Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 13, 2025

Administrator
Knute Nelson Care Center
420 12th Avenue East
Alexandria, MN 56308

RE: CCN: 245435
Cycle Start Date: March 5, 2025

Dear Administrator:

On March 5, 2025, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 June 5, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by September 5, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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March 13, 2025

Administrator
Knute Nelson Care Center
420 12th Avenue East
Alexandria, MN 56308

Re: State Nursing Home Licensing Orders
Event ID: CCLE11

Dear Administrator:

The above facility was surveyed on March 3, 2025 through March 5, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 ______	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNUTE NELSON CARE CENTER	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
E 000	Initial Comments On 3/3/25 to 3/5/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/3/25 to 3/5/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		4/9/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 03/20/2025

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 623	Continued From page 1	F 623		

Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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F 623	Continued From page 2 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility	F 623		

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F 623	Continued From page 3 must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the Long Term Care (LTC) ombudsman of a facility initiated transfer for 1 of 1 residents (R64) who was transferred to an acute care facility on an emergency basis reviewed for hospitalization. Findings include: R64's admission Minimum Data Set (MDS) dated 11/4/24, indicated R64 had severe cognitive impairment and had diagnoses which included right femur (long bone in the leg) fracture, cancer, and hypertension (elevated blood pressure). Identified R64 required staff assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. Review of R64's progress notes dated 12/3/24, revealed the following: -on 12/3/24 at 5:35 p.m., R64 was seated in the dining room in his wheelchair eating supper. R64	F 623	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Ombudsman was updated that R64 was hospitalized. List of facility initiated discharges from 12/1/24 to 3/20/25 will be sent to Ombudsman. Education provided to staff. ¿How the facility will identify other residents having the potential to be affected by the same deficient practice. Audit of residents transferred. Monitor for transfers and notifications made. Ombudsman will be notified of all facility initiated discharges from 12/1/24 to 3/20/25. ¿¿¿¿¿¿ What measures will be put into place, or systemic changes made, to	

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F 623	Continued From page 4 stood up from the wheelchair and as R64 went to sit back down the wheelchair rolled away and R64 landed on the floor and a loud crack was heard. R64 was unable to move his right leg and had shortening of the right leg The medical doctor (MD) and R64's family were immediately notified and R64 was sent to the emergency room for a possible right hip fracture. -on 12/3/25 at 9:19 p.m., R 64 was admitted to the hospital for a closed right hip fracture. R64's medical record lacked documentation the notice of the hospital transfer was sent to the long-term care (LTC) Ombudsman. During an interview on 3/5/25 at 9:50 a.m., administrator verified the LTC ombudsman had not been notified of R64's emergency hospital transfer. Administrator further stated he was unaware the LTC Ombudsman was to be notified when a resident transferred to the hospital. Review of a facility policy titled Transfer or Discharge Facility-Initiated dated 2001, identified when residents were sent to an acute care setting it was considered a facility- initiated transfer. Further identified a notice of transfer would have been provided to resident and resident representative and to the LTC ombudsman. -	F 623	ensure that the deficient practice will not recur. Education will be provided at all staff meeting 4/2/25 and all relevant staff will receive training on the Ombudsman notification requirements for facility-initiated transfers. Training will include guidelines on the timing of notifications, required documentation, and the process for submitting notifications to the Ombudsman. Discharge and transfer notes in Point Click Care will be updated to include notifications made. A tracking system will be put in place to monitor each transfer initiated by the facility, ensuring that notifications to the Ombudsman are timely and complete.¿¿¿¿ How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Routine audits will be conducted to ensure that all transfers have been appropriately communicated to the Ombudsman. Results will be reported at monthly quality meeting. ¿ The date that each deficiency will be corrected. 4/9/25	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		4/9/25

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F 686	Continued From page 5 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely assistance with repositioning occurred for 1 of 5 residents (R2) with a current pressure ulcer and at risk for further development of pressure ulcers. Findings include: R2's quarterly Minimum Data Set (MDS) dated 1/15/25, identified R2 had severe cognitive impairment and diagnoses which included diabetes mellitus (DM), hypertension (elevated blood pressure) and dementia. Identified R2 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. Identified R2 had two pressure ulcers and was on a repositioning program. R2's annual Care Area Assessment (CAA) dated 10/22/24, identified R2 was a at risk for skin breakdown and had a pressure ulcer to her left heel. Identified R2 required extensive assistance	F 686	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Education provided to staff. Immediate reassessment of R2 for repositioning compliance. Notify staff members of the identified compliance issues and reinforce the importance of repositioning as part of standard care according to the prescribed schedules. How the facility will identify other residents having the potential to be affected by the same deficient practice. Review of clinical care plans to determine those at risk for pressure sores. Review of clinical care plans to verify repositioning schedules are care planned for residents at risk for pressure ulcers. Review of scheduled tasks associated with	

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F 686

Continued From page 6

to reposition in bed and in the wheelchair.

R2's care plan dated 4/25/24, identified R2 had a pressure ulcer on her left heel. Care plan directed staff to reposition or assist to stand R2 every two hours while awake.

R2's weekly wound assessment dated 2/27/25, identified R2 had a pressure ulcer to her left heel which measured 8 centimeters (cm) in length 5.7 cm in width and had a depth of 0.2 c.m. Identified pressure ulcer was a stage 4 (a pressure ulcer where the wound extends through all layers of skin, damaging underlying muscle, tendon, and potentially bone, often with visible exposed tissue) and R2 required frequent repositioning.

R 2's current physician orders signed 2/22/25, identified left heel: stage 4 pressure ulcer - cleanse area, apply crushed Flagyl 250 mg tablet and place on wound bed to help with odor control with each dressing change, apply skin prep, Hydrofera Blue, ABD, and kerlix 3 x/week and prn. one time a day every Tues, Thur, Sun for wound care and as needed.

R2's nursing assistant task sheet undated, directed staff to reposition or assist R2 to stand every two hours while awake.

During a continuous observation on 3/4/25 from 9:20 a.m. to 12:30 p.m., the following was revealed:

-9:20 a.m., R2 was seated in her wheelchair at the nurses station.
-9:28 a.m., activity aide (AA)-A wheeled R2 to the activity room.
-10:19 a.m., R2 remained seated in her

F 686

repositioning for documentation of repositioning offers and completion or refusal.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

All care staff will attend mandatory training on the importance of repositioning to prevent pressure ulcers, the appropriate repositioning intervals, and documentation on 4/2/25. Refresher courses on repositioning will be provided as needed to ensure staff remains knowledgeable about best practices and requirements. Nurses, nursing assistants, and other direct care staff will receive specific training relevant to their role in repositioning and documenting the process.

¿How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

Random audits will be established to monitor repositioning and verify compliance with care plans. Audits will be reported to DON and reviewed at quality for next 6 months. Any discrepancies will be addressed immediately. Repositioning protocols will be customized to each resident's needs, considering their medical conditions, skin integrity, and overall risk for pressure ulcers. These plans will be reviewed regularly and updated as necessary.

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KNUTE NELSON CARE CENTER	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 686	Continued From page 7 wheelchair in the activity room. -10:44 a.m., R2 remained seated in her wheelchair in the activity room. -11:06 a.m. AA-A wheeled R2 to her room. -11:24 a.m., R2 wheeled self into the hallway and AA-A wheeled R2 to the front desk. -11:32 a.m., AA-A wheeled R2 into the dining room. -11:36 a.m. R2 remained seated in her wheelchair in the dining room waiting for lunch to be served. -12:04 a.m., R2 remained seated in her wheelchair in the dining room eating lunch. -12:25 p.m., R2 remained seated in her wheelchair in the dining room finishing eating her lunch. -at 12:30 p.m., R2 had remained seated in her wheelchair in the dining room and surveyor requested nursing assistant (NA)-A to reposition R2 after R2 remained seated in her wheelchair and not repositioned for over three hours. During an observation on 3/4/25 at 1238 p.m., NA-A wheeled R2 back to her room. NA-A and RN clinical manager (CM)-A sanitized hands, put a gown and gloves on and hooked R2 up to the mechanical lift and placed R2 onto the bed, changed R2's incontinent product and repositioned R2. During an interview on 3/4/25 at 12:47 p.m.,NA-A stated R2 required staff assistance to reposition and the last time R2 had been repositioned was some time around 9:30 a.m. when NA-A assisted R2 to transfer into her wheelchair after her bath. NA-A stated R2 had a pressure ulcer on her left heel and was at risk for further pressure ulcer development and should have been repositioned every two hrs while in her chair.	F 686	The date that each deficiency will be corrected. 4/9/25	

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	245435	A. BUILDING ______ B. WING ______	03/05/2025

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F 686	Continued From page 8 During an interview on 3/4/25 at 12:52 p.m., CM-A verified R2 had a pressure ulcer on her left heel and recently had one on her buttocks that had healed. CM stated R2 required staff assistance to reposition. CM-A stated R2 was at continued risk of developing further skin breakdown and should have been repositioned every two hours during the day. CM-A stated her expectation was that R2's care plan would have been followed to help prevent any further skin breakdown. During an interview on 3/4/25 at 2:49 p.m., director of nursing (DON) verified R2 required staff assistance to reposition. DON stated R2 had a pressure ulcer on her left heel and was at risk for further skin breakdown. DON stated her expectation was that R2's care plan for repositioning would have been followed. Review of a facility policy titled Repositioning revised 1/25 identified, staff were to check the care plan or the assignment sheet to determine resident specific positioning needs and number of staff required to complete the procedure.	F 686		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		4/9/25

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F 812	Continued From page 9 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food and beverages stored in the refrigerators, were labeled, dated and discarded properly. Further, the facility failed to maintain proper holding food temperatures during the noon meal on the Pines unit. This deficient practice had the potential to affect 59 residents who received food and beverages from the refrigerators. Findings include: On 3/3/25 at 11:05 p.m., during the kitchen tour with the dietary manager(DM), the following concerns were identified: Kitchen refrigerator: -half of a large container of orange sauce with a black crusty substance around the lid with an open date of 1/6/25. -half of a large container of barbeque sauce with a crusty black substance around the lid without a notation of an open date and an expiration date of 1/6/25. - one chicken salad sandwich without notation of a date. - three bowls of pureed bread without notation of	F 812	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. F812 was addressed and corrective action was taken immediately. Products that were outdated have been discarded. Proper Labeled dates were used on the products that were not labeled. Education on how to handle cold foods properly when serving was given. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be impacted by meal foods and labels procedures being followed.	

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F 812 Continued From page 10
a date.
-bottle of staff pop without notation of a date.

Freezer:
-six pork sausages in a bag without notation of an opening date.

Food temps:

During an observation on 3/3/25 at 11:25 a.m., DM removed one of approximately 30 bowls of potato salad from the refrigerator and temped the one bowl of potato salad in the main dining room prior to meal service. Temperature of the potato salad was 39 degrees F (Fahrenheit). The remaining bowls of potato salad were placed on a cart without any ice and delivered to the Pines unit to be served at the noon meal.

During an observation on 3/3/25 at 12:25 p.m., there were approximately 20 small bowls of potato salad present on the counter without any ice in the Pines dining room

During an observation on 3/3/25 at 12:30 p.m., after meal service had began and approximately eight residents had been served the potato salad in the Pines dining room, dietary aide (DA)-A temped one of the remaining small bowls of potato salad. The temperature of the potato salad was 51 degrees F. DA-A continued serving the potato salad.

During an interview on 3/3/25 at 12:45 p.m., DA-A stated all cold food should have been served at 41 degrees F. or lower. DA-A stated she should have put the potato salad on ice while serving to ensure the temperature remained in a safe zone to prevent food borne illness.

F 812

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

The Culinary Team have been educated on the importance of following the proper procedures of handling foods and keeping them at proper temperatures. Education on how to use ice baths and proper refrigeration storage to maintain quality and correct temperatures has been given to all employees on the team. Manager and Supervisors have been taking tasks of going through walk in coolers and server coolers to check on proper dating and labeling of products that include prepped items and purchased bottled products. All Foods stored in coolers that will be made will have proper dating and labeling.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

Daily audits by Dietary Manager observing preparation on foods and service of foods. Keeping proper food temperature logs

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F 812	Continued From page 11 During an interview on 3/3/25 at 1:00 p.m., DM verified the above findings during the kitchen tour. DM stated his expectation was that all opened food should have been dated and thrown away after the shelf life or the expiration date. DM further stated his expectation was all cold food should have been held at 41 degrees F or lower to prevent food borne illness. Review of a facility policy titled Food Labeling revised 1/25, identified all foods should have been labeled with contents, preparation date and any specific instructions. Review of a facility policy titled Food Temperature Policy revised 1/25, identified all cold food items must be served to the resident at a temperature of at least 40 degrees Fahrenheit or below at the time the resident receives the food.	F 812	and doing weekly walk through checks in coolers for correct dates and labels and Audits will be recorded March through June 1st. Audits will be reported at monthly quality meetings. The date that each deficiency will be corrected. 4/9/2025	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/04/2025. At the time of this survey, Knute Nelson was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/18/2025

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	K 000		

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

By e-mail to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

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 not included in this survey. In 1970 an addition was

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K 000	Continued From page 2 added to the south that was determined to be Type II(000) construction. In 1976 an addition was added 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 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 83 beds and had a census of 57 at the time of the survey. The requirements at 42 CFR Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on oberservation and staff interview, the facility failed to maintain the means of egress per NFPA 101 (2012 edition), Life Safety Code,	K 211	1. The rolling chairs have been removed from the chapel that were blocking the exit door.	3/18/25

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K 211	Continued From page 3 sections 19.2.1, and 7.1.10.1. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 03/04/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that the exit door in the chapel was blocked by rolling chairs that were placed in front of the door. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	2. Education will be provided to staff to not block means of egress with chairs or any other items. 3. A monthly work order will be created to audit all fire doors to ensure they're not blocked. 4. Director of Facilities, Pete Uphus, is responsible for the corrective action and monitoring. 5. Proposed date of completion is 4/9/2025.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321		4/9/25

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K 321	Continued From page 4 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, and 19.3.6.3.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/04/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that the self-closing doors to the following combustible storage rooms did not latch when closed using the self-closing devices on the doors: Rooms 111, 165, 166, and 168. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 321	1. Doors to 111, 165, 166, and 168 will be repaired so they latch. 2. An quarterly work order will be submitted to check function of fire doors & storage doors by maintenance. 3. Work order results will be reported at quality meeting. 4. Director of Facilities, Pete Uphuss, is responsible for the corrective action and monitoring. 5. Facility will be in compliance by 4/9/2025.	
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the	K 341		4/9/25

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K 341	Continued From page 5 building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain and install Fire Alarm Systems per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, and 9.6.1.3, and NFPA 72 (2010 editions), National Fire Alarm and Signaling Code, section 17.5.3.1. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 03/04/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that a smoke detector was missing from the ceiling in the Visiting Doctor's Charting Room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 341	1. Smoke Detector has been installed and Summit has been into building to ensure detectors is connected to alarm system. 2. Education will be provided to staff to never remove a smoke detector and to contact maintenance for battery/repair issues. 3. Summit will complete audit of all rooms to ensure proper smoke detector installation by 5/31/25. 4. Director of Facilities, Pete Uphus, is responsible for the corrective action and monitoring. 5. Facility will be in compliance by 4/9/2025.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are	K 353		4/9/25

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K 353	Continued From page 6 inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 03/04/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that a wire was zip tied to the sprinkler pipe in the Housekeeping Supply Room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	1. Wire has been removed from sprinkler pipe in Housekeeping Supply Room. 2. Education will be provided to staff to not put any wiring on sprinkler system plumbing. 3. Audit 5 rooms each quarter for 6 months to ensure there is not wiring attached to sprinkler system plumbing. 4. Director of Facilities, Pete Uphus, is responsible for the corrective action and monitoring. 5. Facility will be in compliance by 4/9/2025.	

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K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		4/9/25

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	245435	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/04/2025**

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

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K 363	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3.1, and 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/04/2025 between 9:00 AM and 12:00 PM , it was revealed by observation that the door for Room 206 did not latch when it was closed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	1. Room 206 door will be repaired so it will latch when it closes. 2. Education will be provided to staff to notify maintenance if door doesn't fully shut. 3. Work order will be scheduled quarterly to audit smoke & fire doors to ensure they latch appropriately. 4. Director of Facilities, Pete Uphus, is responsible for the corrective action and monitoring. 5. Facility will be in compliance by 4/9/2025.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 374		4/9/25

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K 374	Continued From page 9 Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8, and 8.5.4.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 03/04/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that the Smoke Barrier doors by rooms 161 and 162 did not close completely when released from the magnetic hold-open device leaving a gap between the door leaves. 2. On 03/04/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that the Smoke Barrier doors leading into the Administrative area of the building did not close completely leaving a gap between the door leaves. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	1. Smoke Barrier Doors by rooms 161, 162, and doors leading into administrative area will be repaired so they close all the way. 2. Education will be provided to staff to notify maintenance if door doesn't fully shut. 3. Work order will be scheduled quarterly to audit smoke and fire doors to ensure they shut appropriately. 4. Director of Facilities, Pete Uphus, is responsible for the corrective action and monitoring. 5. Facility will be in compliance by 4/9/25.	
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded	K 712		4/9/25

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K 712	Continued From page 10 announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/04/2025 between 9:00 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was not conducted during the second shift of the 3rd quarter of 2024. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	1. Maintenance will follow schedule from fire plan to ensure drill is completed on each shift quarterly. 2. Education will be provided on requirement for fire drill on all shifts each quarter. 3. Fire drills will be reported at monthly quality meetings to administrator. 4. Director of Facilities, Pete Uphus, is responsible for the corrective action and monitoring. 5. Facility will be in compliance by 4/9/2025.	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.	K 761		4/9/25

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K 761	Continued From page 11 Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire door assemblies and hardware per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, and 4.6.12.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.4.2(7). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 03/04/2025 between 9:00 AM and 12:00 PM, it was revealed that the coordinator above the smoke barrier doors leading into the 200 wing of the Maples was not adjusted properly preventing the doors from closing as designed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	1. The coordinator above the smoke barrier doors leading into 200-wing will be repaired so doors close as designed. 2. Education will be provided to staff to ensure they submit work order for doors that don't close all the way. 3. A work order by submitted quarterly to have all smoke/fire doors audited so they latch appropriately. 4. Director of Facilities, Pete Uphus, is responsible for the corrective action and monitoring. 5. Facility will be in compliance by 4/9/2025.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal	K 920		4/9/25

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K 920	Continued From page 12 electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, section 400.8. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 03/04/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that there was an orange extension cord was being used to provide power to a refrigerator in the Payroll Office. 2. On 03/04/2025 between 9:00 AM and 12:00 PM, it was revealed by observation that there was a yellow extension cord was being used to provide power to the make-up boiler water pump	K 920	1. Extension cords have been removed from payroll office and boiler room in basement. 2. Education will be provided to staff to not use extension cords in the facility. 3. Audit 5 rooms quarterly for 6 months to ensure extension cords are not in use. 4. Director of Facilities, Pete Uphus, is responsible for the corrective action and monitoring. 5. Facility will be in compliance by 4/9/2025.	

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K 920	Continued From page 13 in the basement. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920		

Minnesota Department of Health

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On 3/3/25 to 3/5/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and

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2 000	Continued From page 1	2 000		

identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely assistance with repositioning occurred for 1 of 5 residents (R2) with a current pressure ulcer and at risk for further development of pressure ulcers. Findings include: R2's quarterly Minimum Data Set (MDS) dated 1/15/25, identified R2 had severe cognitive impairment and diagnoses which included diabetes mellitus (DM), hypertension (elevated	2 900	Corrected	3/20/25

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2 900	Continued From page 3 blood pressure) and dementia. Identified R2 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. Identified R2 had two pressure ulcers and was on a repositioning program. R2's annual Care Area Assessment (CAA) dated 10/22/24, identified R2 was a at risk for skin breakdown and had a pressure ulcer to her left heel. Identified R2 required extensive assistance to reposition in bed and in the wheelchair. R2's care plan dated 4/25/24, identified R2 had a pressure ulcer on her left heel. Care plan directed staff to reposition or assist to stand R2 every two hours while awake. R2's weekly wound assessment dated 2/27/25, identified R2 had a pressure ulcer to her left heel which measured 8 centimeters (cm) in length 5.7 cm in width and had a depth of 0.2 c.m. Identified pressure ulcer was a stage 4 (a pressure ulcer where the wound extends through all layers of skin, damaging underlying muscle, tendon, and potentially bone, often with visible exposed tissue) and R2 required frequent repositioning. R 2's current physician orders signed 2/22/25, identified left heel: stage 4 pressure ulcer - cleanse area, apply crushed Flagyl 250 mg tablet and place on wound bed to help with odor control with each dressing change, apply skin prep, Hydrofera Blue, ABD, and kerlix 3 x/week and prn. one time a day every Tues, Thur, Sun for wound care and as needed. R2's nursing assistant task sheet undated, directed staff to reposition or assist R2 to stand every two hours while awake.	2 900		

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2 900	Continued From page 4	2 900		

Continued From page 4

During a continuous observation on 3/4/25 from 9:20 a.m. to 12:30 p.m., the following was revealed:

-9:20 a.m., R2 was seated in her wheelchair at the nurses station.
-9:28 a.m., activity aide (AA)-A wheeled R2 to the activity room.
-10:19 a.m., R2 remained seated in her wheelchair in the activity room.
-10:44 a.m., R2 remained seated in her wheelchair in the activity room.
-11:06 a.m. AA-A wheeled R2 to her room.
-11:24 a.m., R2 wheeled self into the hallway and AA-A wheeled R2 to the front desk.
-11:32 a.m., AA-A wheeled R2 into the dining room.
-11:36 a.m. R2 remained seated in her wheelchair in the dining room waiting for lunch to be served.
-12:04 a.m., R2 remained seated in her wheelchair in the dining room eating lunch.
-12:25 p.m., R2 remained seated in her wheelchair in the dining room finishing eating her lunch.
-at 12:30 p.m., R2 had remained seated in her wheelchair in the dining room and surveyor requested nursing assistant (NA)-A to reposition R2 after R2 remained seated in her wheelchair and not repositioned for over three hours.

During an observation on 3/4/25 at 1238 p.m., NA-A wheeled R2 back to her room. NA-A and RN clinical manager (CM)-A sanitized hands, put a gown and gloves on and hooked R2 up to the mechanical lift and placed R2 onto the bed, changed R2's incontinent product and repositioned R2.

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2 900	Continued From page 5 During an interview on 3/4/25 at 12:47 p.m.,NA-A stated R2 required staff assistance to reposition and the last time R2 had been repositioned was some time around 9:30 a.m. when NA-A assisted R2 to transfer into her wheelchair after her bath. NA-A stated R2 had a pressure ulcer on her left heel and was at risk for further pressure ulcer development and should have been repositioned every two hrs while in her chair. During an interview on 3/4/25 at 12:52 p.m., CM-A verified R2 had a pressure ulcer on her left heel and recently had one on her buttocks that had healed. CM stated R2 required staff assistance to reposition. CM-A stated R2 was at continued risk of developing further skin breakdown and should have been repositioned every two hours during the day. CM-A stated her expectation was that R2's care plan would have been followed to help prevent any further skin breakdown. During an interview on 3/4/25 at 2:49 p.m., director of nursing (DON) verified R2 required staff assistance to reposition. DON stated R2 had a pressure ulcer on her left heel and was at risk for further skin breakdown. DON stated her expectation was that R2's care plan for repositioning would have been followed. Review of a facility policy titled Repositioning revised 1/25 identified, staff were to check the care plan or the assignment sheet to determine resident specific positioning needs and number of staff required to complete the procedure. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary	2 900		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 6 treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food and beverages stored in the refrigerators, were labeled, dated and discarded properly. Further, the facility failed to maintain proper holding food temperatures during the noon meal on the Pines unit. This deficient practice had the potential to affect 59 residents who received food and beverages from the refrigerators. Findings include: On 3/3/25 at 11:05 p.m., during the kitchen tour with the dietary manager(DM), the following concerns were identified: Kitchen refrigerator:	21015	Corrected	3/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00113	A. BUILDING: ____ B. WING ____	03/05/2025

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21015	Continued From page 7 -half of a large container of orange sauce with a black crusty substance around the lid with an open date of 1/6/25. -half of a large container of barbeque sauce with a crusty black substance around the lid without a notation of an open date and an expiration date of 1/6/25. - one chicken salad sandwich without notation of a date. - three bowls of pureed bread without notation of a date. -bottle of staff pop without notation of a date. Freezer: -six pork sausages in a bag without notation of an opening date. Food temps: During an observation on 3/3/25 at 11:25 a.m., DM removed one of approximately 30 bowls of potato salad from the refrigerator and temped the one bowl of potato salad in the main dining room prior to meal service. Temperature of the potato salad was 39 degrees F (Fahrenheit). The remaining bowls of potato salad were placed on a cart without any ice and delivered to the Pines unit to be served at the noon meal. During an observation on 3/3/25 at 12:25 p.m., there were approximately 20 small bowls of potato salad present on the counter without any ice in the Pines dining room During an observation on 3/3/25 at 12:30 p.m., after meal service had began and approximately eight residents had been served the potato salad in the Pines dining room, dietary aide (DA)-A temped one of the remaining small bowls of potato salad. The temperature of the potato salad	21015		

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21015	Continued From page 8	21015		

was 51 degrees F. DA-A continued serving the potato salad.

During an interview on 3/3/25 at 12:45 p.m., DA-A stated all cold food should have been served at 41 degrees F. or lower. DA-A stated she should have put the potato salad on ice while serving to ensure the temperature remained in a safe zone to prevent food borne illness.

During an interview on 3/3/25 at 1:00 p.m., DM verified the above findings during the kitchen tour. DM stated his expectation was that all opened food should have been dated and thrown away after the shelf life or the expiration date. DM further stated his expectation was all cold food should have been held at 41 degrees F or lower to prevent food borne illness.

Review of a facility policy titled Food Labeling revised 1/25, identified all foods should have been labeled with contents, preparation date and any specific instructions.

Review of a facility policy titled Food Temperature Policy revised 1/25, identified all cold food items must be served to the resident at a temperature of at least 40 degrees Fahrenheit or below at the time the resident receives the food.

SUGGESTED METHOD OF CORRECTION:
The dietary manager, or designee, could ensure appropriate sanitation and proper disposal of food items in the kitchen. In addition, the dietary manager, or designee, could ensure proper holding temps of food served to residents. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, or designee could perform audits and report audit

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21015	Continued From page 9 findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a Tuberculosis (TB) symptom screening for 2 of 5 employees, nursing assistant (NA)-B and dietary aide (DA)-B	21426	Corrected	3/20/25

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21426	Continued From page 10 reviewed for TB testing. Findings include: NA-B was hired on 7/1/24. NA-B's Quantiferon-TB blood test dated 4/14/24, indicated a negative test. NA-B's employee file lacked documentation the baseline TB symptom screening had been completed. DA-B was hired on 12/9/24. DA-B's Quantiferon-TB blood test dated 12/12/24, indicated a negative test. DA-B's employee file lacked documentation the baseline TB symptom screening had been completed. During an interview on 3/5/25 at 12:15 p.m., infection preventionist (IP) who was also the director of nursing (DON), confirmed the TB symptom screenings had not been completed for NA-B and DA-B. DON stated the facility no longer completed TB symptom screening as all new employees received the Quantiferon-TB blood test. Review of a facility policy revised 11/24, titled Tuberculosis, Screening Employee, indicated each newly hired employee was screened for TB after an employment offer had been made but prior to the employee's duty assignment. The policy lacked documentation of a TB symptom screening. SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the current TB policy to ensure staff were screened for symptoms of TB when hired to the facility. The Quality Assurance and Assessment committee could randomly audit records to ensure compliance.	21426		

Minnesota Department of Health

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21426	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 24, 2025

Administrator
Knute Nelson Care Center
420 12th Avenue East
Alexandria, MN 56308

RE: CCN: 245435
Cycle Start Date: March 5, 2025

Dear Administrator:

On April 14, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 24, 2025

Administrator
Knute Nelson Care Center
420 12th Avenue East
Alexandria, MN 56308

Re: Reinspection Results
Event ID: CCLE12

Dear Administrator:

On April 14, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 5, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us