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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: DLRB
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**
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 **11/28/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 05 HHA, 09 ESRD, 13 PTIP, 22 CLIA, 02 SNF/NF/Dual, 06 PRTF, 10 NF, 14 CORF, 03 SNF/NF/Distinct, 07 X-Ray, 11 ICF/IID, 15 ASC, 04 SNF, 08 OPT/SP, 12 RHC, 16 HOSPICE

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

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

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

12. Total Facility Beds **93** (L18)

13. Total Certified Beds **93** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	93			
(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 :
Gail Anderson, Unit Supervisor 11/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/27/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **11/22/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245435

January 27, 2017

Ms. Michelle Solwold, Administrator
Knute Nelson
420 12th Avenue East
Alexandria, Minnesota 56308

Dear Ms. Solwold:

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 15, 2016 the above facility is certified for:

93 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 93 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 29, 2016

Ms. Michelle Solwold, Administrator
Knute Nelson
420 12th Avenue East
Alexandria, Minnesota 56308

RE: Project Number S5435027

Dear Ms. Solwold:

On October 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 6, 2016. 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 November 28, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 17, 2016 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 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 6, 2016, effective November 15, 2016 and therefore remedies outlined in our letter to you dated October 19, 2016, 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.

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
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245435	A. Building B. Wing	11/28/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 11/08/2016	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	Correction Completed 11/08/2016	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 10/07/2016
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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GA/mm	11/29/2016	28034	11/28/2016
REVIEWED BY CMS RO	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
☐				

FOLLOWUP TO SURVEY COMPLETED ON	
10/6/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245435	A. Building 01 - MAIN BUILDING 01 B. Wing	11/17/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 11/15/2016	ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 10/20/2016	ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 11/04/2016
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 10/18/2016	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 STATE AGENCY ☒	REVIEWED BY (INITIALS) TL/mm	DATE 11/29/2016	SIGNATURE OF SURVEYOR 36536	DATE 11/17/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/5/2016	☐ 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

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PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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Facility ID: 00113

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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 **10/06/2016** (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 **93** (L18)

13.Total Certified Beds **93** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	93			
(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 :
Tammy Williams, HFE NEII 11/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/22/2016 (L20)

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

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 19, 2016

Ms. Michelle Solwold, Administrator
Knute Nelson
420 12th Avenue East
Alexandria, Minnesota 56308

RE: Project Number S5435027

Dear Ms. Solwold:

On October 6, 2016, 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;

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

<u>Informal Dispute Resolution</u> - **your right to request an informal reconsideration to dispute the attached deficiencies.**

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

DEPARTMENT CONTACT

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

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

Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 15, 2016, 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 15, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (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 6, 2017 (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 6, 2017 (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
Health Regulation Division
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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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 ______	10/06/2016

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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified and respectful dining experience for 1 of 4 residents (R90) observed during the evening meal in the Maple dining room. Findings include: R90's quarterly Minimum Data Set (MDS), dated 8/25/16, identified R90 had severe cognitive impairment, required staff supervision for toileting, transfers and dressing and was independent with eating after set-up. R90's care plan revised 6/13/16, identified R90 had dementia, was independent with eating after set-up, and listed various interventions which included to be oriented as needed to the dining room, and staff were to encourage R90 to eat 75-100% of her meals daily. Further, R90's care plan identified per R90 and R90's family, had a	F 241	F 000 Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Knute Nelson of the truth of the facts alleged in this statement of deficiency and plan of correction is submitted exclusively to comply with state and federal law. Knute Nelson reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. This statement of deficiencies will be taken to Knute Nelson□s Quality Assurance Performance Improvement Committee. We are in full compliance as of November 8, 2016 and respectfully request a desk review in lieu of a post survey revisit.	11/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 10/24/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING ______ B. WING ______	10/06/2016

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 241	Continued From page 1	F 241		

long history of loose stools when R90 ate foods such as soup.

On 10/03/16, continuous observations of the Maple dining room were conducted from 5:35 p.m. to 6:03 p.m. At 5:35 p.m. R90 was seated at a dining room table with R13, R65 and R82. Nursing assistant (NA-A) approached R90's table, with a plate of food items in both hands. The plate contained a bowl of chicken and dumpling soup, and a ham sandwich. When NA-A reached across the table to set the plate in front of R90, R90 called out loudly, "I don't want that." NA-A stated, in a abrupt, gruff voice "You said you wanted this." NA-A proceeded to put the soup and sandwich items in front of R90 and immediately walked away from the table. NA-A was observed to roll her eyes as she turned away from R90 at the table.

At that time, NA-B approached R90 and asked her, "Do you want to just try it?" R90 laughed sarcastically under her breath and NA-B immediately walked away. R90 independently ate the ham sandwich and drank beverages next to her plate.

On 10/03/16, at 6:03 p.m. R90 wheeled herself away from the table, towards the exit out of the dining room. Staff had not provided R90 with a food alternative, nor offered any food alternatives to R90 for the entire observation. R90 consumed 0% of her soup, 75% of her sandwich, and drank all of her milk, juice and coffee.

On 10/03/16, at 6:34 p.m. NA-B stated when soup was on the menu, R90 usually looked at the soup and stated she didn't want it. She confirmed R90 was confused at times.

F 241 Dignity and Respect of Individuality
It is the practice of Knute Nelson to promote care for residents in a manner and in an environment that maintains or enhances each resident□s dignity and respect in full recognition of his or her individuality.
A.What corrective action(s) will be accomplished for those residents to have been found affected by the deficient practice?
Resident 90 suffered no adverse effects as a result of this practice. Resident 90 was interviewed by the Dining Services Director and no concerns were expressed.
B.How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken?
All residents have the potential to be affected by the alleged deficient practice. All residents have been interviewed by the Dining Services Director and designee to assure that no other residents were affected. No residents voiced any concerns.
C.What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur?
The facility has a policy regarding dignity and respect. Re-Education will be conducted by the Dining Services Director on Tuesday, November 8, 2016, on dignity and respect of individuality for all care center staff. Specifically, re-education on dignity and respect maintained during the dining experiences. Staff will be educated

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 241	Continued From page 2 On 10/03/16, at 6:49 p.m. NA-A stated if a resident couldn't verbalize what they wanted they would get what was served. She indicated if a resident told a staff person she didn't want a food item and the staff person left the same food in front of her, it wouldn't be dignified. On 10/04/16, at 11:01 a.m. unit manager (UM-A) stated R90 had a diagnosis of dementia, and she stated NA-A's behavior during R90's meal "was just not right." She stated staff had been educated on dignity and dining in the past and the treatment of R90 was not acceptable or dignified. She stated every resident had the right to choose. On 10/04/16, at 2:48 p.m. the director of nurses (DON) stated R90 made up her own mind, and there was no changing it and further stated we all have to accept that. She stated staff had been educated on dignity in dining in the past and would expect R90 and all residents to be treated with dignity. On 10/04/16, at 3:05 p.m. Director of Dietary stated R90 had not had a dignified dining experience, and stated residents should be offered choices about their meals and their choices honored. On 10/04/16, at 3:08 p.m. the administrator stated she felt it was a choices concern,and R90's dining experience had been undignified. She stated staff were aware of her expectations regarding resident dignity and choices. She stated the facility had a process in place for resident choices, and staff had been educated on dignity and dining in the past.	F 241	during orientation and will also be educated yearly with a resident rights in-service. D.How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Dining Services Director or designee will conduct Quality Assurance Performance Improvement audits by interview tools to ensure continued compliance. Audits will be 3 times a week times one month, weekly times one month, bi-weekly times one month and monthly times three. The Dining Services Director or designee will report the results of the audits monthly to the Quality Assurance Performance Improvement Committee who will determine the need for further monitoring. Administrator will oversee the process. E.Completion date: November 8, 2016	

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F 241	Continued From page 3 Review of the facility policy, Meal Service-Dignity during Dining identified resident needs would be recognized and their dignity and respect maintained during the dining experience. if residents did not like the choices that were offered or served to them they may order of the "Everyday Menu,"and staff were educated on menu choices and they knew what other options to offer residents. The policy further identified staff were to speak to residents politely and respectfully.	F 241		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and odor free environment for 1 of 1 resident (R23) room with a pervasive urine odor. In addition, the facility failed to ensure each resident room was well maintained for a homelike environment, for 2 of 73 residents (R65 & R74) reviewed for environmental concerns. Findings include: R23's quarterly Minimum Data Set (MDS) dated 8/4/16, identified R23 had intact cognition, required extensive assistance with transfers, dressing, toileting and personal hygiene, and was always incontinent of urine and bowel.	F 253	F 253 Houskeeping & Maintenance Services It is the practice of Knute Nelson to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. A.What corrective action(s) will be accomplished for those residents to have been found affected by the deficient practice? Residents 23, 65 & 74 suffered no adverse effects as a result of this practice. Resident 23□s room is being cleaned daily. The facility is meeting with a vendor to purchase some odor eliminators to place in the residents□ room. Resident 65□s room and bathroom has been	11/8/16

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KNUTE NELSON	**420 12TH AVENUE EAST** **ALEXANDRIA, MN 56308**

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F 253	Continued From page 4 R23's care plan dated 12/20/14, indicated R46 had total bladder incontinence. R23's toileting program was discontinued due to R23 not willing to participate. R23 refused to use the commode or toilet, and would purposely urinate in her incontinent brief, and R23 had a history of refusing incontinence cares by staff. R23's care plan indicated she had a private room because of behaviors related to inappropriate voiding. On 10/3/16, at 4:28 p.m. R23's bedroom and bathroom was noted to have a pungent, pervasive urine odor in which permeated into the hallway outside of the room. On 10/4/16, at 12:30 p.m. R23's room was noted to have a strong, pungent urine smell which permeated into the hallway two doors down from R23's room. On 10/6/16, at 2:08 p.m. R23's room and bathroom was noted to have a overwhelming strong smell of urine which continued to permeate out into the hallway outside of the room. On 10/6/16, at 11:12 a.m. licensed practical nurse (LPN)-A confirmed R23's room usually had a strong urine smell, and reported R23 would at times refuse cares, including toileting and personal hygiene. On 10/6/16, at 2:08 p.m. the environmental service director (ESD) and administrator both confirmed the strong, pungent urine odor in R23's room, bathroom and hallway outside her room. The ESD stated the urine odor needed "special attention", and stated the staff would need to do a	F 253	completed repainted by a third party contractor. Resident 74s wall near the headboard has been patched and painted to remove the gouges and scratches. B.How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken? All residents have the potential to be affected by the alleged deficient practice. All resident rooms have been inspected by the Environmental Services Director and designee to assure that no other residents were affected. No other resident rooms were affected. C.What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? The facility has a policy regarding housekeeping and maintenance services. Re-Education will be conducted by the Environmental Services Director on Tuesday, November 8, 2016, on housekeeping and maintenance services to all care center staff. Specifically, re-education on the audit policy on where staff should record any environmental concerns in the maintenance log book. D.How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Environmental Services Director or designee will conduct Quality Assurance Performance Improvement audits by observation tools to ensure continued compliance. Audits will be three times a week times one month, weekly times one month, bi-weekly times one month,	

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F 253	Continued From page 5 more thorough job cleaning or possibly look at using a different cleaning product. The ESD and administrator both confirmed they were not aware of the urine odor, and confirmed staff had not reported the issue in the maintenance log book. On 10/3/16, at 5:10 p.m. observed R65's bathroom wall located to the left of the toilet, had multiple black scuff marks and paint scraped off in various locations of the wall. In addition, there was an extensive area of paint missing from the bathroom door jam from the top to the bottom on the inside door jam. On 10/6/16, at 2:00 p.m. the ESD and administrator confirmed R65's environment lacked maintenance and confirmed staff had not reported the concerns in the maintenance log. On 10/4/16, at 9:46 a.m. observed R74's room, multiple gouges and scratches from the paint in the wall by the head of the bed, an area approximately 12 x 14 inches. During interview on 10/6/16, at 2:00 p.m. the ESD reported he completed a monthly rotating walk through of each neighborhood to identify concerns on an ongoing basis. The ESD stated the facility also had a maintenance book or log on each neighborhood for staff working on the floor to utilize to bring concerns to his attention. The ESD stated he checked the maintenance books/logs multiple times per day to ensure concerns had been addressed. On 10/6/16, at 2:26 p.m. the ESD and administrator confirmed R74's findings and confirmed they had not be aware of R74's room	F 253	monthly times three months. The Environmental Services Director or designee will report the results of the audits monthly to the Quality Assurance Performance Improvement Committee who will determine the need for further monitoring. Administrator will oversee the process. E.Completion date: November 8, 2016	

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F 253	Continued From page 6 condition. The confirmed the environment lacked maintenance and confirmed staff had not reported the concerns in the maintenance log. The facility's Environmental Services Room Audit policy, dated 3/2014 indicated staff were to record any environmental concerns in the maintenance log book upon discovery in resident rooms.	F 253		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food service equipment in the main kitchen was properly cleaned to prevent the potential for food borne illness in the facility. This deficient practice had the potential to affect 71 of the 71 residents who received food from the facility kitchen. Findings include: On 10/03/16, at 1:24 p.m. during initial tour of the main kitchen for the facility, a large can opener which was observed affixed to the end of the	F 371	F371 Food Procedure, Store/Prepare/Serve Sanitary It is the practice of Knute Nelson to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, and prepare, distribute, and serve food under sanitary conditions. A.What corrective action(s) will be accomplished for those residents to have been found affected by the deficient practice? No residents suffered adverse effects as	10/7/16

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F 371	Continued From page 7 stainless steel counter. The kitchen can opener had thick, black, tar-like substance which covered the can opener blade and gears. Many loose metal shavings were observed hanging from the blade of the can opener. On 10/03/16, at 7:20 p.m. Cook (Cook)-A confirmed the silver shavings which hung from the can opener blade and gears, and the black sticky substance on and around the can opener blade. She confirmed the can opener was the only can opener used by dietary staff and was used every day to open food items for food preparation and serving to the residents. Cook-A pulled out the shaft from the affixed can opener and confirmed the entire length of the post was covered with a sticky, brown substance. She stated she felt both the black and brown sticky substances were from juice cans that leaked from the canned goods, and had built up over time. Cook-A stated she wasn't sure how old the can opener was, and was not sure the last time the blade had been changed or cleaned, nor was she aware who was responsible for cleaning the can opener. She stated she felt the can opener probably should have been sent through the dishwasher to clean it after each use or once a day. She stated she wasn't sure when the can opener had been taken apart and sent through the dishwasher last. She confirmed there was potential for the loose shavings and black/ brown substances to get into the resident food. On 10/03/16, at 7:25 p.m. the Director of Dietary(DD) confirmed the only can opener used in the kitchen was affixed to the stainless steel table. She stated the can opener was used daily for all meals. She confirmed the loose metal	F 371	a result of this practice. B.How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken? All residents in the facility have the potential to be affected by this practice. This is being addressed by the systems described below. C.What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur The facility has a policy regarding cleanliness and kitchen sanitation. Food service personnel have been re-educated on this policy. The can opener has been cleaned and the cleaning scheduled has been reviewed with the food service personnel. D.How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The Dining Services Director or designee is conducting Quality Assurance Performance Improvement audits of kitchen sanitation. Random audits are being conducted three times a week times one month, weekly times one month, bi-weekly times one month, monthly times three months. The Dining Services Director or designee will report the results of the audits monthly to the Quality Assurance Performance Improvement Committee who will determine the need for further monitoring. Administrator will oversee the process. E.Completion date:	

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F 371	Continued From page 8	F 371		

shavings hanging from the blade, and the black sticky material on and around the blade and gears. DD confirmed the dark brown sticky material which covered the entire length of the stainless steel shaft that inserted into the counter unit. DD stated she felt the black and brown sticky substances were from the juice of the canned goods that ran into shaft and had built up. She stated the unit should have probably been sent through the dish machine to clean it. DD stated she wasn't sure how long ago the blades were replaced, how long ago the blades were cleaned, or who was responsible for cleaning the can opener. She confirmed the metal shavings and the black sticky substance had the potential to get into resident food.

Review of the facility policy, Food Production and Food Safety-Food Preparation and Handling, revised 3/21/06, identified kitchen equipment would be clean and food would be prepared and free of injurious substances.

Review of the facility form titled Dietary Cleaning Roster: Assigned Cleaning Areas, undated, indicated cleaning of the kitchen can opener was to be done by both cooks and bakers.

October 7, 2016

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 ______	10/05/2016

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

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K 000	INITIAL COMMENTS	K 000		

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

By e-mail to:
Marian.Whitney@state.mn.us
and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/24/2016

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 Angela.kappenman@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 sprinkler system. The facility has a complete fire alarm system with smoke detection in the	K 000		

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KNUTE NELSON	420 12TH AVENUE EAST ALEXANDRIA, MN 56308

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K 000	Continued From page 2 corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 93 beds and had a census of 74 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 2 corridor doors according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 23 of the 74 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include:	K 018	K 18 NFPA 101 (2000) Edition Life Safety Code Standard Section 19.3.6.3.1 The resident room door 209 and 211 to the corridor was warped enough to be a concern in performing a proper smoke barrier from the corridor in the event of a fire. We placed a custom order of Bayer Built manufacturer doors for the correct size and stain, along with the correct	11/15/16

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

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	**10/05/2016**

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K 018	Continued From page 3 On the facility tour between 8:00 am to 1:00 pm on 10/5/2016 observations and staff interview revealed resident rooms 209 and 211 did not fit tightly in the frame. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services.	K 018	swing, with Hilltop Lumber Company to replace doors to room 209 and room 211.. The Bayer Built doors have a 20 minute fire rating as were the original doors. It will take approximately 3 to 4 weeks for delivery. When they are delivered our Maintenance staff will install the replacement doors. Completion Date: November 15,2016 Responsible Person: Thomas Storer, Director of Environmental Services	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5	K 025		10/20/16
	This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper construction of 4 of 11 smoke barrier walls according to the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect 41 of the 74 residents and an undetermined amount of staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On the facility tour between 8:00 am to 1:00 pm on 10/5/2016 observations and staff interview revealed penetrations in the smoke barriers approximately 1-2 inches in diameter above the		K 025 NFPA 101 2000 Edition Life Safety Code Standard Section 8.3, 19.3.7.3, 19.3.7.5 The smoke barrier wall above the ceiling tile in line with the smoke barrier doors of the 500 hall, 700 hall and 800 hall had a whole penetration that could allow smoke to propagate from one smoke compartment to another smoke compartment. The IT Department that ran communication cables was asked to follow through with filling the holes with Fire Rated calking to prevent smoke transferring from one compartment to another compartment. When they	

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K 025	Continued From page 4 ceiling at the cross corridor doors in resident wings 700, 800 and on the east and west end of wing 500. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services.	K 025	complete the installation of fire calking they will place a date next to the area. Maintenance staff will verify work completed. We have instructed the IT department in the future cable installations to fill all penetration points with fire calking and date when completed. Completion Date: 10/20/2016 Responsible Person: Thomas Storer, Director of Environmental Services	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain 2 exits in accordance with the egress requirements of NFPA 101 Life Safety Code (00) section 7.2.1.3, floor level and 7.10.8.1, no exit. This deficient practice could affect the safe and efficient exiting of 45 of the 74 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 10/5/2016 observations and staff interview revealed, 1. A 2 1/2 inch gap between the sidewalk and the door threshold at the exterior exit of wing 700 near resident room 715. 2. A door leading to the exterior in the main dining area was not labeled with a "No Exit" sign due to the lack of a firm surface leading to a public way.	K 038	K 038 NFPA 101 Life Safety Code Standard Section 7.2.1.3, 7, 10.8.1 1.The concrete pad outside of an emergency exit door of our 700 hall corridor by room 714 that has the 2 ¿ inch gap between the sidewalk and door threshold will be removed by Bitzan Masonry company. They will remove and Install a new concrete pad to the proper level and distance insuring a safe exit passage for all residents, visitors and staff. The completion is estimated by 11/04/2016. 2. Door in the main dining leading to the exterior that doesn t have a firm surface leading to a public pathway was not labeled with a No Exit sign. The door will have lettering in accordance to the	11/4/16

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K 038	Continued From page 5 This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services.	K 038	required size for the word No at a 2 inch size and the word EXIT in 1 size. Completion Date: 10/11/2016 Responsible Person: Thomas 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 record review and staff interview, 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 74 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 10/5/2016 observations and staff interview revealed the sprinkler system was not being maintained properly for the following reasons. 1. Sprinkler heads were full of dirt and lint in laundry room and the room behind the dryers and in the main dining area behind the serving line. 2. The sprinkler head in resident room 714 was covered with ceiling texture. 3. A escutcheon was missing from the sprinkler	K 062	K62 NFPA 101 Life Safety Code Standard Section 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. The sprinkler heads in the laundry room area and the room behind the dryers had dust and lint on the sprinkler heads. In the main dining room serving line the sprinkler heads were also dusty and greasy. This could negatively affect the full and proper operation of the sprinkler system. These heads were dusted in the Laundry area. The sprinkler heads above the serving line of dining were cleaned with dish soap and will now provide uniform response of emergencies. I have assigned the custodian to inspect and clean, as needed, the sprinkler heads on a quarterly basis. Completion date: 10/12/2016. 2. The sprinkler head located on the Pines in room 715 of the 700 hallway had texture overspray on it. During our Annual Fire Sprinkler Inspection by Summit Companies, who are a State certified Fire	10/18/16

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K 062	Continued From page 6 head in the closet of the main kitchen. 4. The sprinkler pressure gauge on the riser in the main kitchen storage was not replaced or calibrated within the last 5 years. 5. Mechanical room 427 has missing ceiling tiles. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services.	K 062	Protection contractor, replaced the sprinkler head. This will provide the required response of emergency. Completion Date: 10/17/2016. 3. The escutcheon cover to the sprinkler head in the storage room in the Dietary office / kitchen area was missing. During our Annual Fire Inspection Summit Companies installed the escutcheon cover. Completion Date: 10/17/2016. 4. The sprinkler pressure gauge on the main riser in main kitchen storage was out dated beyond the five year replacement time period. During our Annual Fire Sprinkler Inspection Summit Companies replaced with a new pressure gauge and placed the replacement date on the face of the gauge. Completion Date: 10/17/2016. 5. The missing ceiling tile in the Mechanical room has ceiling tiles out of place affecting the integrity of the Smoke barrier. They were replaced accordingly. Completion Date: 10/18/2016 Responsible Person: Thomas Storer, Director of Environmental Services	