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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6VH1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00113

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/4/2014** (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 **85** (L18)

13.Total Certified Beds **85** (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: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(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):

17. SURVEYOR SIGNATURE Date :
Patrici Bernstetter, HFE NEII 12/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/22/20144 (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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245435

December 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 November 18, 2014 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 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/ letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulations Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 10, 2014

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

RE: Project Number S5435025

Dear Ms. Urman:

On October 31, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 17, 2014. This survey found the most serious deficiencies 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 December 4, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 12, 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 standard survey, completed on October 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 18, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 17, 2014, effective November 18, 2014 and therefore remedies outlined in our letter to you dated October 31, 2014, will not be imposed.

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

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

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

Sincerely,

Mark Meath

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

Telephone: (651) 201-4118
Fax: (651) 215-9697

5435r15

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245435	A. Building B. Wing	12/4/2014

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **11/18/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **11/14/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **11/18/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **11/18/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/mm	12/10/2014	33563	12/04/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/17/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245435	A. Building / B. Wing: 01 - MAIN BUILDING 01	11/12/2014

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 K0050	10/31/2014	ID Prefix Reg. # NFPA 101 LSC K0062	10/29/2014	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** PS/mm	**Date:** 12/10/2014	**Signature of Surveyor:** 27200	**Date:** 11/12/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 10/14/2014		**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

ID: 6VH1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00113

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/17/2014** (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 **85** (L18)

13.Total Certified Beds **85** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(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):

17. SURVEYOR SIGNATURE Date :
Miriam Thornquist, HFE NEII 11/19/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/17/2014 (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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 31, 2014

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

RE: Project Number S5435025

Dear Ms. Urman:

On October 17, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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. 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:

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

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

Remedies - 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;

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

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 November 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 November 26, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 January 17, 2015 (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 April 17, 2015 (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) 215-0525

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

5435s15

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 _____	10/17/2014

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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		11/18/14

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

Electronically Signed | 11/07/2014

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 _____	10/17/2014

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 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure private heath information was not accessible to the public for 2 of 32 residents (R62, R156) who resided on the Pines unit. Findings include: During observations on 10/14/14 at 9:02 a.m. and 10/15/14 at 7:36 a.m., R62's weekly activity routine was affixed to the outside of the bedroom door facing the hallway. R62's weekly activity routine was typed on a 8 1/2 x 11 inch sheet of white paper which included R62's first and last name, various activities that were to be offered, and on the bottom of the paper was typed "Resident to be ambulated minimum of 2x per day." During interview on 10/16/14, at 9:07 a.m. R62 reported she/he was not aware that the weekly activity routine that included personal care direction was posted to the outside of the bedroom door, and could not recall being asked permission prior to the facility posting the document on the door. During interview on 10/16/14, at 9:12 a.m.	F 164	F 164 a. For resident R62 and R156, Knute Nelson removed all personal information that was able to be viewed by others. Knute Nelson will provide an environment that maintains or enhances dignity. No clinical information will be posted on the resident□s doors or in view of visitors and other residents to see. To ensure that no other personal information was posted for others to view the Director of Nursing did a walk through to ensure that no personal information was posted for others to view. b. All residents in the facility have the potential to be affected by this practice. c. An observational walk through was completed throughout the facility to assure that there was not any confidential information posted on doors or in view of visitors and other residents to see. The Director of Nursing completed education to all staff on maintaining the resident□s dignity by not posting confidential information specific to the resident□s for others to view. The training also included promoting dignity and respect of residents, by not displaying confidential information. The training was held on November 11, 2014.	

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 _____	10/17/2014

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 164	Continued From page 2 activity assistant (AD)-A stated R62's wife had requested the activity calendar to be posted on the bedroom door so staff would know what activities were to be offered, AD-A was not aware the personal care direction was on the bottom of the activity routine and did not know who added that information. During interview on 10/16/14, at 9:15 a.m. registered nurse (RN)-C stated she was not aware the weekly activity routine was posted to the outside of R62's bedroom door. RN-C stated personal information should not be on a bedroom door and acknowledged the door the sign was attached to was visible to everyone who passed through the hallway which included visitors, family members and residents. RN-C further stated any resident personal information was located in a binder for staff to reference there. At 9:28 a.m. RN-C stated the personal care direction was detached from the weekly activity routine and the document was relocated to the inside of R62's room. R156's care plan was observed on a counter accessible to the public. During continuous observation on 10/15/14 from 7:23 a.m. to 8:50 a.m. R156's care plan was noted to be on a counter by the nurses station located on the pines unit. The exposed care plan included R156's first and last name, admission date, date of birth, allergies, skin care interventions and fall prevention interventions. The three page care plan was on the counter with just the first page of information visible, page two and three were accessible, but not visible.	F 164	d. The Director of Nursing /designee will conduct audits weekly for four weeks and then monthly for three months then periodically by doing walk through throughout the facility to ensure that no confidential information is posted or in view for others to see. If audits reflect that nursing staff are not following the facility policy the Director of Nursing will do further education with the staff that is involved on the importance of following the facility policy. The results of the audits will be reviewed by the Quality Assurance Committee and further direction will be taken from this committee. e. Completion date is November 18,2014.	

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 _____	10/17/2014

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 164	Continued From page 3 During the observation, multiple staff members from multiple departments walked by the counter without covering up R156's personal healthcare information. At 7:37 a.m. a female resident walked up to the counter directly in front of the care plan and picked up and smelled the vase of flowers which was to the right of R156's care plan. At 8:30 a.m. housekeeping supervisor (HS) walked up to the counter, pushed the exposed care plan to the right taped the paper care plan to the desk, then left the area without concealing the personal information. During an interview on 10/15/14, at 8:30 a.m. nursing assistant (NA)-A stated the resident's care plans were placed in binders located behind the nurses station for staff to reference them. During an interview on 10/15/14, at 8:50 a.m., RN-C confirmed the document on the counter was R156's care plan, and stated it should not be lying out on the counter. RN-C reported care plans were kept in binders located behind the nurses station. RN-C stated R156 had just moved to another unit and staff probably took it out of binder and set it on the counter. During an interview on 10/16/14, at 9:08 a.m. the director of nursing (DON) indicated resident's personal information including care plans should be kept private and not disclosed to any others not authorized to view. The facility's Administrative Privacy and Security Policy dated 09/2013, directed to only allow parties with legitimate interests to access confidential information.	F 164		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		11/14/14

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 _____	10/17/2014

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 279 SS=D	Continued From page 4 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan related to care and precautions of dialysis access for 1 of 1 resident (R138) receiving dialysis services. Findings include: R138 had diagnoses which included chronic renal failure and had a fistula in the right upper arm which was accessed for dialysis three times per week. The admission Minimum Data Set (MDS) dated 9/6/14, identified R138 was cognitively	F 279	F 279 a. For resident R138 the facility will develop a comprehensive care plan which will reflect the dialysis access type and location, precautions to use with the dialysis access and emergency procedures related to the dialysis fistula and therapy. b. All residents receiving dialysis therapy have the potential to be affected by this practice. c. All residents who are receiving dialysis services will have an updated care plan	

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 _____	10/17/2014

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 279	Continued From page 5 intact and required assistance with all activities of daily living. The care plan dated 4/22/14, identified R138 recieved dialysis treatments every Monday, Wednesday and Friday, and directed staff to observe shunt site for any signs and symptoms of infection and notify the M.D. as needed. However, the care plan lacked direction as to identify the dialysis access type and location, precautions to use with the dialysis access and emergency procedures related to the dialysis fistula and dialysis therapy. The assignment sheet/cardex which the facility utilized to inform the nursing assistants about resident's needs did not identify R138's dialysis access type and location, and precautions to use with the dialysis access. Review of the nursing progress notes revealed a note on 9/25/14, which identified R138 had gone out to an appointment and was found to have had stenosis within the fistula and was treated with angioplasty. Discharge instructions included to avoid sleeping on access arm and avoid carrying weight more than 5 pounds with the access arm. Review of R138's October, 2014 medication and treatment record revealed documentation of daily monitoring of R138's weight. However, the care plan lacked documentation of monitoring/evaluation of R138's access site for presence/absence of pulse, signs and symptoms of infection or unusual bleeding. During interview on 10/15/14, at 1:00 p.m. licensed practical nurse (LPN)-B reported she/he	F 279	that reflects the care of the dialysis shunt, precautions to observe for, presence/absence of pulse, signs and symptoms of infection or unusual bleeding and emergency procedures. The nursing assistant□s kardex will reflect to observe for signs and symptoms of bruising, residents diet , fluid intakes and restrictions. All nursing staff will attend training on updating resident□s care plan with pertinent information related to residents receiving dialysis therapy. This training will be held on November 11, 2014. d. The Director of Nursing/designee will do audits weekly for four weeks then periodically to ensure that residents who are receiving dialysis therapy have their care plan and kardex updated with pertinent information related to dialysis therapy. These audits will be taken to the Quality Assurance Committee for review and further discussion. e. Completion date is November 14. 2014	

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 _____	10/17/2014

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 279	Continued From page 6	F 279		

monitored the dialysis site, but did not document the findings. LPN-B confirmed there were no orders or directions on R138's care plan to check and document the dialysis site for patency. LPN-B also confirmed the care plan and orders lacked any direction in the event of an emergency related to dialysis.

During interview on 10/16/14, at 10:03 a.m. nursing assistant (NA)-B stated she/he was unsure if R138 had a dialysis site, then stated there was no port. NA-B was unaware of any monitoring or special precautions that should be taken related to R138 receiving dialysis other than to monitor for bruising in general and diet and fluid intakes.

During interview on 10/15/14, at 1:37 p.m. registered nurse (RN)-C reported the facility staff did not assess or document R138's fistula for patency, and stated R138's dialysis access site was checked at the dialysis center before and after receiving dialysis therapy. On 10/16/14, at 9:20 a.m. RN-C confirmed R138's care plan lacked the type of dialysis access, access site, precautions and emergency protocol related to dialysis therapy.

During interview on 10/16/14, at 1:41 p.m. licensed practical nurse (LPN)-A was unaware of the location or type of R138's dialysis access site, and stated she/he would have to look it up. LPN-A was unaware of any special monitoring or precautions related to R138 dialysis access and indicated she was only aware R138 received a diabetic diet.

During interview on 10/17/14, at 9:22 a.m.

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 _____	10/17/2014

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 279	Continued From page 7 nursing assistant (NA)-A reported the staff do not have much to do with R138's dialysis site, stated it is somewhere on his shoulder/arm area. NA-A reported staff do not take any special precautions for R138's dialysis access site. During interview on 10/16/14, at 1:02 p.m. director of nursing (DON) confirmed R138's care plan lacked the dialysis access type and location, precautions and emergency protocol. The DON stated it would be "good practice" to have the dialysis site on the care plan, but staff would see where the access is and would know how to take care of it, including during bathing. The DON stated she felt the nurses knew where R138's access site was and monitored the site. The DON stated the care plan did not include emergency protocol because the facility is located close to the dialysis center. The DON confirmed staff were not formally trained in caring for a resident that receives dialysis therapy, and stated staff were informed regarding the needs on an individual basis through communication and report. The facility's Care Planning Policy dated October 2011, identified the care plan was developed to identify the individual needs of each resident.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		11/18/14

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 _____	10/17/2014

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 309	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement care planning interventions related to dialysis access care for 1 of 1 resident (R138) receiving dialysis services. Findings include: R138 had diagnoses which included chronic renal failure and had a fistula in the right upper arm which was accessed for dialysis three times per week. The admission Minimum Data Set (MDS) dated 9/6/14, identified R138 was cognitively intact and required assistance with all activities of daily living. The care plan dated 4/22/14, identified R138 recieved dialysis treatments every Monday, Wednesday and Friday, and directed staff to observe shunt site for any signs and symptoms of infection and notify the M.D. as needed. However, the care plan lacked direction as to identify the dialysis access type and location, precautions to use with the dialysis access and emergency procedures related to the dialysis fistula and dialysis therapy. The assignment sheet/cardex which the facility utilized to inform the nursing assistants about resident's needs did not identify R138's dialysis access type and location, and precautions to use with the dialysis access. Review of the nursing progress notes from 9/5/14 to 10/16/14 revealed a note on 9/18/14 which	F 309	F 309 a. Resident R 138, facility updated the resident care plan and Kardex to include intervention□s related to his dialysis access care, precautions to use with the dialysis access and emergency procedures related to the dialysis fistula and dialysis therapy. The Director of Nursing completed an audit on all residents who receive dialysis therapy to ensure that their care plans and kardex have been updated. b. All residents of Knute Nelson who receive dialysis services have the potential to be affected by this practice. c. All residents who are receiving dialysis services will have an updated care plan that reflects the care of the dialysis shunt, precautions to observe for, presence/absence of pulse, signs and symptoms of infection or unusual bleeding. The nursing assistant□s kardex will reflect to observe for signs and symptoms of bruising, residents diet, fluid intakes and restrictions. The Director of Nursing completed education of all nursing staff that a dialysis problem has been added to our care plan library with all the appropriate interventions and goals for residents who receive dialysis therapy. This training was held on November, 11, 2014. d. Director of Nursing/designee will do weekly audits for four weeks, and then monthly for three months, then	

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 _____	10/17/2014

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 309	Continued From page 9 identified R138 had been hospitalized, was weaker, and no longer ambulated or transferred self with walker as he had prior to hospitalization. On 9/25/14, the progress notes identified R138 had gone out to an appointment and was found to have had stenosis within the fistula and was treated with angioplasty. Discharge instructions included to avoid sleeping on access arm and avoid carrying weight more than 5 pounds. Review of R138's October, 2014 medication and treatment record revealed documentation of daily monitoring of R138's weight. However, the care plan lacked documentation of monitoring/evaluation of R138's access site for presence/absence of pulse, signs and symptoms of infection or unusual bleeding. During observation on 10/15/14, at 12:37 p.m. R138 was observed with a white dressing taped to the right forearm. R138 stated it was a pressure dressing that was applied after dialysis, and stated she/he usually removed the pressure dressing later in the afternoon. R138 reported there was a constriction in the dialysis shunt awhile back, but was fine now. R138 stated staff "occasionally" assess the dialysis site, but not everyday. During interview on 10/15/14, at 1:00 p.m. licensed practical nurse (LPN)-B reported she/he monitored the dialysis site, but does not document the findings. LPN-B confirmed there were no orders or directions in R138's medical record to check and document the dialysis site for patency. LPN-B also confirmed the care plan and orders lacked any direction in the event of an emergency related to dialysis. On 10/16/14, at	F 309	periodically on residents who are receiving dialysis services to assure that their care plan reflects the care of their dialysis access, precautions to use with the dialysis access, and emergency procedures related to the dialysis access. If audits reflect that nursing staff are not following the facility policy the Director of Nursing will do further education with the staff that is involved on the importance of following the facility policy. The results of the audits will be reviewed by the Quality Assurance Committee and further direction will be taken from this committee. e. Completion date 11/18/2014.	

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 _____	10/17/2014

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 309	Continued From page 10	F 309		

1:57 p.m. LPN-B stated she/he was unaware of a dialysis reference book, stated today (10/16/14) was the first day she/he had seen it.

During interview on 10/16/14, at 10:03 a.m. nursing assistant (NA)-B stated she/he was unsure if R138 had a dialysis site, then stated there was no port. NA-B was unaware of any monitoring or special precautions that should be taken related to R138 receiving dialysis other than to monitor for bruising in general and diet and fluid intakes. NA-B stated she/he had not noticed any bandages or wraps on R138's on arms or hands. NA-B stated she/he had not received any dialysis education, NA-B stated the staff get information from the nurse regarding specific residents. NA-B confirmed she had worked with R138 and was aware the resident was receiving dialysis therapy.

During interview on 10/15/14, at 1:37 p.m. registered nurse (RN)-C reported the facility staff did not assess or document R138's fistula for patency, and stated R138 had the dialysis access site checked at the dialysis center before and after receiving dialysis therapy. On 10/16/14, at 9:20 a.m. RN-C confirmed R138's care plan lacked the type of dialysis access, access site, precautions and emergency protocol related to dialysis therapy. At 1:14 p.m. RN-C confirmed the facility's Hemodialysis Policy and Procedure was not included in R138's medical record or care plan, then stated there is a reference book from the dialysis center at the nurses station for staff to consult, RN-C confirmed the dialysis reference information was not part of R138's medical record or care plan.

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 _____	10/17/2014

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 309	Continued From page 11	F 309		

During interview on 10/16/14, at 1:41 p.m. licensed practical nurse (LPN)-A indicated she/he unaware of the location or type of R138's dialysis access site, and stated she/he would have to look it up. LPN-A was unaware of any special monitoring or precautions that may need to be taken for R138, LPN-A stated R138 received a diabetic diet. LPN-A reported she/he did not work frequently and confirmed the facility had not provided any dialysis education.

During interview on 10/17/14, at 9:22 a.m. nursing assistant (NA)-A reported the staff do not have much to do with R138's dialysis site, stated it is somewhere on his shoulder/arm area. NA-A reported staff do not take any special precautions for R138's dialysis access site. NA-A confirmed the facility had not provided any dialysis education.

During interview on 10/16/14, at 1:02 p.m. director of nursing (DON) confirmed R138's care plan lacked the dialysis access type and location, precautions and emergency protocol. The DON stated it would be "good practice" to have the dialysis site on the care plan, but staff would see where the access is and would know how to take care of it, including during bathing. The DON stated the nurses know where R138's access site is and monitored the site. The DON stated the care plan did not include emergency protocol because the facility is located close to the dialysis center. The DON confirmed staff were not formally trained in caring for a resident that receives dialysis therapy, and stated staff were informed regarding the needs on an individual basis through communication and report.

The facility's Hemodialysis policy and procedure

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 _____	10/17/2014

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 309	Continued From page 12 dated July 2014, directed the care of vascular access type to be specified on the care plan, along with precautions regarding assessing blood pressures, dressings and emergency protocols.	F 309		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		11/18/14

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 _____	10/17/2014

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 431	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure facility procedure for accurate reconciliation of controlled medications for the prevention of potential diversion was followed in 4 of 4 facility medication storage carts in the facility. Findings include: During review of facility medication storage with facility nurses, the following was observed: In each of all four units of the facility, Pines, Maple, the Short term Care Unit East and Short term care unit West, there were locked medication carts each of which contained a double locked box that contained schedule 2 narcotic medications for administration to identified residents. On top of each unit's cart there were a bound black book with numbered pages for the documentation of physician ordered narcotic pain medications. On each numbered page of the books, there was documented a resident's name, the name of the narcotic medication ordered and the count of medications remaining from the initial delivery from the contracted pharmacy. The pages lacked documentation of persons responsible for each change of shift reconciliation of the number of narcotic medication remaining after resident use. In each unit , a three ring binder was kept in a separate area in the nurses' station which held facility forms titled, "Knute Nelson, Shift Scheduled Pharmacy Count". Each form had	F 431	F 431 a. The facility ensured that the licensed nurses are documenting each shift that they are doing reconciliation of controlled medications, this was completed by the Director of Nursing/Assistant Director of Nursing by doing visual audits of the Shift Scheduled Pharmacy Count to ensure that each nurse is documenting their initials that verifies that they did the reconciliation of the controlled mediations. b. All residents have the potential to be affected by this deficiency. c. The Director of Nursing completed education to the licensed nursing staff on the importance of following the facility policy and procedure for reconciliation of controlled medications which is completed at the beginning of each shift with the on-coming nurse and the off-going nurse. The reconciliation record was put in the front of the bound black controlled medication book and must be initialed off by each of the two nurses. This in-service was held on November 11, 2014. d. The Director of Nursing/designee will do audits weekly for four weeks and then monthly audits for three months then periodically to ensure that the facility policy and procedure for reconciliation of controlled medications is being followed by the licensed nursing staff, the audits will ensure that the licensed nurses are initialing the Shift Scheduled Pharmacy	

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 _____	10/17/2014

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 431	Continued From page 14 room for one month's worth of documentation of the unit narcotic medication count by two nursing staff per shift. Review of the forms revealed missing signatures/initials as follows: Pines unit *June 1st to October 16th 16 shifts in June 13 shifts in July 38 shifts in August 36 shifts in September 11 shifts in October Maples unit *October 1st to October 16th 11 shifts *Short term care unit East July 1st to October 16th 30 shifts in July (July 22nd and 29th lacked documentation for 24 hours) 59 shifts in August (August 2nd and 25th lacked documentation for 24 hours) 73 shifts in September (September 17th and 18th lacked documentation for 24 hours) 37 shifts in October (October 12th lacked documentation for 24 hours) *Short term care unit West June 1st to 30th and August 1st to October 15th 43 shifts in June 48 shifts in August 58 shifts in September 30 shifts in October On 10/16/2014, at 10:47 a.m., during review of the narcotic count forms in the Pines unit, licensed practical nurse, (LPN)-A reviewed the narcotic count forms with the surveyor and	F 431	Count verifying that they did the reconciliation of the controlled medications. . If audits reflect that nursing staff are not following the facility policy the Director of Nursing will do further education with the staff that is involved on the importance of following the facility policy. The results of the audits will be reviewed by the Quality Assurance Committee and further direction will be taken from this committee. e. Completion date November 18, 2014.	

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 _____	10/17/2014

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 431	Continued From page 15	F 431		

confirmed the usual routine for narcotic count was to have two nurses count at each change of shift and document their initials on the form. LPN-A confirmed there were areas of missing initials on the narcotic count form.

On 10/16/14, at 10: 50 a.m. LPN-B indicated there should have been documentation on reconciliation of current narcotic medication counts with two nurses for each shift on the narcotic count form.

On 10/17/2014, at 9:39 a.m. registered nurse (RN)-C a clinical supervisor, confirmed the facility narcotic count forms were to be initialed by two nurses at each change of shift to document the narcotic count in the medication carts was correct. RN-C confirmed this practice was to minimize the potential for possible diversion of narcotic medication. RN-C stated there had been a narcotic reconciliation issue in July that had been identified by the facility consultant pharmacist during a monthly facility visit. Review of the facility form titled Medication Error Report, dated 7/28/14, was provided which identified the narcotic pain medication Hydrocodone had been delivered by the facility supply pharmacy and 28 doses were subsequently found to be missing. The report identified that the facility, "couldn't find meds when pharmacist here to destroy." An investigation was performed and the medication was found to have been returned to the facility supply pharmacy. However RN-C confirmed the facility had not identified the narcotic pain medication as missing until "a couple of days later" when the consultant pharmacist had come to destroy unused and/or expired narcotic medications.

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 _____	10/17/2014

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 431	Continued From page 16	F 431		

On 10/16/14, at 2:18 p.m. LPN-E confirmed the usual practice for counting narcotic medications was to have two nurses count between each shift, however LPN-E was unaware of the narcotic count form for documenting initials of nurses who had performed the count. LPN-E stated the count was verified verbally.

On 10/16/14, at 2:15 p.m., during observation of the narcotic medication count, RN-A and RN-B were observed to verbally verify that the narcotic count was correct. RN-A and RN-B, then initialed the narcotic count form.

On 10/16/14, at 2:25 p.m., RN-B stated the documentation for the unit narcotic count was done in the three ring binder kept at the nurses' desk and required two nurses' initials. RN-B confirmed there were areas of missing documentation of reconciliation of facility narcotic supply in the binder.

On 10/17/14, at 10:05 a.m., the facility director of nurses (DON) confirmed the narcotic medication reconciliation policy and that it would be expected that two nurses would count narcotic medications between shifts and document their initials in the narcotic count form in the three ring binders at each unit. DON further confirmed all signature areas should have been complete to indicate correct count of narcotic medications. DON indicated this was the facility practice to minimize diversion of narcotic medications. DON indicated the appropriate practice for narcotic count documentation had been addressed previously with facility staff due to incomplete documentation by staff of the narcotic supply present in the facility.

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 _____	10/17/2014

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 431	Continued From page 17 Review of the facility policy titled Controlled Drugs-Reconciliation, dated January 2014, directed that medications included in the drug enforcement administration (DEA) classification as controlled substances are subject to special record keeping in the facility. The policy directed reconciliation for all scheduled narcotics was to be done at the change of shift by the licensed nurse or trained medical assistant coming on duty and the licensed nurse or trained medical assistant going off duty. The policy directed this was to be done prior to going off duty and both would initial on the reconciliation signature sheet.	F 431		

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 _____	**10/14/2014**

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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Knute Nelson Memorial Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/03/2014

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 **01 - MAIN BUILDING 01** B. WING _____	**10/14/2014**

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
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		

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 _____	**10/14/2014**

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
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 85 beds and had a census of 83 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents, visitors, and staff. Findings include: On facility tour between 9:00 AM and 12:00 PM	K 050	The fire drill schedule will be monitored and altered as needed on a quarterly basis to ensure that a fire drill is held on each shift each quarter and at varying times. Fire drills will be scheduled and held at unexpected times under varying conditions, quarterly on each shift. Each fire drill will be documented as to the date and time, along with the staff who participated in the fire drills. The schedule will continue on a 12 month rotation to ensure that each shift has 4 fire drills in	10/31/14

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 _____	**10/14/2014**

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
K 050	Continued From page 3 on 10/14/2014, during the review of all available maintenance documentation and interview with the Facility Administrator (AU) it was revealed that the facility failed to conduct 2 of 12 fire drills for the night shift during the last 12-month period. This deficient practice was verified by the Facility Administrator (AU).	K 050	any 12 month rolling calendar at varying times each quarter. The Director of Environmental Services will monitor the fire drills and schedule to ensure compliance in accordance with NFPA Life Safety Code 101(00), 19.7.1.2. Completion Date: 10/31/2014 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 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, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). 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 9:00 AM and 12:00 PM	K 062	The facility has confirmed a scheduled date and time each year for our annual fire sprinkler test/inspection for our fire sprinkler system. This test will occur each October. Our vendor, Summit Fire, has confirmed they will be completing the annual fire sprinkler test/inspection every October and the quarterly inspections every January, April & July. The Director of Environmental Services and maintenance department will be responsible for proper maintenance and inspection of sprinkler system and compliance with NFPA 13(00) and NFPA 25(98).	10/29/14

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 _____	**10/14/2014**

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
K 062	Continued From page 4 on 10/14/2014, a review of documentation and interview with the Facility Administrator (AU), revealed the facility failed to provide documentation for the annual fire sprinkler test as required by NFPA 13(99) and NFPA 25(98). At the time of the inspection the last documented fire sprinkler annual test/inspection was conducted on 08/28/2013. This deficient practice was verified by the Facility Administrator (AU).	K 062	Completion Date: 10/29/2014 Responsible Person: Tom Storer, Director of Environmental Services	