facility failed to immediately report the injuries to the SA.

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{F 226}	Continued From page 10 R158's annual MDS revealed R158 had diagnoses which included dementia and anxiety. The MDS identified R158 had severe cognitive impairment and required extensive assistance with mobility, transfer from bed to chair, dressing and toileting. R158's nursing assistant care plan, dated 3/13/14, directed staff to transfer R158 with a standing mechanical lift for transfers. Review of R158's progress notes revealed the following: On 3/24/14, at 9:58 p.m., a bruise on R158's left forearm was measured at 4 x 2 centimeters (cm) was dark purple in color, and lighter in the middle. Two bruises were noted on R158's left lower leg. One measured 2.5 x 3 cm and the other measured 4 x 3 cm, both were light blue in color. Review of R158's incident report dated 3/24/14, revealed three bruises were observed during R158's bath. Left forearm bruise measured 4 x 2 cm dark purple in color and lighter in the middle. Two bruises on the left lower leg, one measured 2.5 cm x 3 cm and another measuring 4 cm x 3 cm. The report indicated R158 did not know what happened to cause the bruises. The report identified R158 was confused, had impaired memory and was orientated to person only. Further, the report identified there had been no witnesses to R158 sustaining the bruises/injury of unknown origin. The facility submitted a report to the SA indicating an injury of unknown source, regarding R158's bruises, on 3/25/14, at 4:35 p.m., eighteen hours and thirty three minutes after the bruises were	{F 226}		

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{F 226}	Continued From page 11 discovered. R56 sustained two bruises on her right hand and wrist, which was determined to be an injury of unknown origin. The facility failed to immediately report the injuries to the SA. R56's significant change MDS dated 3/14/14, identified R56 had a diagnosis of dementia, had severe cognitive impairment and received extensive assistance with all ADL's. R56's Bruise report dated 3/23/14, indicated that staff first identified bruises at 7:00 a.m. The facility incident report dated 3/23/14, at 12:45 p.m. identified one dark purple bruise on the right wrist that measured 2.4 cm x 3.8 cm, and one dark purple bruise on the right hand that measured 2.2 cm x 2.5 cm. The report indicated R56 was unaware of how the bruises occurred. The facility reported R56's bruises, as injuries of unknown source to the SA on 3/24/14, at 5:16 p.m., thirty five hours and sixteen minutes after identifying R56's bruises 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	{F 226}		

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	245435	A. BUILDING ______ B. WING ______	R 04/02/2014

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{F 226}	Continued From page 12 ensure timely reporting to the SA and also stated the facility policy directed staff to report to the SA immediately, within twenty four hours. During interview on 4/2/14, at 11:50 a.m. the administrator stated the facility reports the initial incident to the SA within twenty four hours, then stated, "If we know it is abuse, a bruise is in a suspicious area, or neglect, the facility reports to the state agency immediately." The administrator then stated, "If the facility feels its a small bruise on a resident and is not in a suspicious area, the report is made to the state agency within twenty four hours." The administrator confirmed that it is expected that reports are made to the SA within twenty four hours per the facility policy.	{F 226}		

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{F 000}	INITIAL COMMENTS An onsite revisit was conducted by the MDH on 4/2/2014. During this visit the following regulations were determined not to be corrected.	{F 000}		
{F 225} SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	{F 225}		4/16/14

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

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{F 225}	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report instances of potential mistreatment, suspicious injuries of unknown origin and unwitnessed fall with injury to the state agency (SA) in a timely manner for 3 of 5 residents (R15, R158, R56). Findings include: R15 sustained a fracture to left hip following a fall. The facility failed to immediately report the injury to the SA. R15 was found lying on the floor of her room on 3/22/14, at 3:50 p.m., in front of the electric recliner chair, which was in a high position. There were no witnesses to the fall. R15 was observed to have displacement of the right hip, abrasion on left knee and large bump on the right knee. R15 was sent to the emergency room for evaluation of injuries and complaints of pain in the left hip area. R15 was admitted to the hospital with a left hip 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. R15's annual Minimum Data Set (MDS), dated 10/1/13, identified R15 had diagnoses which	{F 225}	F 225 a. For residents R56 and R158 they will have injuries of unknown cause or injuries from an accident/incident reported to the state agencies immediately upon discovery of the injury. These injuries will be reported to the Administrator and /or Director of Nursing immediately upon discovery. Resident R15 has expired. b. All resident of Knute Nelson have the potential to be affected by this practice. All reportable allegations will be reported per facility policy. c. All licensed staff was trained on completing the initial report to state agencies on all injuries of unknown cause and injuries that result from an accident/ incident immediately when the injury has been discovered. A step by step procedure has been given to licensed staff to follow to do a report. They have been instructed to notify the Administrator and/or Director of Nursing when a reportable injury has been discovered and to immediately to report that injury or incident to the state agencies. Licensed staff has received training that after the immediate initial report of injury or incident to the state agencies they then start their investigation of the injury or incident. Facility Vulnerable Adult Abuse/Neglect	

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{F 225}	Continued From page 2 included dementia and depression. The MDS further identified R15 had severe cognitive impairment, required extensive assistance with mobility, transferring, toileting and did not ambulate. Further, the MDS identified R15 had functional limitations in both sides of her upper and lower body. R15's Care Area Assessment (CAA), dated 10/4/13, revealed R15 had a history of cerebrovascular accident (stroke), dementia, kyphosis (overcurvature of the thoracic vertebrae) and depression with behaviors. The CAA further identified R15 did not stand and required a total lift to transfer from bed to chair and back. R15's fall risk assessment, dated 3/5/14, identified R15 was at high risk for falls related to the inability to stand, the need for extensive assistance with transfers and the use of medications for hypertension and depression. R15's care plan, dated 3/12/14, directed staff to utilize a total body lift for transferring the resident from bed to chair and back related to R15's inability to ambulate. The care plan further revealed R15 utilized an electric recliner chair. Review of the progress notes from 3/19/14 to 3/23/14 revealed: On 3/22/14, at 3:50 p.m., R15 was found lying on the floor on her back with her head towards the door and her feet towards the windows. R15 was calling out, "help, help" and the power recliner lift chair was in a high position. R15's right hip looked displaced, right leg was facing outward and complained of pain in the left hip and had an abrasion on her left knee. R15 was then transferred per ambulance to the local hospital at 4:40 p.m. The progress note indicated the director of nursing and administrator had been	{F 225}	Prevention policy has been revised to reflect that licensed nurses will report immediately any injuries of unknown cause upon discovery of the injury to state agencies. d. On-going/ at least daily audits will be conducted of all injuries or incident by the Director of Nursing and/or designee to ensure staff are following the facility s Vulnerable Adult Reporting Policy, and that all injuries of unknown cause and injuries from an accident /incident have been reported immediately upon discovery of the injury to the state agencies and that the Administrator has been notified immediately of the injury or incident. These audits will be taken to the Quality Assurance Committee for review and discussion. e. Completion date: 4/16/2014	

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{F 225}	Continued From page 3	{F 225}		

notified at that time.

At 11:02 p.m., the local hospital notified the facility that R15 had sustained a displaced left hip fracture.

Review of the facility incident report, dated 3/22/14 revealed R15 had been found on the floor, yelling "HELP!! HELP!! Her power recliner lift chair was in high position. The report indicated there were no witnesses for the fall, and indicated R15 had recent changes in cognitive status and an acute illness was listed as a possible cause of the fall.

Review of the report submitted to the SA, dated 3/23/14, revealed the report was received by the SA at 11:35 a.m., nineteen hours and forty five minutes after R15 experienced serious injury from R15's unwitnessed fall.

R158 sustained three large bruises on her forearm and leg, which was determined to be an injury of unknown origin. The facility failed to immediately report the injuries to the SA.

R158's annual MDS revealed R158 had diagnoses which included dementia and anxiety. The MDS identified R158 had severe cognitive impairment and required extensive assistance with mobility, transfer from bed to chair, dressing and toileting.

R158's nursing assistant care plan, dated 3/13/14, directed staff to transfer R158 with a standing mechanical lift for transfers.

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{F 225}	Continued From page 4	{F 225}		

Review of R158's progress notes revealed the following:

On 3/24/14, at 9:58 p.m., a bruise on R158's left forearm was measured at 4 x 2 centimeters (cm) was dark purple in color, and lighter in the middle. Two bruises were noted on R158's left lower leg. One measured 2.5 x 3 cm and the other measured 4 x 3 cm, both were light blue in color.

Review of R158's incident report dated 3/24/14, revealed three bruises were observed during R158's bath. Left forearm bruise measured 4 x 2 cm dark purple in color and lighter in the middle. Two bruises on the left lower leg, one measured 2.5 cm x 3 cm and another measuring 4 cm x 3 cm. The report indicated R158 did not know what happened to cause the bruises. The report identified R158 was confused, had impaired memory and was orientated to person only. Further, the report identified there had been no witnesses to R158 sustaining the bruises/injury of unknown origin.

The facility submitted a report to the SA indicating an injury of unknown source, regarding R158's bruises, on 3/25/14, at 4:35 p.m., eighteen hours and thirty three minutes after the bruises were discovered.

R56 sustained two bruises on her right hand and wrist, which was determined to be an injury of unknown origin. The facility failed to immediately report the injuries to the SA.

R56's significant change MDS dated 3/14/14, identified R56 had a diagnosis of dementia, had

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{F 225}	Continued From page 5	{F 225}		

severe cognitive impairment and received extensive assistance with all ADL's. R56's Bruise report dated 3/23/14, indicated that staff first identified bruises at 7:00 a.m. The facility incident report dated 3/23/14, at 12:45 p.m. identified one dark purple bruise on the right wrist that measured 2.4 cm x 3.8 cm, and one dark purple bruise on the right hand that measured 2.2 cm x 2.5 cm. The report indicated R56 was unaware of how the bruises occurred.

The facility reported R56's bruises, as injuries of unknown source to the SA on 3/24/14, at 5:16 p.m., thirty five hours and sixteen minutes after identifying R56's bruises 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 ensure timely reporting to the SA and also stated the facility policy directed staff to report to the SA immediately, within twenty four hours.

During interview on 4/2/14, at 11:50 a.m. the administrator stated the facility reports the initial incident to the SA within twenty four hours, then stated, "If we know it is abuse, a bruise is in a suspicious area, or neglect, the facility reports to the state agency immediately." The administrator

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{F 225}	Continued From page 6 then stated, "If the facility feels its a small bruise on a resident and is not in a suspicious area, the report is made to the state agency within twenty four hours." The administrator confirmed that it is expected that reports are made to the SA within twenty four hours per the facility policy. The undated facility policy titled, Vulnerable Adult Abuse/Neglect Prevention Plan, directed that all suspect violations or abuse would be immediately reported to the several persons or agencies which included state licensing/certification agency responsible for surveying the facility, Adult Protection Services, the local/state Ombudsman and Law Enforcement Officials. A fax or telephone call to the state agency would be acceptable to meet the requirement of immediate reporting. The policy identified verbal or written notices to agencies will be made within 24 hours of the occurrence of the incident. However, the policy contains conflicting information about the timing of reporting to the state agency which needs to be immediately.	{F 225}		
{F 226} SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility demonstrated a systematic failure to	{F 226}	F 226 a. Knute Nelson will follow their	4/16/14

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{F 226}

Continued From page 7

implement their abuse prohibition policies for immediate reporting to the state agency (SA) for 3 of 5 residents (R15, R158, R56) reviewed for abuse prohibition. This deficient practice had the potential to affect all 92 of 92 residents who resided in the facility.

Findings include:

The undated facility policy titled, Vulnerable Adult Abuse/Neglect Prevention Plan, directed that all suspect violations or abuse would be immediately reported to the several persons or agencies which included state licensing/certification agency responsible for surveying the facility, Adult Protection Services, the local/state Ombudsman and Law Enforcement Officials. A fax or telephone call to the state agency would be acceptable to meet the requirement of immediate reporting. The policy identified verbal or written notices to agencies will be made within 24 hours of the occurrence of the incident. However, the policy contains conflicting information about the timing of reporting to the state agency which needs to be immediately.

R15 sustained a fracture to left hip following a fall. The facility failed to immediately report the injury to the SA.

R15 was found lying on the floor of her room on 3/22/14, at 3:50 p.m., in front of the electric recliner chair, which was in a high position. There were no witnesses to the fall. R15 was observed to have displacement of the right hip, abrasion on left knee and large bump on the right knee. R15 was sent to the emergency room for evaluation of

{F 226}

Vulnerable Adult Reporting Policy by reporting injuries of unknown cause and injuries from an accident/incident reported to the state agencies immediately upon discovery of injury. All reportable injuries will be reported immediately to the Administrator and/or Director of Nursing. Residents R56 and R158 will have injuries of unknown cause and/or injuries from accident/incident reported immediately. Resident R15 has expired.

b. All residents of Knute Nelson have the potential to be affected by this practice. All reportable allegations will be reported per facility policy.

c. All licensed staff was trained on completing the initial report to state agencies on all injuries of unknown cause and injuries that result from an accident/incident immediately when the injury is discovered. A step by step procedure has been given to the licensed staff to follow to do a report. They have been instructed to notify the Administrator and /or Director of Nursing when a reportable injury has been discovered to inform of the injury and the report made to the state agency. Licensed staff has received the training that after the immediate initial report to the state agency they start their investigation of the injury or incident. Licensed staff has been instructed to follow the facility s Vulnerable Adult Reporting Policy. Facility Vulnerable Adult Abuse/Neglect Policy has been revised to reflect the changes of the licensed nurse reporting injuries of unknown cause immediately upon discovery of the injury to the state

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{F 226}	Continued From page 8 injuries and complaints of pain in the left hip area. R15 was admitted to the hospital with a left hip 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. R15's annual Minimum Data Set (MDS), dated 10/1/13, identified R15 had diagnoses which included dementia and depression. The MDS further identified R15 had severe cognitive impairment, required extensive assistance with mobility, transferring, toileting and did not ambulate. Further, the MDS identified R15 had functional limitations in both sides of her upper and lower body. R15's Care Area Assessment (CAA), dated 10/4/13, revealed R15 had a history of cerebrovascular accident (stroke), dementia, kyphosis (overcurvature of the thoracic vertebrae) and depression with behaviors. The CAA further identified R15 did not stand and required a total lift to transfer from bed to chair and back. R15's fall risk assessment, dated 3/5/14, identified R15 was at high risk for falls related to the inability to stand, the need for extensive assistance with transfers and the use of medications for hypertension and depression. R15's care plan, dated 3/12/14, directed staff to utilize a total body lift for transferring the resident from bed to chair and back related to R15's inability to ambulate. The care plan further revealed R15 utilized an electric recliner chair. Review of the progress notes from 3/19/14 to 3/23/14 revealed:	{F 226}	agencies. d. On-going/ at least daily audits will be conducted of all incidents by the Director of Nursing and/or designee to ensure staff are following the facility s Vulnerable Adult Reporting Policy, and that all injuries of unknown cause and injuries from accident/incident have been reported immediately upon discovery to the state agencies and that the Administrator has been notified immediately of the injury or incident. These audits will be taken to the Quality Assurance Committee for review and discussion. e. Completion date: 4/16/2014	

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{F 226}	Continued From page 9	{F 226}		

On 3/22/14, at 3:50 p.m., R15 was found lying on the floor on her back with her head towards the door and her feet towards the windows. R15 was calling out, "help, help" and the power recliner lift chair was in a high position. R15's right hip looked displaced, right leg was facing outward and complained of pain in the left hip and had an abrasion on her left knee. R15 was then transferred per ambulance to the local hospital at 4:40 p.m. The progress note indicated the director of nursing and administrator had been notified at that time.

At 11:02 p.m., the local hospital notified the facility that R15 had sustained a displaced left hip fracture.

Review of the facility incident report, dated 3/22/14 revealed R15 had been found on the floor, yelling "HELP!! HELP!! Her power recliner lift chair was in high position. The report indicated there were no witnesses for the fall, and indicated R15 had recent changes in cognitive status and an acute illness was listed as a possible cause of the fall.

Review of the report submitted to the SA, dated 3/23/14, revealed the report was received by the SA at 11:35 a.m., nineteen hours and forty five minutes after R15 experienced serious injury from R15's unwitnessed fall.

R158 sustained three large bruises on her forearm and leg, which was determined to be an injury of unknown origin. The facility failed to immediately report the injuries to the SA.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 226}	Continued From page 10	{F 226}		

R158's annual MDS revealed R158 had diagnoses which included dementia and anxiety. The MDS identified R158 had severe cognitive impairment and required extensive assistance with mobility, transfer from bed to chair, dressing and toileting.

R158's nursing assistant care plan, dated 3/13/14, directed staff to transfer R158 with a standing mechanical lift for transfers.

Review of R158's progress notes revealed the following:

On 3/24/14, at 9:58 p.m., a bruise on R158's left forearm was measured at 4 x 2 centimeters (cm) was dark purple in color, and lighter in the middle. Two bruises were noted on R158's left lower leg. One measured 2.5 x 3 cm and the other measured 4 x 3 cm, both were light blue in color.

Review of R158's incident report dated 3/24/14, revealed three bruises were observed during R158's bath. Left forearm bruise measured 4 x 2 cm dark purple in color and lighter in the middle. Two bruises on the left lower leg, one measured 2.5 cm x 3 cm and another measuring 4 cm x 3 cm. The report indicated R158 did not know what happened to cause the bruises. The report identified R158 was confused, had impaired memory and was orientated to person only. Further, the report identified there had been no witnesses to R158 sustaining the bruises/injury of unknown origin.

The facility submitted a report to the SA indicating an injury of unknown source, regarding R158's bruises, on 3/25/14, at 4:35 p.m., eighteen hours and thirty three minutes after the bruises were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING ______ B. WING ______	R 04/02/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 226}	Continued From page 11 discovered. R56 sustained two bruises on her right hand and wrist, which was determined to be an injury of unknown origin. The facility failed to immediately report the injuries to the SA. R56's significant change MDS dated 3/14/14, identified R56 had a diagnosis of dementia, had severe cognitive impairment and received extensive assistance with all ADL's. R56's Bruise report dated 3/23/14, indicated that staff first identified bruises at 7:00 a.m. The facility incident report dated 3/23/14, at 12:45 p.m. identified one dark purple bruise on the right wrist that measured 2.4 cm x 3.8 cm, and one dark purple bruise on the right hand that measured 2.2 cm x 2.5 cm. The report indicated R56 was unaware of how the bruises occurred. The facility reported R56's bruises, as injuries of unknown source to the SA on 3/24/14, at 5:16 p.m., thirty five hours and sixteen minutes after identifying R56's bruises 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	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING ______ B. WING ______	R 04/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 226}	Continued From page 12 ensure timely reporting to the SA and also stated the facility policy directed staff to report to the SA immediately, within twenty four hours. During interview on 4/2/14, at 11:50 a.m. the administrator stated the facility reports the initial incident to the SA within twenty four hours, then stated, "If we know it is abuse, a bruise is in a suspicious area, or neglect, the facility reports to the state agency immediately." The administrator then stated, "If the facility feels its a small bruise on a resident and is not in a suspicious area, the report is made to the state agency within twenty four hours." The administrator confirmed that it is expected that reports are made to the SA within twenty four hours per the facility policy.	{F 226}		

AH Form Approved

4/14/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00113	A. Building B. Wing	4/2/2014

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

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 21000 Reg. # MN Rule 4658.0610 Subp. 4 LSC	03/21/2014	ID Prefix 21665 Reg. # MN Rule 4658.1400 LSC	03/21/2014	ID Prefix 21685 Reg. # MN Rule 4658.1415 Subp. 2 LSC	03/21/2014
ID Prefix 21990 Reg. # MN St. Statute 626.557 Subd. 4 LSC	03/21/2014	ID Prefix 22000 Reg. # MN St. Statute 626.557 Subd. LSC	03/21/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/GA	04/14/2014	31593	04/02/2014

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/14/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 6SQ3
Facility ID: 00113

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/14/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **108** (L18)

13. Total Certified Beds **108** (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	108			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 03/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/21/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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;

<u>Appeal Rights</u> - 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. <u>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.</u>

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/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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING ______ B. WING ______	02/14/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted as the facility was found to be in substandard quality of care at F226, due to failure to operationalize abuse prohibition policies regarding immedate reporting to state agency allegations of mistreatment and bruises of unknown origin.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		3/21/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING ______ B. WING ______	02/14/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate and report instances of potential neglect, mistreatment and suspicious injuries of unknown origin to the state agency (SA) and the facility administrator, for 4 of 4 residents (R24, R70, R50 and R103) and for 1 of 4 resident (R24) failed to immediately notify the administrator who were reviewed for abuse prohibition. Findings include: R24 experienced a fall from a full-body	F 225	F 225 a. For R24, this resident has expired. For R50, R70 and R103 all further injuries of unknown cause or suspected abuse, neglect or mistreatment, or injury from an incident or accident will have an incident report and a thorough investigation will be complete by the charge nurse and nurse manager. The DON and Administrator will be notified immediately. If the investigation determined that the resident has injuries of unknown cause or if it is suspected that abuse, neglect or	

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mechanical lift on 9/14/13, at 6:50 p.m., during a staff-assisted transfer. The facility failed to complete an individualized assessment for selection of, and proper positioning for the lift sheet during his transfers, as was instructed by the lift manufacturer and failed to follow the care plan for sling placement while in the chair. The facility failed to report this incident of potential neglect of care to the SA.

R24's annual Minimum Data Set (MDS) dated 8/29/13, identified had moderately impaired cognition, did not ambulate and required extensive assistance of two staff for all activities of daily living (ADLs). The corresponding Care Area Assessment (CAA) identified R24 was at risk for falls, was unsteady and was "only able to stabilize with staff assistance" and utilized a mechanical lift for transfers. Review of R24's plan of care revised 9/14/13, identified diagnoses including dementia, arthritis, multiple sclerosis, kyphoscoliosis and osteoarthrosis. The care plan identified R24 was totally dependent upon staff for all ADLs and was unable to bear weight. The care plan noted R24 had an unsteady gait, physical limitations, and lack of strength. The care plan goals included safe transfers and no falls or injuries. The care plan directed two person transfers utilizing a maxilift (full body mechanical lift) and directed staff to use an amputee transfer/lift sheet and to leave the sheet in place while he was in his recliner, per R24's request. Interventions included showing R24 how to position his body parts in the lift sheet when transferring with the full-body, mechanical lift.

Review of progress notes dated 9/14/13, to

mistreatment has occurred, or an injury sustained from an incident or accident, a report will be made to OHFC and CEP.
b. All residents who have any injury, accident or incident have the potential to be affected.

c. All staff will attend a mandatory training on recognizing that injuries from unknown causes, injuries that are sustained during an incident or accident need to be reported immediately to the DON, Administrator and OHFC/CEP. Licensed staff will receive training that will include that after the initial report staff will complete a thorough investigation of all the injuries of unknown cause and any injuries from accidents or incidents, and what interventions need to be put into place to keep residents safe from abuse, neglect or mistreatment. Will receive training on using the new assessment tool to determine the correct size of mechanical lift transfer slings that each resident should be using. Staff will be trained on following the plan of care for each resident. The staff will be instructed on following Knute Nelson s Policy on incident and accident investigations and reporting.

d. Audits will be conducted daily with all incidents by DON/designee on prompt and proper incident reporting, investigation and putting interventions into place. The information from the investigation will be reviewed by the IDT team daily Monday through Friday,

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F 225	Continued From page 3 10/5/13, identified R24 fell in his room on 9/14/13, at 6:50 p.m. while being transferred from his recliner to his bed. The note indicated R24 slipped out of the lift sheet, which resulted in his head on the floor, with his legs still entwined in the lift sheet. R24 suffered a laceration to the top of his head, and complained of pain in the left-lower rib area and lower back. R24 was noted as grimacing and indicated pain when he inhaled. The note identified the root-cause for the fall as "lift sheet to [sic] small." A progress note dated 9/14/13, identified R24 was sent to the emergency room via ambulance at 7:40 p.m. for evaluation and treatment of his injuries from the fall. Review of R24's Fall forms (the follow-up documentation of R24's fall) dated 9/14/13, revealed the following: · Nursing assistant (NA)-H identified R24 was seated in his reclining chair when staff placed the lift sheet around him. While he was in the air, being transferred to the bed with the mechanical lift, he slipped out of the lift sheet and fell to the floor. NA-H documented no recent change in his condition and indicated R24 was not trying to do anything at the time of the fall. · NA-I identified R24 was in his chair when staff placed the lift sheet under him. As R24 was transferred, he slipped out of the lift sheet. NA-I noted, "He fell because the sheet slipped." NA-I documented no recent change in his condition and indicated R24 was not trying to do anything at the time of the fall. · Licensed practical nurse (LPN)-A identified R24 was being transferred from his recliner to his bed using the full-body mechanical lift when he slipped out of the lift sheet and hit his head on	F 225	looking at the cause, investigation and what interventions have been put into place. On weekends and holidays RN supervisor will review the incident reports that occur, after her initial assessment of the injury and if an injury of unknown cause or suspected abuse, neglect or mistreatment or injury from incident or accident is found the RN supervisor will report immediately to the DON, Administrator and OHFC/CEP. Audits will be done randomly on sling assessments to determine that the appropriate size slings are being used. If audits are not in compliance, further education will be conducted and if indicated disciplinary action will occur. These audits will be taken to the Quality Assurance Committee for review and discussion. e. Completion date : 3/21/14	

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the floor.

Review of R24's Fall Investigation Form dated 9/14/13, identified that prior to his fall staff had performed catheter care and changed him. No unusual actives or behaviors were present during the three hours prior to the fall. Environmental issues identified were lighting and a concern with the transfer technique detailed as "possible that lift sheet is to [sic] small." The director of nursing (DON) identified R24's fall from the full body lift on 9/14/13, resulted in an emergency room visit for staples due to a head laceration and diagnosis of thoracic contusions. The DON identified NA-I and NA-H were the staff transferring R24 with the use of a mechanical lift. NA-I and NA-H were instructed the lift sheet was to remain under R24 at all times while up, and a larger lift sheet with three hooks on each side was to be used for resident safety. Registered nurse (RN)-A identified LPN-A, NA-I, and NA-H, were re-educated on the importance of using the correct lift sheet size, the correct way to apply the lift sheet to R24, and the correct application of the lift sheet to the full body lift.

Review of email correspondence from the DON to the administrator dated 9/15/13, at 4:00 p.m. identified R24 was care planned for the lift sheet to remain under him. However, the sheet had been removed, so staff placed a lift sheet under him prior to use of the lift. The e-mail further identified, an unspecified NA "felt that maybe the lift sheet wasn't placed as evenly on both sides as it should have been, so when he leaned to the left side, he fell out of the sheet." The NA also indicated a larger sheet, one with three hooks on each side, would have been "much safer" for

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R24, and should have been used. DON noted she did not feel the staff were in error. Therefore, a report to the SA was not necessary.

During an interview on 2/13/14, at 1:30 p.m. the assistant director of nursing (ADON) confirmed R24 fell out of the full-body lift, which resulted in an emergency room visit, diagnosis of thoracic contusions, and a head injury requiring staples. The ADON stated an investigation was completed and the determination was that the lift sheet was "too small." The ADON further confirmed the staff involved with this incident were re-educated after the fall. The ADON stated this was a "reportable" incident, and should have been submitted to the SA.

During an interview on 2/14/14, at 10:02 a.m. the administrator confirmed R24's care plan, fall on 9/14/13, and that all documentation of the fall was provided. The administrator confirmed she was immediately notified of R24's fall. The administrator was not aware of the reason R24 did not have a lift sheet under him, or why a lift sheet which was too small was used during the transfer. The administrator confirmed the DON investigated the incident the following day and deemed it to be "not our fault." Therefore, it was not reported. At 11:26 a.m., the administrator indicated a resident injury due to not following the care plan was reportable to the SA, depending upon the extent of the injury.
R70 alleged she was physically abused had multiple, large bruises of unknown origin. However, facility failed to thoroughly investigate R70's allegation of mistreatment, failed to report the allegation and pattern of bruising to the SA, and failed to consistently report the bruising of

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unknown origin to the facility administrator.

R70's quarterly MDS dated 12/26/13, identified R70 had diagnoses including dementia, renal failure and anemia. The MDS revealed R24 was severely cognitively impaired and required extensive assistance with bed mobility, dressing and toileting. The MDS also noted R70 utilized a wheelchair for mobility.

Review of R70's medical record revealed the following:

· 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

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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 R70's bed rails to be padded. The incident report

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lacked evidence to indicate the facility administrator was informed of these bruises. Progress notes dated 2/3/14, at 10:34 p.m. indicated R70's physician, family and nursing supervisor were notified. However, the notes did not indicate notification was made to the facility administrator.

Though these were the third and fourth bruises identified on R70 in a span of ten days, the facility had no evidence of having reported the bruising to the SA. R70's medical record also lacked evidence to indicate the facility administrator was immediately notified of the bruising discovered on 2/3/14.

During interview on 2/13/14, at 11:40 a.m. the administrator stated she reviewed the investigation completed by staff, and felt R70's bruises were explainable because she had a history of bruises, behaviors, combativeness, and was demented. The administrator reported she felt the allegation of mistreatment was not substantiated, then added, "of course [R70] does not trust men, so we limit men going into her room." The administrator also stated staff would not have gone into R70's bedroom in the middle of the night, as they tried to leave her alone as much as possible. The administrator added, the staff did not want to disturb her and cause behaviors, because then she would be up all night. The administrator confirmed that the facility did not report R70's allegation of mistreatment and injuries of unknown origin to the SA.

On 2/14/14, at 10:21 a.m. RN-A verified she was aware of the repeated incidents of bruising for

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R70, and R70's complaint of mistreatment. RN-A stated R70 was cognitively impaired and had different stories regarding the cause of the bruising. RN-A further indicated the facility considered the incidents not reportable.

R50 and R103 had very large bruises with no known cause. The facility failed to thoroughly investigate the bruising and failed to report the bruising to the SA.

R50's annual MDS, dated 11/27/13, identified diagnoses including arthritis, peripheral vascular disease and dementia, with severely impaired cognition. R50's CAA dated 11/27/13, identified R50 had a history of dementia which impacted his ability to communicate his needs and had memory problems

An incident report for R50, dated 9/10/13, at 6:15 a.m. identified two bruises. One bruise was noted on his right bicep area, "black and blue," and measured ten by nine cm. The second bruise was on R50's right elbow, measured 15 cm by 7 cm, and was noted as the same color. R50 lacked the ability to report the cause of theses bruises. On 12/6/13 (two months and 25 days after the large, bruised areas on R50's arm and elbow were identified), a note was added to the incident report which indicated R50 knew how the bruising occurred. The revised report indicated the bruises were "possibly related to furniture or doorways." The incident report confirmed the facility administrator was immediately notified.

Progress notes dated 9/10/13, at 6:23 a.m. identified the cause of the bruises was unknown.

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Review of an injury of unknown origin decision tree (part of R50's medical record) included a hand-written note dated 9/11/13, which read, "Unexplained bruises, right upper arm and elbow, denies staff abuse. Upon review and investigation no abuse or neglect suspected." The investigation included evidence of three interviews with NAs involved with R50. The possible cause of the bruising was identified as unknown.

No further investigation of R50's bruising was completed. There was no evidence that R50's bruising was reported to the SA.

R103's quarterly MDS dated 11/6/13, identified him with diagnoses including dementia, a history of falls, and anemia. The MDS also identified R103 was severely cognitively impaired. The CAA dated 1/29/14, identified R103 had difficulty with communication due to the progression of his dementia. The CAA instructed it was necessary for facility staff to look for non-verbal cues to determine his needs.

An incident report on 10/29/13, at 9:50 p.m. identified a "red-purple" bruise which measured 14 by seven cm on the back of R103's left hand. A "blue-purple" bruise, which measured 19 cm by 8 cm was also noted, from his right wrist extending to his upper forearm. On 12/10/13 (one month and 11 days after the large bruised areas were identified), a note was added to the incident report and identified R103 with a history of self-transfers and combativeness with facility staff. The incident report confirmed the facility administrator was immediately notified.

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F 225	Continued From page 11 A progress note dated 10/29/13, at 10:35 p.m. by LPN-B, indicated the possible cause of the large bruises was R103's self-transfers and combativeness. The investigation included evidence of three interviews with NAs involved with R103, with possible causes for the bruising identified as combativeness. No further evidence of an investigation was provided for R103's bruising. There was no evidence that R103's bruising was reported to the SA. On 2/14/14, at 10:21 a.m. RN-A verified she was aware of the bruises on R50 and R103. RN-A further indicated the facility considered the incidents not reportable. On 2/14/14, at 4:21 p.m. the ADON confirmed bruising on R50 and R103. The ADON further confirmed these incidents had not been reported to the SA. Review of Injuries of Unknown Source (a tool used by the facility), prepared by Care Providers of Minnesota, undated, identified the definition of an injury of unknown source, which included the source could not be explained by the resident, and the injury was suspicious because of the extent or location. The "decision tree" on the document, directed suspicious injuries of unknown origin be immediately reported to the SA. Review of the facility's Vulnerable Adult Abuse/Neglect Prevention Plan dated 11/11, identified the purpose of the policy was to protect all adults who were dependent on others for their	F 225		

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F 225	Continued From page 12 care and to provide a safe environment. The policy included definitions of injuries of unknown source such as the extent of injury or the incidence of injuries over time. The policy further defined suspicious bruising included a bruise of significant size any place on the body that was unexplained.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility demonstrated a systematic failure to implement their abuse prohibition policies for immediate reporting to the state agency (SA), for 4 of 4 residents (R24, R70, R50 and R103) reviewed for abuse prohibition. This had the potential to affect all 98 of 98 residents who resided in the facility. The facility also failed to implement their policies for immediate reporting to the facility administrator for 1 of 4 residents (R70) and thorough investigating for 3 of 4 residents (R70, R50 and R103) with allegations of mistreatment and/or suspicious injuries of unknown origin. Findings Include: Review of the facility's policy and interviews with administration revealed a systematic failure to	F 226	F 226 a. Knute Nelson will put into place a system to ensure that the facility is following their abuse prohibition policy for immediate reporting injuries of unknown cause and injuries that are sustained because of an incident or accident. All such injuries will be immediately reported to the DON and Administrator, and immediately reported to OHFC and CEP. b. All the residents of Knute Nelson have the potential to be affected by this. Knute Nelson staff will follow their abuse prohibition policy for all the residents of the facility. c. All staff will attend a mandatory training on recognizing that injuries, from unknown causes, injuries that are	3/21/14

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implement their policy for immediate reporting of suspected or potential incidents of mistreatment, neglect and suspicious bruising of unknown origin to the SA. Review of incidents for R24, R70, R50 and R103 supported these findings.

The facility's Vulnerable Adult Abuse/Neglect Prevention Plan Policy dated 11/11, directed all suspected violations, including mistreatment, neglect, injuries of unknown source or abuse; and all substantiated incidents of abuse be reported immediately to the appropriate SA. The policy included definitions of injuries of unknown source such as the extent of injury or the incidence of injuries over time, the policy further defined suspicious bruising included a bruise of significant size any place on the body that was unexplained.

During interview on 2/13/14, at 11:40 a.m. the administrator described the facility's system for handling allegations of mistreatment, neglect and injuries of unknown origin. She stated that facility administration determined whether allegations of mistreatment and injuries of unknown origin were to be reported to the SA, after reviewing the facility's completed internal investigation. She stated if the investigation revealed no substantiating evidence, the facility did not report it to the SA. The administrator stated if the facility decided to make a report to the SA after the review of a completed investigation, the timing of the notification to the SA depended on how quick the facility was able to complete the investigation.

During interview on 2/13/14, at 12:45 p.m. the assistant director of nursing (ADON) described

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sustained during an incident or accidents need to be reported immediately to the DON, Administrator and OHFC/CEP. Training will include that after the initial report staff will complete a thorough investigation of all injuries of unknown cause and any injuries from incident/accidents and what interventions need to be put into place to keep residents safe from abuse, neglect or mistreatment. The information from this investigation will be reviewed by the IDT team daily Monday through Friday, looking at the cause, investigation and what interventions have been put into place. All nursing staff will attend training of proper transferring techniques and safe resident handling and positioning to decrease the potential of resident injury. On weekends and holidays the RN supervisor will review the incident reports that occur, after her initial assessment of the injury or incident/accident and it is determined that it needs to be reported, the RN supervisor will immediately report to DON and Administrator and immediately report to OHFC and CEP. Following Knute Nelson s policy and Federal and State Regulations, any suspected abuse and neglect will be reported immediately to the DON and Administrator and immediately to OHFC / CEP.

d. Audits will be conducted with all incidents daily by the DON or designee to ensure policies are being followed that prohibits mistreatment, abuse and neglect. These audits will be taken to the

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KNUTE NELSON	420 12TH AVENUE EAST ALEXANDRIA, MN 56308

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F 226	Continued From page 14 the facility's system for handling instances of mistreatment, neglect and injuries of unknown origin. She reported that if abuse was witnessed, it was reported right away to the SA. If there was an allegation of rough treatment or an injury of unknown origin, then an internal investigation was started. The completed investigation was reviewed by the administrator, director of nursing (DON) and ADON. After the investigation, they decided whether it was substantiated or not. If an investigation was substantiated, the facility then reported the incident to the SA. The ADON indicated they reported to the SA, "hopefully" within 24 to 48 hours. The ADON confirmed that it could have taken several days for an investigation to be completed and reviewed and the SA was not notified until after the determination of substantiated or not. During interview on 2/14/14, at 11:52 a.m. the licensed social worker (LSW) described the facility's system for handling instances of mistreatment, neglect and injuries of unknown origin. She stated the facility completed a "comprehensive investigation" for all allegations of mistreatment. After completion of the "comprehensive investigation," the DON and the administrator decided whether an allegation was substantiated or not. LSW reported if the allegation was substantiated, it was then reported to the SA within 24 hours. R24 experienced a fall from a full-body mechanical lift on 9/14/13, at 6:50 p.m., during a staff-assisted transfer. The facility failed to complete an individualized assessment for selection of, and proper positioning for the lift sheet during his transfers, as was instructed by	F 226	Quality Assurance Committee for review and discussion. Continual training will occur for staff that provides direct care. All incident reports will be reviewed by the Administrator with the DON. e. Completion date: 3/21/14	

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the lift manufacturer. The facility failed to report this incident of potential neglect of care to the SA.

R24's annual Minimum Data Set (MDS) dated 8/29/13, identified moderate cognitive impairment, did not ambulate and required extensive assistance of two staff for all activities of daily living (ADLs). The corresponding Care Area Assessment (CAA) identified R24 was at risk for falls, he was unsteady and was "only able to stabilize with staff assistance." Review of R24's plan of care revised 9/14/13, identified diagnoses including dementia, arthritis, multiple sclerosis, kyphoscoliosis and osteoarthrosis. The care plan identified he was totally dependent upon staff for all ADLs, and was unable to bear weight. The care plan directed 2 staff transfers utilizing a maxilift (full body mechanical lift) and directed staff to use an amputee transfer/lift sheet and to leave the sheet in place while he was in his recliner, per R24's request. Interventions included showing R24 how to position his body parts in the lift sheet when transferring with the full-body, mechanical lift.

Review of progress notes dated 9/14/13, identified R24 fell in his room on 9/14/13, at 6:50 p.m. while being transferred from his recliner to his bed. The note indicated R24 slipped out of the lift sheet, which resulted in his head on the floor, with his legs still entwined in the lift sheet. R24 suffered a laceration to the top of his head, and complained of pain in the left-lower rib area and lower back. R24 was noted as grimacing and indicated pain when he inhaled. The note identified the root-cause for the fall as "lift sheet to [sic] small." A progress note dated 9/14/13, identified R24 was sent to the emergency room

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via ambulance at 7:40 p.m. for evaluation and treatment of his injuries from the fall.

Review of R24's Fall forms (the follow-up documentation of R24's fall) dated 9/14/13, revealed the following:

· Nursing assistant (NA)-H identified R24 was seated in his reclining chair when staff placed the lift sheet around him. While he was in the air, being transferred to the bed with the mechanical lift, he slipped out of the lift sheet and fell to the floor. NA-H documented no recent change in his condition and indicated R24 was not trying to do anything at the time of the fall.

· NA-I identified R24 was in his chair when staff placed the lift sheet under him. As R24 was transferred, he slipped out of the lift sheet. NA-I noted, "He fell because the sheet slipped." NA-I documented no recent change in his condition and indicated R24 was not trying to do anything at the time of the fall.

· Licensed practical nurse (LPN)-A identified R24 was being transferred from his recliner to his bed using the full-body mechanical lift when he slipped out of the lift sheet and hit his head on the floor.

Review of R24's Fall Investigation Form dated 9/14/13, identified that prior to his fall staff had performed catheter care and changed him. No unusual activities behaviors were present during the three hours prior to the fall. Environmental issues identified were lighting and a concern with the transfer technique detailed as "possible that lift sheet is to [sic] small." The DON identified R24's fall from the full body lift on 9/14/13, resulted in an emergency room visit for staples due to a head laceration and diagnosis of

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thoracic contusions. The DON identified NA-I and NA-H were the staff transferring R24 with the use of a mechanical lift. NA-I and NA-H were instructed the lift sheet was to remain under R24 at all times while up, and a larger lift sheet with three hooks on each side was to be used for resident safety. Registered nurse (RN)-A identified LPN-A, NA-I, and NA-H, were re-educated on the importance of using the correct lift sheet size, the correct way to apply the lift sheet to R24, and the correct application of the lift sheet to the full body lift.

Review of email correspondence from the DON to the administrator dated 9/15/13, at 4:00 p.m. identified R24 was care planned for the lift sheet to remain under him. However, the sheet had been removed, so staff placed a lift sheet under him prior to use of the lift. The e-mail further identified, an unspecified NA "felt that maybe the lift sheet wasn't placed as evenly on both sides as it should have been, so when he leaned to the left side, he fell out of the sheet." The NA also indicated a larger sheet, one with three hooks on each side, would have been "much safer" for R24, and should have been used. DON noted she did not feel the staff were in error. Therefore, a report to the SA was not necessary.

During an interview on 2/13/14, at 1:30 p.m. the ADON confirmed R24 fell out of the full-body lift, which resulted in an emergency room visit, diagnosis of thoracic contusions, and a head injury requiring staples. The ADON stated an investigation was completed and the determination was that the lift sheet was "too small." The ADON further confirmed the staff involved with this incident were re-educated after

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the fall. The ADON stated this was a "reportable" incident, and should have been submitted to the SA.

During an interview on 2/14/14, at 10:02 a.m. the administrator confirmed R24's care plan, fall on 9/14/13, and that all documentation of the fall was provided. The administrator confirmed she was immediately notified of of R24's fall. The administrator was not aware of the reason R24 did not have a lift sheet under him, or why a lift sheet which was too small was used during the transfer. The administrator confirmed the DON investigated the incident the following day and deemed it to be "not our fault." Therefore, it was not reported. At 11:26 a.m., the administrator indicated a resident injury due to not following the care plan was reportable to the SA, depending upon the extent of the injury.

R70 alleged she was physically abused had multiple, large bruises of unknown origin. However, facility failed to thoroughly investigate R70's allegation of mistreatment, failed to report the allegation and pattern of bruising to the SA, and failed to consistently report the bruising of unknown origin to the facility administrator.

R70's quarterly MDS dated 12/26/13, identified she had diagnoses including dementia, renal failure and anemia. The MDS revealed she was severely cognitively impaired and required extensive assistance with bed mobility, dressing and toileting. The MDS also noted R70 utilized a wheelchair for mobility.

Review of R70's medical record revealed the following:

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· 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, addressed the allegation of mistreatment. The note revealed interviews with NAs were

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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 R70's bed rails to be padded. The incident report lacked evidence to indicate the facility administrator was informed of these bruises. Progress notes dated 2/3/14, at 10:34 p.m. indicated R70's physician, family and nursing supervisor were notified. However, the notes did not indicate notification was made to the facility administrator.

Though these were the third and fourth bruises identified on R70 in a span of ten days, the facility had no evidence of having reported the bruising to the SA. R70's medical record also

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lacked evidence to indicate the facility administrator was immediately notified of the bruising discovered on 2/3/14.

During interview on 2/12/14, at 2:30 p.m. the ADON stated she was certain the DON did a thorough investigation of R70's allegation and bruising, but verified she did not report either to the SA.

During interview on 2/13/14, at 11:40 a.m. the administrator stated she reviewed the investigation completed by staff, and felt R70's bruises were explainable because she had a history of bruises, behaviors, combativeness, and was demented. The administrator reported she felt the allegation of mistreatment was not substantiated, then added, "of course [R70] does not trust men, so we limit men going into her room." The administrator also stated staff would not have gone into R70's bedroom in the middle of the night, as they tried to leave her alone as much as possible. The administrator added, the staff did not want to disturb her and cause behaviors, because then she would be up all night. The administrator confirmed that the facility did not report R70's allegation of mistreatment and injuries of unknown origin to the SA.

On 2/14/14, at 10:21 a.m. RN-A verified she was aware of the repeated incidents of bruising for R70, and R70's complaint of mistreatment. RN-A stated R70 was cognitively impaired and had different stories regarding the cause of the bruising. RN-A further indicated the facility considered the incidents not reportable.

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R50 and R103 had very large bruises with no known cause. The facility failed to thoroughly investigate the bruising and failed to report the bruising to the SA.

R50's annual MDS, dated 11/27/13, identified diagnoses including arthritis, peripheral vascular disease and dementia, with severely impaired cognition. R50's CAA dated 11/27/13, identified R50 had a history of dementia which impacted his ability to communicate his needs and had memory problems

An incident report for R50, dated 9/10/13, at 6:15 a.m. identified two bruises. One bruise was noted on his right bicep area, "black and blue," and measured ten by nine cm. The second bruise was on R50's right elbow, measured 15 cm by 7 cm, and was noted as the same color. R50 lacked the ability to report the cause of theses bruises. The incident report confirmed the facility administrator was immediately notified. On 12/6/13 (two months and 25 days after the large, bruised areas on R50's arm and elbow were identified), a note was added to the incident report which indicated R50 knew how the bruising occurred. The revised report indicated the bruises were "possibly related to furniture or doorways."

Progress notes dated 9/10/13, at 6:23 a.m. identified the cause of the bruises was unknown.

Review of an injury of unknown origin decision tree (part of R50's medical record) included a hand-written note dated 9/11/13, which read, "Unexplained bruises, right upper arm and elbow, denies staff abuse. Upon review and

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investigation no abuse or neglect suspected." The investigation included evidence of three interviews with NAs involved with R50. The possible cause of the bruising was identified as unknown.

No further investigation of R50's bruising was completed. There was no evidence that R50's bruising was reported to the SA.

R103's quarterly MDS dated 11/6/13, identified him with diagnoses including dementia, a history of falls, and anemia. The MDS also identified R103 was severely cognitively impaired. The CAA dated 1/29/14, identified R103 had difficulty with communication due to the progression of his dementia. The CAA instructed it was necessary for facility staff to look for non-verbal cues to determine his needs.

An incident report on 10/29/13, at 9:50 p.m. identified a "red-purple" bruise which measured 14 by seven cm on the back of R103's left hand. A "blue-purple" bruise, which measured 19 cm by 8 cm was also noted, from his right wrist extending to his upper forearm. On 12/10/13 (one month and 11 days after the large bruised areas were identified), a note was added to the incident report and identified R103 with a history of self-transfers and combativeness with facility staff. The incident report confirmed the facility administrator was immediately notified.

A progress note dated 10/29/13, at 10:35 p.m. by LPN-B, indicated the possible cause of the large bruises was R103's self-transfers and combativeness. The investigation included evidence of three interviews with NAs involved

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F 226	Continued From page 24 with R103, with possible causes for the bruising identified as combativeness. On 2/14/14, at 10:21 a.m. RN-A verified she was aware of the bruises on R50 and R103. RN-A further indicated the facility considered the incidents not reportable. On 2/14/14, at 4:21 p.m. the ADON confirmed bruising on R50 and R103. The ADON further confirmed these incidents had not been reported to the SA. No further evidence of an investigation was provided for R103's bruising. There was no evidence that R103's bruising was reported to the SA. Review of Injuries of Unknown Source (a tool used by the facility), prepared by Care Providers of Minnesota, undated, identified the definition of an injury of unknown source, which included the source could not be explained by the resident, and the injury was suspicious because of the extent or location. The "decision tree" on the document, directed suspicious injuries of unknown origin be immediately reported to the SA.	F 226		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		3/21/14

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F 323	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure manufacturer's guidelines and care plan interventions were followed to minimize the risk of injury for 1 of 4 residents (R24) reviewed for accidents. In addition the facility failed to ensure a safety assessment had been completed for 1 of 1 resident (R223) who utilized an ill-fitting mattress. This practice resulted in actual harm for R24. Findings include: According to review of nurses' notes, R24 (closed record) experienced a fall from a full body mechanical lift during staff assisted transfer from a reclining chair to a bed on 9/14/13, at 6:50 p.m. The facility had not followed the manufacturer's instructions for individualized assessment of the lift sheet selection, proper positioning of the lift sheet and care plan interventions during the transfer for R24. R24 sustained a laceration to the head, which required staples, a contusion to the left chest wall, and lower back pain. Review of R24's medical record identified R24 had diagnoses which included dementia, arthritis, multiple sclerosis (degenerating nerve disease), kyphoscoliosis (abnormal curvature front to back of the upper spine) and osteoarthrosis. The annual Minimum Data Set (MDS) dated 8/29/13, identified R24 had moderate cognitive impairment, had impairments on both sides of upper and lower body and did not ambulate. The MDS identified R24 required extensive	F 323	F 323 a. For R24, resident has expired, R223, resident has been discharged. b. All residents have the potential to be affected. c. All staff will receive education on ensuring that the resident s environment remains as free of accident hazards as is possible. Licensed nursing staff will be trained on completing a new assessment tool that has been developed for all residents who use full mechanical lifts for appropriate sling size. Resident care plans will be reviewed by the nursing assistants prior to providing care. All nursing staff will attend an in-service training on reading and following the plan of care. All staff will be trained on a new safety assessment tool that has been developed and will be completed by Environmental Services on each bed that when a resident discharges and the bed is being prepared for a new resident that the staff will do a safety assessment to make sure that the mattress fits the bed appropriately and anytime a mattress is switched out a new assessment is completed. d. Audits will be put into place to monitor that facility is kept free of accident hazards. DON or designee will do random audits that mechanical sling assessments are being completed and that appropriate size slings are being used for residents	

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F 323	Continued From page 26 assistance of 2 staff for all activities of daily living (ADL), including transfers, bed mobility and toileting. The Care Area Assessment (CAA), dated 9/3/13, identified R24 was 5 feet 8 inches tall and weighed 220 pounds, had memory problems,required verbal reminders, and utilized oxygen for episodes of shortness of breath. Further, the MDS identified R24 required assistance with ADLs and mobility and was transferred with assist from two staff and a full lift. R24's care plan, revised 9/30/13, identified a problem related to transferring with a goal for continued safe transfers with no falls or injury. The care plan directed two person transfers utilizing a maxilift (full body mechanical lift), and use of an amputee transfer/lift sheet for transfers. The care plan further directed staff to leave the lift sheet in place when in recliner per request, due to his discomfort while trying to place lift sheet in place when time to transfer to bed. Review of progress notes from 9/14/13, to 10/5/13, identified R24's fall in room on 9/14/13, at 6:50 p.m. while being transferred from recliner to bed. The note indicated R24 slipped out of the lift sheet resulting in his head landing on the floor and legs still entwined in the lift sheet. R24 had a laceration on the top of his head, complained of pain in the left lower rib area, and lower back. R24 was grimacing and stated it was painful when he inhaled. The note identified the root cause or source of occurrence of injury as "lift sheet too small." The progress note at 7:40 p.m., identified R24 had been transferred to the emergency room for treatment after the fall. Review of the emergency room physician	F 323	that transfer with mechanical lifts. DON or designee will do random audits to ensure that the care plans are being reviewed and followed prior to providing cares, by interviewing staff and observing cares. Environmental services will do random audits that each resident bed has a mattress that matches the bed length. These audits will be taken to the Quality Assurance Committee for review and discussion. e. Completion date: 3/21/14	

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F 323	Continued From page 27 documentation dated 9/14/13, identified R24 had slipped out of the lift, fallen, hitting the right side of his head on a dresser and hitting the right upper chest on the floor. R24 complained of head pain, and bilateral (both sides) lower rib pain, and new lower back pain. Emergency room treatment included x-rays of the head, spine, abdomen, staples placed for the three centimeter (cm) head laceration and a narcotic pain medication was ordered for R24's pain. Review of the follow up documentation of the fall from the lift, completed by involved facility personnel revealed the following: - Nursing assistant (NA)-H identified R24 was seated in his reclining chair, staff placed the lift sheet around R24 and while R24 was in the air being transferred to the bed, with the use of the mechanical lift, he slipped out of the lift sheet and fell to the floor. NA-H documented no recent change in R24's condition, and R24 had not been trying to do anything. - NA-I identified R24 was in his chair when staff placed the lift sheet under him, as R24 was transferred he slipped out of the lift sheet. NA-I documented "he fell because the sheet slipped". NA-I documented no recent change in R24's condition, and R24 had not been trying to do anything. - Licensed practical nurse (LPN)-A identified the resident was being transferred from his recliner to his bed using the full body mechanical lift, when he slipped out of the lift sheet and hit his head on the floor. - A form titled Fall Investigation Form dated 9/14/13, identified prior to R24's fall on 9/14/13, at 6:50 p.m. staff had performed catheter care and changed R24, no unusual actives or	F 323		

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behaviors were present 3 hours prior to the fall. The form included an identified concern with transfer technique had been documented as "possible that lift sheet is to small."
-The director of nursing (DON) documentation of the fall identified R24's fall from a full body lift on 9/14/13, resulted in an emergency room visit for staples placed for a head laceration and diagnosis of thoracic contusions. The DON identified R24 did not have the lift sheet under him, so the lift sheet had to be placed while R24 was in the recliner. NA-I and NA-H started to lift R24 with the mechanical lift, his buttock was out some on the left side of the lift, they pulled it down and continued with the transfer. R24 was noted to lean to the right and as he was moved near the bed, R24 moved and slid out of the lift sheet to the floor. The documentation indicated after the fall, NA-I and NA-H were instructed the lift sheet was to remain under R24 at all times when up, and a larger lift sheet with 3 hooks on each side was to be used for resident safety.
- Registered Nurse (RN)-A's fall follow up documentation dated 9/19/13, identified LPN-A, NA-I, and NA-H, were re-educated on the importance of correct lift sheet size use, correct way to apply the lift sheet to R24, and the correct application of the lift sheet to the full body lift. However, the facility lacked documentation that all nursing staff were educated on the proper size selection and positioning for lift slings.

An e-mail (electronic mail) correspondence, provided by the facility, from the director of nursing (DON) to the administrator, dated 9/15/13, at 4:00 p.m. identified R24 care plan included the need for a lift sheet to remain under him, however it had been removed and staff had

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placed a lift sheet under him prior to use of the lift. The e-mail further identified the "NA felt that maybe the lift sheet wasn't placed as evenly on both sides as it should have been so when he leaned to the left side he fell out of the sheet." The e-mail indicated the NA stated a larger sheet, one with three hooks on each side should be used as it would be "much safer" for R24.

Review of the medical record revealed the care area assessment (CAA) dated 9/3/13, identified R24 utilized a full body mechanical lift for transfers, however the record lacked documentation of an assessment for lift sheet sizing or type for R24. No further assessments of proper sling use or sizing was found in the medical record.

During interview on 2/13/14, at 1:30 p.m. the assistant director of nursing (ADON) confirmed R24's care plan and confirmed R24 had fallen while transferred with the full body lift, which resulted in injury for R24. The ADON stated an investigation had been completed and determined the lift sheet was "too small." The ADON further confirmed the staff involved with this incident were reeducated after the fall.

During interview on 2/14/14, at 9:21 p.m. registered nurse (RN)-A indicated R24's fall was due to use of a lift sheet that "was too small." RN-A was not aware what lift sheet type or size was used during R24's transfer and was not aware why a lift sheet which was too small had been used. RN-A confirmed that no documented assessments for lift sheet size were performed. She stated she was not aware of a specific person in charge of choosing the correct lift sheet

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size for residents and stated the individual lift sheets used for transfers were chosen by any staff member including the nursing assistants. Once the lift sheet was placed in a residents' room for use, the lift sheet remained there unless it needed laundering. RN-A indicated at times physical therapy would assess and recommend use of the mechanical lift for resident transfers. However, therapy would not recommend a specific size of lift sheet for the individual residents. RN-A stated she instructed staff involved with R24's fall on the proper size lift sheet for each resident and reviewed how to apply a lift sheet. She indicated all nursing staff completed an annual competency review of mechanical lift use. RN-A indicated she was unaware of how the sizing of the lift sheets were determined and stated, "I think they are color coded."

During interview on 2/14/14, at 10:02 a.m. the administrator confirmed R24's care plan at the time of the fall, and confirmed the findings in the investigation of the fall. The administrator was not aware of the reason R24 did not have a lift sheet under him or why a lift sheet which was too small had been used during the transfer. The administrator confirmed the current facility policy and stated the DON was responsible for the follow up of the fall and had done so.

During interview on 2/14/14, at 11:03 a.m. LPN-E confirmed the manufacturer's guidelines for lift use and Positioning Instructions & Sling Application Guide, and stated these were in a cloth pouch on each mechanical lift, to be available for staff reference.

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During interview on 2/14/14, at 12:23 p.m. the ADON confirmed she would expect the manufacturer's guidelines for mechanical lift use were to be followed by all staff. The ADON confirmed staff were expected to follow care plan interventions.

Review of the product information provided by the facility revealed the manufacturer's guidelines from T.H.E. Medical, professional patient care products titled Sling Models and Specifications listed various models for use with sizing and average weight guidelines. However, the form identified weight guidelines were approximate only, and identified proper sizing depended more on patient body composition (muscle tone, medical condition, % of body fat etc.). The specifications directed patient assessment to be performed on a case by case basis to ensure safe sling sizing.

Review of the literature attached to the facility mechanical lifts revealed the following:
- Operating Instruction's Manual, Ultralift 2500X/3500X dated 8/23/07, revealed various instructions which included running the boom and maintenance of the lift. However, the manual did not include instructions for proper sizing, placement and use of the lift sheets using with the mechanical lift device.
- Patient Positioning Instructions and Sling Application Guide, undated, by T.H.E. Medical Professional Patient Care Products, included instructions for positioning for proper placement of a sling and directed to ensure the sling is properly centered under the patient.

The facility's policy titled Safe Patient Handling

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F 323	Continued From page 32 /Limited Lift Policy, review date 5/2013, indicated initial screening was required on all residents to assess transfer status. The policy also indicated a registered nurse should perform the assessments with the potential assist of physical therapy, and a charge nurse or nurse manager was responsible for changes to the care plan. Review of the facility form titled, Competency Checklist, Maxi Mechanical Lifts, dated 6/27/12, listed Critical Elements for use of the mechanical lift during transfers. However, the competency checklist did not include elements related to proper sizing of the slings to be used for residents. R223 utilized one side rail and had a mattress that was not compatable with her bed frame, potentially exposing gaps with the risk for entrapment, without assessment of her safe use of these atypically matched devices. R223's hospital admission records dated 1/24/14, revealed she had a history of frequent falls and diagnoses which included a fractured right arm, back pain and osteoporosis. The admission MDS dated 2/6/14, identified R223 was cognitively intact and required extensive assistance of one with bed mobility and transfers. Review of the care plan dated 1/24/14, indicated R223 required assistance of one staff for dressing, ambulation, and transfers. The care plan did not address bed mobility. During observation on 2/11/14, at 12:29 p.m. R223 was on the bed, lying on her back. R223's eyes were closed and a silver colored one-half side rail was noted on the outer side of the bed, in the upright position. The mattress on R223's	F 323		

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bed was observed to be shorter than the length of the bed. There was a four inch gap from the head of the bed to the top of the mattress.

On 2/11/14, at 3:25 p.m. NA-A stated R223 required one assist with transfers and utilized a walker with an arm raiser on the walker due to her fractured arm. NA-A added, R223 required one assist to sit up in bed and was independent in bed mobility.

On 2/11/14, at 4:07 p.m. the ADON confirmed the mattress on R223's bed was too small for the bed frame. However, the ADON indicated she was not previously aware she had an ill-fitting mattress. The ADON verified no assessment had been completed to evaluate R223's safety with use of the ill-fitting mattress. She added, she expected the correct mattress to be used for each bed.

On 2/11/14, at 4:10 p.m. RN-B confirmed R223's mattress was not compatible with the bed frame. However, she was not aware how the mismatch occurred.

During observations on 2/12/14, at 7:10 a.m. and 7:27 a.m., R223 was lying in bed with the same ill-fitting mattress. At 7:46 a.m., the ADON confirmed the mattress had not yet been changed. At 8:07 a.m., R223's mattress was replaced with a mattress that was appropriate for the bed frame.

On 2/12/14, at 8:07 a.m. the certified occupational therapy assistant (COTA) said they were working with R223 with ADLs, transfers in and out of bed, and toilet transfers. The COTA

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F 323	Continued From page 34 indicated R223 required a minimal amount of verbal cues from staff and required standby assistance of one. The facility did not have a policy for correct mattress sizing but used the undated, manufacturer guidelines for bed assembly instructions. The guidelines indicated the Maxxum bed had been designed to minimize the risk of entrapment and the side rails worked together with the mattress to minimize the gaps exposed to during normal use. In addition, it directed it was up to the end user to determine whether a different mattress was suitable for minimizing entrapment risks.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement hand hygiene practices to minimize the potential for food borne illness, for 3 of 59 residents (R39,R45,R62,) who were served food from the Pine dining room, and 3 of 12 residents (R131,R25,R42) observed in the Maple's dining	F 371	F 371 a. All food prepared and served will be done so under sanitary conditions. Staff that is responsible for serving residents will not touch the resident s food without a glove on or use of a utensil. Staff preparing food will not touch any	3/21/14

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F 371	Continued From page 35 room. Findings include: Observations of the Pine dining room, cook (C)-A failed to practice proper hand hygiene during meal service to R39, R45 and R62. During observation in the Pines dining room on 2/10/14, at 5:26 p.m. C-A donned vinyl-type gloves on both hands. C-A grabbed the refrigerator handle, opened the refrigerator, picked up several covered canisters, and placed them on a table directly across from the refrigerator. C-A opened each covered canister and prepared to make a chef salad. Using the same gloves contaminated by the refrigerator handle and canisters, C-A reached into each of the canisters containing lettuce, ham, tomatoes, cheese, and hard boiled eggs, handing these items with both hands. C-A then arranged the salad items on the plate with the same gloved hands. C-A then removed the contaminated gloves at 5:28 p.m. At 5:34 p.m., C-A donned a new pair of gloves. C-A grabbed the refrigerator handle, opened the refrigerator, reached into the refrigerator and opened a covered canister of pears. Using the same gloves contaminated by the refrigerator handle and canister, C-A reached into the canister of pears with her hands and picked out a handful of pears and put them in a bowl. Without changing gloves, C-A prepared another chef salad, again reaching into each of the canisters and handling lettuce, ham, cucumbers, tomatoes, cheese, and a hard-boiled eggs. C-A then arranged all items on a plate with the same dirty	F 371	contaminated object while preparing food with gloved hands. b. All residents in the facility have the potential to be affected by this, as all residents have their food prepared and served by staff. c. Staff will attend training on how to prepare and serve residents and not touching the food with ungloved hands or use of a utensil. Staff that prepares food will be trained on not touching any item which may be contaminated including refrigerator handles and containers of food while preparing food with a gloved hand which may cause cross contamination. Staff will receive in-service training on following policy on proper hand washing techniques to follow between glove usages. Staff serving food will be trained on not touching the residents food without a gloved hand or not using a utensil. d. Audits will be conducted randomly by DON or designee and Dietary Manager to ensure cross contamination in not occurring with food preparation with gloved hands and following policy on hand washing, as well as audits will be conducted on all staff that serve and assist with tray set up ensuring that no food item is touched with ungloved hand. These audits will be taken to the Quality Assurance Committee for review and discussion. e. Completion date: 3/21/14	

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gloved hands.

At 5:44 p.m., C-A donned a clean pair of gloves. C-A used her gloved hands to open a drawer to grab a spatula, then immediately picked up two slices of unwrapped cheese with the gloved hands contaminated by the drawer handle. C-A used a spatula to move a grilled cheese sandwich from the grill to a plate, and then proceeded to place one gloved hand directly over the entire sandwich and cut the sandwich with the other gloved hand. The chef salads made by C-A, were then served to R39 and R45. The grilled cheese sandwich made by C-A, was served to R62.

During interview on 2/10/14, at 5:58 p.m. C-A reported that she normally changed gloves after touching dirty items and before touching ready to eat foods. C-A stated, "I think I did the salads wrong because I touched the outside of the containers and fridge handle which were dirty and used the same gloves." C-A confirmed that the handle on the refrigerator, drawer handle, and containers were considered not clean. C-A added, "We use a lot of gloves and it is really busy tonight."
During observations in the Maples dining room, nursing assistants (NA)-J and NA-K used their bare hands to handle ready-to-eat foods that had been served to R131, R25 and R42.

During observation of the Maple's dining room, evening meal service on 2/10/14, at 5:32 p.m. NA-J placed her bare hand on top of R131's chicken sandwich bun. NA-J pressed down on the bun while using her other hand to cut the sandwich in half with a knife.

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At 5:35 p.m. NA-K removed the top bun of R25's chicken sandwich with her bare hand, and placed it on R25's plate. NA-K applied mayonnaise to the chicken sandwich, then reapplied the top bun with her bare hands.

At 5:38 NA-J handled R42's chicken sandwich bun with bare hands and adjusted the top bun onto the chicken patty. NA-J touched and pushed the quartered sandwich, multiple times with her bare fingers. NA-J then picked up a fork and continued to push at the sandwich pieces.

During interview on 2/10/14, at 5:55 p.m. NA-K confirmed she had handled R131 and R42's food with bare hands while she offered and applied condiments for their chicken sandwiches. NA-K confirmed touching ready-to-eat foods with bare hands was not a usual practice. She further stated that she should have asked the resident to move the bun and if they could not, a glove should have been used. NA-K confirmed gloves were available in the kitchen for staff use.

During an interview on 2/10/14, at 7:34 p.m. NA-J confirmed she had touched R42's foods with bare hands during the evening meal service. NA-J stated, "It was wrong of me," and confirmed the usual practice would have been to use a fork and knife to touch the ready-to-eat foods.

During interview on 2/12/14, at 12:27 p.m. the assistant director of nursing (ADON) confirmed staff were not to handle ready-to-eat foods with their bare hands. In addition, the ADON reported she expected staff to wear gloves if touching resident foods directly.

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	245435	A. BUILDING ______ B. WING ______	02/14/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	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.	F 371		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE 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. Findings include:	F 465	F 465 a. Maintenance staff will remove and replace caulking on sink in room R22, repair and replace 2 feet of caulking on top of base of room R123, replace medicine cabinet door of bathroom in room R223, install 3 tile bases in	3/21/14

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F 465	Continued From page 39 During the environmental tour of the facility on 2/14/14, at 8:44 a.m. with the maintenance director, the following concerns were identified: Resident bathroom door frames were noted to have scratched and missing paint on one or both sides, for R129, R146, R92, R153, R70, and R71. Resident toilets had cracked and discolored caulking around the toilet base for R58 and R71. R70's room had a metal plate fastened behind the toilet seat that was rough, discolored and missing paint. Resident bathroom sinks had cracked and discolored caulking at the back of the sink, along the wall for R3 and R22. R123's bathroom base boards were noted to have discolored glue or caulking, spanning two feet along the top of the base board. Resident room and/or bathroom doors were chipped and rough along the edge, for R129, R225, R153, and R3's rooms. Loose and missing bathroom tiles were noted in R6's room. Loose, chipped and rough veneer on the medicine cabinet in R223's resident bathroom. R51's bathroom walls were noted to have missing paint and gouged sheet rock along the lower part of all three walls. R92's resident room was noted to have missing paint and gouged sheet rock in an area measuring one and a half feet, directly behind the resident's reclining chair. Review of the three facility maintenance logs identified that staff made nearly daily entries for repairs, with the tasks then completed by a	F 465	bathroom of room R6, repair walls and paint touchup in bathroom of room R51, repair holes and paint one wall of room R92, sand, stain and seal bathroom door where rough edges are in bathrooms of room R129, R225, R153 and R3. b. All residents in the facility have the potential to be affected by this. c. Maintenance will complete a monthly walk through of resident rooms and bathrooms. First week will cover Short Term Rehab Center. Second week will be the Maples. Third week will be the Pines and Evergreens. The forth week will cover resident common areas. They will check for paint scrapes on doorways, check for door scrapes, wall touch ups and environmental concerns in general. Then complete the necessary repair and log it in the maintenance repair book at each neighborhood station. All staff will receive in-service training on when they notice any immediate environmental concerns that they record in Maintenance repair book to be addressed. d. Audits will be conducted weekly by Maintenance staff and/or designee to ensure that all necessary environmental concerns have been addressed including any concerns in Maintenance repair book has been addressed. These audits will be taken to the Quality Assurance Committee for review and discussion. e. Completion date: 3/21/2014	

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F 465	Continued From page 40 maintenance person. However, only one entry was made for a request of missing paint in a resident room during the past two months. During interview on 2/14/14, at 9:14 a.m. the maintenance director stated the facility plan for resident room repairs was for floor staff to document needs in the log books, with maintenance staff reviewing the log books several times throughout the day. The maintenance director confirmed the only other follow-up for repairs was when a resident moved out of their room. At that time, the room was inspected by maintenance with all repairs being completed, from flooring to paint. The maintenance director confirmed the above findings and the lack of staff request on the maintenance logs for paint and caulking issues. A facility maintenance policy was requested, but not provided.	F 465		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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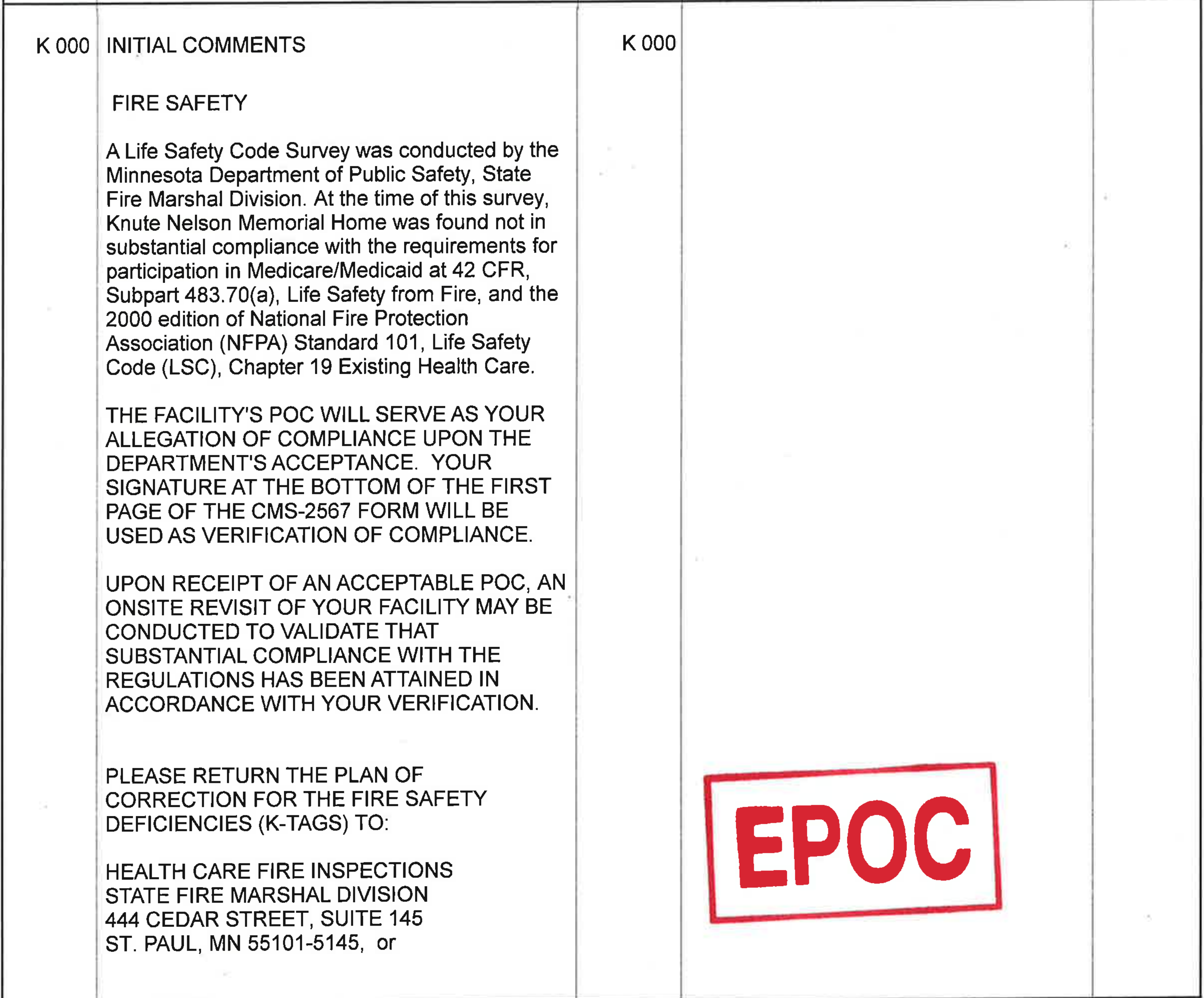

K 000 INITIAL COMMENTS — K 000

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

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Knute Nelson Memorial Home is a 1-story building with a partial basement. The building was constructed at 5 different times. The original building was constructed in 1958 and was determined to be of Type II(111) construction. In 1961, an addition was added to the east was determined to be of Type II(111)construction. These 2 sections of the facility are separated by 2-hour fire resistive construction and are used for administration purposes only and were no included in this survey. In 1970 and addition was added to the south that was determined to be Type II(000) construction. In 1976 an addition was added to to the south that was determined to be Type V(111) construction. In 1980 additions were added to the east and south that were determined to be Type V(111) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The entire facility is protected by a complete fire	K 000		

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K 000	Continued From page 2 sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 108 beds and had a census of 98 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practice could negatively affect the residents, staff, and visitors as smoke and fire in this rooms could enter the corridor making it untenable.	K 029	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 monitor all soiled and clean utility doors for proper fitting door and closure with positive latch	4/15/14

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K 029	Continued From page 3 Findings include: On facility tour between 9:30 AM to 1:30 PM on 02/11/2014, observation revealed, that the door to the 600 wing soiled utility room did not completely close and positively latch into the frame. This deficient practice was verified by the Facility Administrator (AU).	K 029	into the door frames in accordance with 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	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an	K 056	K 056 4 sprinkler heads in the wheelchair washing room were replaced and installed in accordance to NFPA 13, Standard for the Installation of Sprinkler Systems to remove the painted sprinkler heads. The sprinkler gauges on the dry pipe sprinkler	3/17/14

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K 056	Continued From page 4 emergency that would affect all residents, visitors and staff of the facility. Findings include: On facility tour between 9:30 AM to 1:30 PM on 02/11/2014, observations reveled the following deficient conditions affecting the facility's fire sprinkler system: 1. the spare sprinkler head box was not equipped with at least 2 of every type and style of sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the elevated temperature type of sprinkler heads that were located in the northwest boiler room. 2. It could not be verified when the sprinkler gauges located on the main fire sprinkler riser 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).	K 056	riser in the Maples Wing were replaced. The spare sprinkler box is now equipped with 2 spares of every style and type of sprinkler heads located throughout the facility including the missing high temp heads for the northwest boiler room. The sprinkler system will be maintained on a quarterly basis in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. The Director of Environmental Services and maintenance department will be responsible for proper maintenance and inspection of sprinkler system and compliance with NFPA 13 and 25. Completion Date: 03/17/2014 Responsible Person: Tom Storer, Director of Environmental Services	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		3/11/14

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K 062	Continued From page 5 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: On facility tour between 9:30 AM and 1:30 PM on 02/11/2014, a review of documentation and interview with the Facility Administrator (AU), revealed the facility failed to provide documentation for 1 out of the last 4 quarterly fire sprinkler flow tests inspections required by NFPA 13(99) and NFPA 25(98). This deficient practice was verified by the Facility Administrator (AU).	K 062	K 062 The facility has confirmed a scheduled date and time each quarter for our quarterly fire sprinkler flow test for our fire sprinkler system. These tests will occur on the 2nd Tuesday of each March, June, September and December. Our vendor, Simplex Grinnell, has confirmed they missed our quarterly inspection in September 2013 and the annual inspection for June 2013 was done in August 2013. We are back on schedule with the quarterly inspection for the first quarter of 2014 occurring on March 11, 2014. The Director of Environmental Services and maintenance department will be responsible for proper maintenance and inspection of sprinkler system and compliance with NFPA 13 and 25. Completion Date: 03/11/2014 Responsible Person: Tom Storer, Director of Environmental Services	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		3/20/14

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K 067	Continued From page 6 This STANDARD is not met as evidenced by: Based on documentation review, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 9:30 AM to 1:30 PM on 02/11/2014, it was revealed during the review of facility's fire and smoke damper test and inspection documentation and confirmed by interview with the Facility Administrator (AU), that the facility failed to provide documentation that the fire and smoke dampers had been tested/inspected within the last 4 years in accordance with NFPA 90(99) section 3-4.7. This deficient practice was verified by the Facility Administrator (AU).	K 067	K 067 Maintenance failed to complete the testing and inspection of the fire and smoke dampers on a every four year basis. The last inspection was in November 2009. Maintenance will review our Life Safety code book every quarter to ensure all inspections are completed when due and the reports are kept in the book for easy review. The director of environmental services has created a recurring calendar reminder to ensure the fire and smoke damper testing and inspection is completed every four years on time. The Director of Environmental Services and maintenance department will be responsible for maintaining the fire/smoke damper system in accordance with NFPA 90(99) Section 3-4.7. Completion Date: 03/20/2014 Responsible Person: Tom Storer, Director of Environmental Services	