DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA ` I - TO BE COMI						ID: J71M Facility ID: 00113
1. MEDICARE/MEDICAID PROVIDER N (L1) 245435 2.STATE VENDOR OR MEDICAID NO. (L2) 178540100	NO.	3. NAME AND ADI (L3) KNUTE NEL (L4) 420 12TH AV (L5) ALEXANDR	.SON ENUE EAST	Y	(L6)	56308	 TYPE OF ACTION Initial Termination Validation 	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUP 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After C	9. Other
6. DATE OF SURVEY 02/04 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	4/2016 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 85 (L37) (L38) 16. STATE SURVEY AGENCY REMARK	19 SNF (L39)	B. Not in Compli Requirements a ICF (L42)	nce With quirements Based On: .cceptable POC iance with Program and/or Applied Waive IID (L43)	rs:	2. Techn 3. 24 He 4. 7-Day 5. Life \$	nical Personnel our RN y RN (Rural SNF) Safety Code <u>A</u> EETS	Following Requirements: 6. Scope of Ser 7. Medical Dire 8. Patient Room 9. Beds/Room (L12) (L15)	vices Limit ector
	ko (il mi lendele o		anon barb).					
17 SUDVEVOD SIGNATURE		Date :			18 STATE SUDV	EV AGENCY AD	PPOVAL	Date:
17. SURVEYOR SIGNATURE Beth Nowling, HFE NE	CII	Date :	03/10/2016	(1.10)		nonh -	meath	Date: 03/17/2016
				(L19) GIONAL	- To En	nortement	nt Specialist	
	PART II - TO	BE COMPLETEI 20. COM		GIONAL	OFFICE OR S 21. 1. S 2. 0	Ingle stat	nt Specialist	03/17/2016 (L20)
Beth Nowling, HFE NE 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Par	PART II - TO	BE COMPLETEI 20. COM RIGH	D BY HCFA RE	GIONAL	OFFICE OR S 21. 1. S 2. 0	forcemei INGLE STAT INGLE STAT tatement of Financi wnership/Control I oth of the Above :	t Specialist E AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCF	03/17/2016 (L20)
Beth Nowling, HFE NE 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Par 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 02/01/1987	PART II - TO Y (L21) 23. LTC AGREEMI BEGINNING I	BE COMPLETEI 20. COM RIGH ENT 2	D BY HCFA RE IPLIANCE WITH CI ITS ACT: 4. LTC AGREEMEN ENDING DATE	GIONAL VIL	OFFICE OR S 21. 1. S 2. O 3. B 26. TERMINATI VOLUNTARY 01-Merger, Closur	forcemei ingle stat ingle st	t Specialist AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCF	03/17/2016 (L20) FA-1513) (L30) TARY Acet Health/Safety
Beth Nowling, HFE NE 19. DETERMINATION OF ELIGIBILITY _X1. Facility is Eligible to Par 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 02/01/1987 (L24) 25. LTC EXTENSION DATE:	PART II - TO Y ticipate (L21) 23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVI A. Suspension of	BE COMPLETED 20. COM RIGH ENT 2 DATE E SANCTIONS of Admissions:	D BY HCFA RE PLIANCE WITH CI ITS ACT: 4. LTC AGREEMEN	GIONAL VIL	OFFICE OR S 21. 1. S 2. 0 3. B 26. TERMINATI VOLUNTARY	INGLE STAT INGLE STAT Ingle STAT tatement of Financi wnership/Control I: oth of the Above : ION ACTION: 00 re W/ Reimbursemer tary Termination	t Specialist E AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCF	03/17/2016 (L20) FA-1513) (L30) TARY
Beth Nowling, HFE NE 19. DETERMINATION OF ELIGIBILITY	PART II - TO Y (L21) 23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVE	BE COMPLETED 20. COM RIGH ENT 2 DATE E SANCTIONS of Admissions:	D BY HCFA RE PLIANCE WITH CI ITS ACT: 4. LTC AGREEMEN ENDING DATE (L25)	GIONAL VIL	Construction Co	INGLE STAT INGLE STAT Ingle STAT tatement of Financi wnership/Control I: oth of the Above : ION ACTION: 00 re W/ Reimbursemer tary Termination		03/17/2016 (L20) FA-1513) (L30) TARY Acet Health/Safety Acet Agreement
Beth Nowling, HFE NE 19. DETERMINATION OF ELIGIBILITY _X1. Facility is Eligible to Par 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 02/01/1987 (L24) 25. LTC EXTENSION DATE:	PART II - TO Y ticipate (L21) 23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVI A. Suspension o B. Rescind Susp	BE COMPLETED 20. COM RIGH ENT 2 DATE E SANCTIONS of Admissions:	D BY HCFA RE PLIANCE WITH CI ITS ACT: 4. LTC AGREEMEN ENDING DATE (L25) (L44) (L45)	GIONAL VIL	Construction Co	INGLE STAT INGLE STAT Ingle STAT tatement of Financi wnership/Control I: oth of the Above : ION ACTION: 00 re W/ Reimbursemer tary Termination		03/17/2016 (L20) FA-1513) (L30) TARY Acet Health/Safety Acet Agreement
Beth Nowling, HFE NE	PART II - TO Y ticipate (L21) 23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVI A. Suspension o B. Rescind Susp	ENT 2 DATE 25 SANCTIONS of Admissions: pension Date:	D BY HCFA RE PLIANCE WITH CI ITS ACT: 4. LTC AGREEMEN ENDING DATE (L25) (L44) (L45)	GIONAL VIL	COFFICE OR S 21. 1. S 2. O 3. B 26. TERMINATI VOLUNTARY 01-Merger, Closur 02-Dissatisfaction 03-Risk of Involun 04-Other Reason for	INGLE STAT INGLE STAT Ingle STAT tatement of Financi wnership/Control I: oth of the Above : ION ACTION: 00 re W/ Reimbursemer tary Termination		03/17/2016 (L20) FA-1513) (L30) TARY Acet Health/Safety Acet Agreement
Beth Nowling, HFE NE	PART II - TO Y (L21) 23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVI A. Suspension o B. Rescind Susp 29 (L28)	BE COMPLETEI 20. COM RIGH 20. COM 20. COM RIGH 20. COM RI	D BY HCFA RE PLIANCE WITH CI ITS ACT: 4. LTC AGREEMEN ENDING DATE (L25) (L44) (L45) ARRIER NO.	GIONAL VIL VIL (L31)	COFFICE OR S 21. 1. S 2. O 3. B 26. TERMINATI VOLUNTARY 01-Merger, Closur 02-Dissatisfaction 03-Risk of Involun 04-Other Reason for	INGLE STAT INGLE STAT Ingle STAT tatement of Financi wnership/Control I: oth of the Above : ION ACTION: 00 re W/ Reimbursemer tary Termination		03/17/2016 (L20) FA-1513) (L30) TARY Acet Health/Safety Acet Agreement



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245435

March 17, 2016

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

Dear Ms. Urman:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 16, 2016 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 skilled nursing facility beds.

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

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

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

Sincerely,

Mark meath

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 10, 2016

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

RE: Project Number F5435024

Dear Ms. Urman:

On February 4, 2016, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 10, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of February 19, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 10, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on December 10, 2015, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our February 19, 2016 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On February 29, 2016, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 16, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 10, 2015, as of January 16, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of February 19, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

Knute Nelson March 10, 2016 Page 2

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 10, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 10, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 10, 2016, is to be rescinded.

In our letter of February 19, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 10, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 16, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

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

Sincerely,

mark meath

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER			DATE OF REVISIT	
IDENTIFICATION NOWBER	A. Building			
245435 _{Y1}	B. Wing	Y2	2/4/2016	Y3
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).

ITE	Μ	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix Reg. #	F0241 483.15(a)	Correction	ID Prefix F020 Reg. #	82 20(k)(3)(ii)	Correction	ID Prefix Reg. #	F0312 483.25(a)(3)		Correction Completed
LSC		01/07/2016	LSC		01/07/2016	LSC			01/07/2016
ID Prefix	F0314	Correction	ID Prefix F04		Correction	ID Prefix			Correction
Reg. #	483.25(c)	Completed	483.0 Reg. #	65	Completed	Reg. #			Completed
LSC		01/07/2016	LSC		01/07/2016	LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC		_	LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC		_	LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC		_	LSC			
REVIEWE STATE AG		REVIEWED BY (INITIALS) GA/mm	date 02/19/2016	SIGNATURE OF S	SURVEYOR 34088			DATE 02/04	/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOW	JP TO SURVEY CO	OMPLETED ON		DR ANY UNCORRECT				YES	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF REVISIT	
245435 _{Y1}	B. Wing	Y2	2/29/2016	Y3
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).

ITE	M	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix Reg. # LSC	NFPA 101 K0014	Correction Completed 12/30/2015	ID Prefix Reg. # NFPA 1 LSC K0025	Correction 01 Completed 12/29/2015	Reg. #	Correction PA 101 Completed 029 12/29/2015
ID Prefix Reg. # LSC	NFPA 101 K0056	Correction Completed 01/16/2016	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 (INITIALS) TL/mm REVIEWED BY (INITIALS)		SIGNATURE OF SURVEYOR TITLE ANY UNCORRECTED DEFICIENCIES TED DEFICIENCIES (CMS-2567) SEN		
12/8/2015	D					



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 19, 2016

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

Re: Reinspection Results - Project Number S5435026

Dear Ms. Urman:

On February 4, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 10, 2015, with orders received by you on December 30, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 Minnesota Department of Health Email: mark.meath@state.mn.us

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISIT	Γ
00113	B. Wing	Y2	2/4/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
KNUTE NELSON		420 12TH AVENUE EAST		
		ALEXANDRIA, MN 56308		

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE	М	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	20565	Correction	ID Prefix 20900		Correction	ID Prefix	20920	Correction
Reg. #	MN Rule 4658.04 Subp. 3	05 Completed	Reg. # MN Ru Subp. 3	ıle 4658.0525 3	Completed	Reg. #	MN Rule 4658.0525 Subp. 6 B	5 Completed
LSC		01/07/2016	LSC		01/07/2016	LSC		01/07/2016
ID Prefix	21375	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	MN Rule 4658.08 Subp. 1	00 Completed	Reg. #		Completed	Reg. #		Completed
LSC		01/07/2016				LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC						LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
REVIEWE STATE AG		REVIEWED BY (INITIALS) GA/mm	DATE 02/19/2016	SIGNATURE OF SU	rveyor 34088			date 02/04/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE
FOLLOW 12/10/20	JP TO SURVEY CO	DMPLETED ON		ANY UNCORRECTED TED DEFICIENCIES (YES NO

DEPARTMENT OF HEALTH					CENTERS FOR MEDICARE & MEDICAID SERVICES			
					AND TRANSMITTAL	ID: J71M		
					TE SURVEY AGENCY	Facility ID: 00113		
1. MEDICARE/MEDICAID PROVIDER (L1) 245435	R NO.	3. NAME AND AI (L3) KNUTE NE		CILITY		 TYPE OF ACTION: <u>2</u> (L8) Initial 2. Recertification 		
2.STATE VENDOR OR MEDICAID NO).	(L4) 420 12TH AVENUE EAST			1. Initial2. Recertification3. Termination4. CHOW			
(L2) 178540100		(L5) ALEXANDRIA, MN		(L6) 56308	5. Validation 6. Complaint 7. On-Site Visit 9. Other			
5. EFFECTIVE DATE CHANGE OF O	WNERSHIP	7. PROVIDER/SU	PPLIER CATEG	GORY	<u>02</u> (L7)			
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 12/10 /2	, ,	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:	(L10)	•		11 ICF/IID				
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of T	The Following Requirements:		
To (b):			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit		
					3. 24 Hour RN	7. Medical Director		
12.Total Facility Beds	85 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SNI			
13.Total Certified Beds	85 (L17)	X B. Not in Con	npliance with Prog	gram	5. Life Safety Code	9. Beds/Room		
		Requirements	and/or Applied V	Waivers:	* Code: B *	(L12)		
14. LTC CERTIFIED BED BREAKDOW	/N				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
85								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION 1	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Denise Erickson, HF	E NE II	0	01/21/2016	(L19)	<u>Kate JohnsTon, Program Specialist</u> 02/04/2016			
PAR	T II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	OFFICE OR SINGLE ST	FATE AGENCY		
19. DETERMINATION OF ELIGIBILI	ГY	20. COM	IPLIANCE WITH	H CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572)			
X 1. Facility is Eligible to Pa	rticipate	RIGH	ITS ACT:		 Ownership/Control Both of the Above 	l Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible	1				5. Dour of the roove	·		
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNINC	DATE	ENDING DA	ТЕ	VOLUNTARY 00	INVOLUNTARY		
02/01/1987					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ment 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	n <u>OTHER</u>		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)			(L44)			00-Active		
(127)	B. Rescind Su	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	21	. DETERMINATION		DATE				
2.1. NO KEOLII I OI CMID-1337			, JI JII KO VAL	-				
	(L32)			(L33)	DETERMINATION APPR	ROVAL		



Electronically delivered December 24, 2015

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

RE: Project Number S5435026

Dear Ms. Urman:

On December 10, 2015, 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. In addition, at the time of the December 10, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number .

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G) a pattern of deficiencies that constitute actual harm that is not immediate jeopardy (Level H) widespread deficiencies that constitute actual harm that is not immediate jeopardy (Level I), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 10, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

Knute Nelson December 24, 2015 Page 2

> <u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

> <u>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 January 19, 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 January 19, 2016 the following remedy will be imposed:

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

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.

Knute Nelson December 24, 2015 Page 4 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, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies. Knute Nelson December 24, 2015 Page 5

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 March 10, 2016 (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 June 10, 2016 (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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

Knute Nelson December 24, 2015 Page 6

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:

Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely, Mark meath

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

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

		AND HUMAN SERVICES			ORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	T	OME	3 NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION (X:	3) DATE SURVEY COMPLETED
		245435	B. WING _		12/10/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				420 12TH AVENUE EAST	
				ALEXANDRIA, MN 56308	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 000	INITIAL COMMENT	ſS	F 00	00	
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.			
F 241 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with YAND RESPECT OF	F 24	11	1/7/16
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.			
	by: Based on observat review the facility fa dining experience fr R209, R204, R143, observed during the Findings include: During observation dining room on 12/7 R208, R209, R143, remained seated at	NT is not met as evidenced tion, interview, and document alled to provide a dignified or 7 of 7 residents (R208, R198, R211, R201) who were e lunch meal. of the noon meal in the main 7/15, at 12:23 p.m. R204, R190, R211 and R201 tables in the dining room, Dietary aid (DA)-A approached		 a. The facility has developed and implemented a policy in which staff wi educated and trained on proper proce during dining services. Staff will not remove dirty dishes and clean the tab while other residents are still eating. F R208, R209, R204, R143, R198, R21 R201 dignity during dining which will include procedures allowing the reside time to eat in a dignified manner and to feel rushed. b. All residents have the potential to affected by this, due to clearing and 	edure les For 1, ents not
LABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Electronically Signed

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

12/30/2015

PRINTED: 01/21/2016

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY
IND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	COM	PLETED
		245435	B. WING		12/1	0/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KNUTE	NELSON			420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 241	began to pickup gla table, then piled the placed directly acro proceeded to carry kitchen and placed -At 12:25 p.m. DA- picked up a dirty sa then proceeded to room to the table in to stack dirty dishes R211 and R198 con nearby table. DA-A and carried them in -At 12:27 p.m. R20 seated at a table e returned to the dinit table and began to table and carried th -At 12:28 p.m. DA-A kitchen holding a w table and proceede down around R204 lunch. DA-A return walked to R211's a a dirty coffee cup a R198's table while lunch. -DA-A proceeded to table, directly in fro remained seated at while R208, seated to eat his lunch. DA- dishes off the table	loves on both hands and asses and silverware off the em on top of the dirty plate oss from R204. DA-A then the dirty dishes into the them on the counter. A returned to R204's table, aucer which contained red jello, walk to the back of the dining the far right corner and began s on top of a dirty plate while ntinued to eat their lunch at a A picked up the dirty dishes nto the kitchen. 1 and family member were eating their meal. DA-A ng room, walked to a nearby stack dirty dishes from the ne dirty dished into the kitchen. A returned from the dirty ret rag, walked over to R204's ed to wipe the top of the table while she continued to eat her ed the wet rag to the kitchen, nd R198's table and removed nd a glass off of R211's and they continued to eat their o stack dirty dishes off of the nt of R143 while R143 t the table drinking coffee and at a nearby table, continued A-A continued to clean the s in the dining room area in while residents continued to eat	F 241	 washing tables before residents a finished with their meal. c. Director of Dining Services wieducational meeting reviewing dig during dining policy, that staff will remove dirty dishes and clean the while other residents are still eatint table, with on-going training with current/new staff. The in-service wheld on 12/30/2015. d. Quality assurance audits will to ensure that the facility policy ar procedure on dignity during dining followed. These audits will be con weekly for four weeks, then rando Director of Dining services and/or designee. Results of the audits wit taken to the Quality Assurance co for further recommendation. e. Completion date January 7, 2 	II hold not table og at that vill be be done od j is being npleted omly by II be mmittee	

If continuation sheet Page 2 of 36

		AND HUMAN SERVICES			FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245435	B. WING		12/ [.]	10/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	NELSON			420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241 F 282 SS=D	residents are done meal was not provid indicated the usual the residents were of the dirty dishes and On 12/10/15, at 2:5 confirmed staff short tables while resider stated," they should meal without feeling On 12/10/15, at 3:0 was requested, DM have a policy for dig Review of facility por procedure revised of dining experience w quality of life and re during dining. 483.20(k)(3)(ii) SEF PERSONS/PER CA The services provid must be provided by accordance with ea care. This REQUIREMEN by: Based on observat review the facility fa interventions for toil	 eating. DA-B confirmed the ded in a dignified manner and facility policy was to wait until done eating, before cleaning tables. 5 p.m. dietary manager (DM) uld not clear off and wash the ware still eating. DM dishould be able to finish their grushed." 0 p.m. a facility dignity policy I confirmed the facility did not gnity during dining. blicy titled, Dietary Policy And on 3/22/2006, indicated the vill enhance the resident's needs RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility y qualified persons in the resident's written plan of NT is not met as evidenced tion, interview and document ailed to implement care plan leting and positioning for 1 of 1 iewed for urinary incontinence 	F 241		with w the	1/7/16

Facility ID: 00113

If continuation sheet Page 3 of 36

	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245435	B. WING		12/ ⁻	10/2015
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
	IELSON			20 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	R16 was at high ris urinary incontinence right hip. R16's care assist R16 with repu- in bed and chair. R lying down R16 after indicated R16 was in longer aware of the incontinent brief. In directed facility staff needed. On 12/09/15, during from 1:10 p.m. to 4 seated in a wheelch assisted, to repositi - At 1:10 p.m. R16 w pants and a shirt, se Pines unit dining ro- assistant (NA)-F wa and wheeled R16 to located across from common area was openings in which to sat briefly in the corn himself with his feet opening. -At 1:35 p.m. a rest R16, who had conti feet around the con bring him to exercise exercises of active	re plan dated 5/7/15, identified k for pressure ulcers related to e and an open area on the e plan directed facility staff to ositioning every 2 hours while 16's care plan did not address er meals. The care plan also ncontinent of urine and no urge to void so wore an iterventions on the care plan f to check and change R16 as g continuous observations 17 p.m., R16 was observed hair without being offered, or	F 282	 B. All residents were reviewed and who receive assistance with toiletin repositioning have the potential to haffected by this. C. The nursing staff will be instruct following the care plans timely with toileting and repositioning. The nura assistants will use worksheets to document when repositioning and hoccurred, and verbally report this to oncoming shift as well. All nursing will attend in-service training on foll the plan of care for each resident individualized toileting and repositions schedules on 12/30/15. D. Quality assurance audits will be to ensure the care plans are being followed, by interviewing staff, obsecares and reviewing the care plans. These audits will be completed week 4 weeks, then randomly by Directon Nursing and/or designee. The nurs assistant worksheets will be review each shift by the Charge nurse to e that these are completed and that the reporting to oncoming shift. Result audits will be taken to the Quality Assurance Committee for further recommendations. E. completion date January 7, 2016 	g and be ed on sing colleting o the staff owing soning done erving ekly for r of sing red ensure hey are s of the	

If continuation sheet Page 4 of 36

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245435	B. WING _			12/ [.]	10/2015
NAME OF !	PROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	NELSON				20 12TH AVENUE EAST LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	stated R16 needed and was unable to assistance. RA-A a a exercise room in and completed exe extremities, but did resident. -At 2:00 p.m. RA-A seated in the wheel nurses' station. RA- juice next to R16 at -At 2:45 p.m. NA-G remained seated at R16 and asked R16 nodded his head, N from the area. NA-G offer/attempt to ass toileting needs. -At 3:01 p.m. R16 v wheelchair at the ta staff were observed offer/attempt to ass toileting needs. -At 3:27 p.m. R16 v wheelchair at the ta NA-G and NA-D wa observed to attemp repositioning to toile -At 3:49 p.m. R16 v seated in a wheelch station. NA- was ob resident and greeter	a mechanical lift for transfers reposition himself without staff issisted R16 in a wheelchair to an unused hall of the facility ercises to both of R16's lower not offload or reposition the assisted R16, who remained lchair, to a table by the Pines -A placed a cup of coffee and t the table, and exited the area. The table is the table of the table of the area of the table. NA-G stood near 6 if he was alright. When R16 JA-G immediately walked away G was not observed to sist R16 with repositioning or was observed seated in a able by the nurses' station. No d during that time to sist R16 with repositioning of continued to be seated in a able by the nurses' station. alked past R16 and were not ot/offer to assist R16 with eting needs. was observed to continue to be hair at the table by the nurses oserved to walk over to ed R16. NA-G proceeded to 6 without offering or	F 28	82			

If continuation sheet Page 5 of 36

		AND HUMAN SERVICES				FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245435	B. WING _			12 /	10/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	IELSON				20 12TH AVENUE EAST LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	Continued From pa repositioning or toil	-	F 28	32			
	wheelchair, NA-D a questioned how he response and NA-D NA-D was not obse	vas observed to be seated in a approached R16 and was. R16 gave no verbal o walked away from R16. erved to offer/attempt to assist ing or toileting needs.					
	wheelchair at the ta C approached R16 give him a ride. R10	emained seated in a able by the nurses station, NA- and asked R16 if she could was observed to shake his ked away. R16 remained chair.					
	continued to be sea asked R16 how he non-verbal respons R16 she was check from R16. NA-G did	approached R16, who ated in the wheelchair, and was. R16 gave no verbal or e to NA-G. NA-G stated to king on him and walked away d not offer or attempt to assist ing or toileting needs.					
	notified by the surver repositioned or offer for a total of 3 hours approached R16 ar bring him to his roo no, NM-A asked R1 to his room to chan nodded affirmativel him to his room via	urse manager (NM)-A was eyor that R16 had not been red assistance with toileting s and 4 minutes. NM-A nd asked R16 if she could m. R16 initially shook his head 6 again if she could bring him ge his position, R16 then y and allowed NM-A to assist wheelchair. NM-A requested A-C to aid in R16's cares.					
	mechanical lift to tra	and NA-C utilized a ansfer R16 out of the transfer, R16 out of the					

If continuation sheet Page 6 of 36

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245435 B. WING 12/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **420 12TH AVENUE EAST KNUTE NELSON** ALEXANDRIA, MN 56308 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 6 F 282 area of the pants were noted to be wet. The wet area was approximately 12 centimeters (cm) by 12 cm and circular in shape. NA-C and NM-A donned gloves and assisted R16 to move side to side in order to remove his sweat pants. R16 was wearing a white incontinent brief which upon removal was noted to be saturated with blood tinged, amber colored urine. NM-A confirmed R16's brief was saturated with urine and confirmed R16's incontinence had saturated his brief and onto his sweat pants. R16 was then assisted to move to his right side towards NA-C by NM-A and NA-C. R16 was observed to have a Primapore (an adhesive dressing consisting of a breathable non-woven top layer and a low-adherent absorbent pad,) dressing on his right buttocks gluteal fold. NM-A removed R16's Primapore dressing, which was wet with urine on the outside, and R16 was observed to have an open area on the right side of his coccyx. -At 4:26 p.m. NM-A confirmed R16 had a stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister,) on his coccyx. NM-A stated R16 had a current urinary tract infection and indicated R16's skin under the Primapore dressing was dry. NM-A changed gloves and cleansed R16's pressure ulcer. NM-A confirmed R16's stage 2 pressure ulcer measured 1.8 cm x 1.0 cm and was circular in shape. NM-A also confirmed R16's wound bed was covered with granulation tissue (red tissue with " cobblestone " or bumpy appearance, bleeds easily with injured) and had very little depth. NM-A then applied cream and dressed R16's wound with a new dressing. After pericares were completed and a clean brief applied, R16 was assisted to turn onto his left side. A scabbed wound was observed on

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 7 of 36

PRINTED: 01/21/2016

		AND HUMAN SERVICES				FORM	01/21/2016 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245435	B. WING			12/ [.]	10/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
KNUTE	NELSON				20 12TH AVENUE EAST LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	R16's right hip area R16's right hip was was left open to air hip measured appre- had no redness. R16 had not been of offered to reposition changed for a total On 12/9/15, at 4:32 needed extensive a included reposition stated R16 was on schedule and was schanged for urinary frequently incontine was not aware of the repositioned or che stated she had atte around 4:00 p.m. by however R16 refus- unable to offer toile R16 as he would re was often more cor to go for a ride. NA- had a pressure ulce developed pressure buttocks crease. NA- been on an every 2 and there had beer often would increas repositioning of res ulcers though R16's not changed. NA-C make his needs kni anticipate R16's ne repositioning. On 12/9/15, at 5:01	a. NM-A stated the scab on a stage 2 pressure ulcer and . The pressure ulcer on R16's oximately 0.5 cm x 0.5 cm and observed to be assisted or n/offload and not checked and of 3 hours and 7 minutes. p.m. NA-C stated R16 assistance with all cares which ing and toileting needs. NA-C an every 2 hour repositioning supposed to be checked and v incontinence as R16 was ent of urine. NA-C stated she he last time R16 was cked and changed. NA-C mpted to care for R16 at y asking him to go for a ride, ed. NA-C stated the staff was ting or repositioning directly to fuse cares. NA-C stated R16 mpliant when they asked him -C stated she was aware R16 er on his right hip and a newly e ulcer on the right side of the A-C stated R16 had always hour repositioning schedule in o change. NA-C stated they	F 2	282			

If continuation sheet Page 8 of 36

		AND HUMAN SERVICES			FORM	: 01/21/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	E SURVEY IPLETED
		245435	B. WING		12 / ⁻	10/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KNUTE N	ELSON			420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
	assistance with inco she thought R16 has p.m. NM-A stated F ulcers, one on his ri one on his right glut on 12/7/15. NM-A s place at the time the developed was to la his left side or back onto his right side in stated she expected repositioning at leas R16 was often resis staff were also expec- change R16 for urin stated R16 was no void and was freque NM-A confirmed R1 breakdown. On 12/09/15, at 5:0 unaware of when R or assisted with inco he had not attempted repositioning or inco arrived on shift, aro R16 was dependen was on a every 2 ho current pressure uld was on a check and which was to correl stated R16 was ofte toileting and reposit not able to verbalize to anticipate needs. On 12/10/15, at 9:4	repositioned and had ontinence care. NM-A stated ad refused assistance at 1:30 R16 had 2 current pressure ight hip which was healing and teal fold which was first noted stated the intervention put in e new stage 2 pressure ulcer ay R16 in bed after meals on x. NM-A stated R16 often rolled independently in bed. NM-A d R16 to be assisted with st every 2 hours, and indicated stive with cares. NM-A stated ected at that time to check and hary incontinence. NM-A longer able to feel the urge to ently incontinent of urine. 16 was at high risk for skin extended to assist R16 with ontinence cares. NA-D stated ed to assist R16 with ontinence cares since he'd bund 2:00 p.m. NA-D stated at on staff for his needs and our repositioning plan and had cers. NA-D also stated R16 d change plan for incontinence late with repositioning. NA-D en resistive with cares such as tioning. NA-D stated R16 was e his needs and staff needed	F 282			

If continuation sheet Page 9 of 36

		AND HUMAN SERVICES				FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245435	B. WING			12/ [.]	10/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	NELSON				20 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	so staff were encou approaches for coo take R16 for a ride. continued to lose w increased his risk fo she thought R16's p unavoidable. In ado R16 resisted cares assist R16 with rep- checking/changing hours. The DON ve a newly developed gluteal fold and had increase R16's repo R16's continued res- stated they were luc R16 every 2 hours a The DON again cor risk for skin breakd condition was declin R16 had developed hip 10/27/15, which present had anothe gluteal fold. On 12/10/15, at 10: offered cares to R1 however was not ob stated R16 required which included repo changing every 2 h high risk for skin br pressure ulcers, on buttocks (gluteal fol R16 was assisted v was 11:00 a.m., prie stated R16 was free and was not able to	uraged to use alternative operation such as offering to . The DON stated R16 had weight and refuse cares which or pressure ulcers. She stated pressure ulcers may be dition, the DON stated although at times, she expected staff to	F 2	282			

Facility ID: 00113

If continuation sheet Page 10 of 36

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT	E SURVEY IPLETED
		245435	B. WING			12/	10/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KNUTE N	IELSON				20 12TH AVENUE EAST LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 282	Continued From pa anticipate R16's ner	-	F 2	282			
	1/2015, revealed th staff to provide app treatment to help re bladder function an infections. The polic complete urinary as based on the asses implemented to pro incontinence manage facility staff to follow	d, Urinary Incontinence revised e purpose of the policy was for ropriate services and esidents restore or improve d prevent urinary tract cy directed facility staff to sessments of residents and esiment a plan was to be vide residents with gement. The policy directed v the residents individualized in comfort and skin integrity.					
F 312 SS=D	3/2015, revealed a facility staff to deve comprehensive car policy further reveal responsibility to follow report any changes member from follow	e plan for each resident. The led it was the staffs ow resident care plans and to which would prevent a staff ving the care plan. ARE PROVIDED FOR	FS	312			1/7/16
	daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal					
	by: Based on observat review the facility fa	NT is not met as evidenced ion, interview and document iled to provide timely for a check and change			F 312 a. For resident R 16 facility will ensuresident receives timely assistance of		

Facility ID: 00113

If continuation sheet Page 11 of 36

		AND HUMAN SERVICES				FORM	01/21/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245435	B. WING			12/1	0/2015
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
KNUTE I	NELSON				20 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	program for 1 of 1 i urinary incontinence Findings include: Review of R16's ar (MDS) dated 9/30/- cognitive impairme included dementia, MDS also identified assistance with act frequently incontine identified R16 was was on a reposition pressure ulcers. Review of R16's au for assessment refu- identified R16 had required extensive for ADL's and was requiring staff to as CAA summary also assistance with per and had recurrent u The CAA summary resistive to cares a medications which Review of R16's B 9/30/15, identified F moderate to large a assessment also id cognitive impairme staff for transfers w The assessment ref assistance with toil 0500-0600 daily. Th	residents (R16) reviewed for	F	312	repositioning as directed by the pla care for prevention and managemer residents pressure ulcer. Staff will residents toileting plan to check and change incontinent product per the care for management of urinary incontinence. b. All residents were reviewed and needing assistance with toileting ar are at risk for developing pressure have the potential to be affected by c. All nursing staff will attend an in- training on timely following individuat toileting plans for management of u incontinence and providing repositi per residents plan of care for the prevention and management of pre- ulcers. The nursing assistants will u worksheets to document when toile and repositioning occurred, and ver report this to the oncoming shift as Facility policy and procedures on to and repositioning will be reviewed of scheduled in-service on 12/30/15. d. Quality Assurance audits will be ensure the resident individualized of plans are being followed, by interviers staff, observing cares and reviewin care plans. These audits will be completed weekly for 4 weeks, their randomly by Director of Nursing an designee. The nursing assistant worksheets will be reviewed each so the Charge nurse to ensure that the completed and that they are report oncoming shift. Results of these au will be taken to the Quality Assurant Committee for further recommenda e. Completion date January 7, 2100	ent of follow d plan of those d who ulcers this. service alized urinary oning essure use eting rbally well. bileting during done to care ewing g the n d/or shift by ess are ng to udits ce ations.	

Facility ID: 00113

PRINTED: 01/21/2016 FORM APPROVED

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245435	B. WING			12/ [.]	10/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KNUTE I	NELSON				20 12TH AVENUE EAST ILEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	required staff assist Review of R16's ca R16 was at high ris urinary incontinence R16's care plan dire with repositioning e chair. R16's care pl incontinent of urine of the urge to void. R16 wore an incont staff to check and c On 12/09/15, during from 1:10 p.m. to 4 seated in a wheelch assisted, to repositi - At 1:10 p.m. R16 p pants and a shirt, s Pines unit dining ro assistant (NA)-F wa and wheeled R16 to located across from common area was openings in which t sat briefly in the com himself with his fee opening. -At 1:35 p.m. a rest R16, who had conti feet around the com bring him to exercis exercises of active both lower extremit stated R16 needed	tance with incontinence cares. re plan dated 5/7/15, identified k for pressure ulcers related to e and open area on right hip. ected facility staff to assist R16 very 2 hours while in bed and an also revealed R16 was and R16 was no longer aware R16's care plan also revealed inent brief and directed facility change as needed. g continuous observations :17 p.m., R16 was observed nair without being offered, or	F	312			

If continuation sheet Page 13 of 36

		AND HUMAN SERVICES				FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245435	B. WING _			12/ [.]	10/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KNUTE I	NELSON				20 12TH AVENUE EAST LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	assistance. RA-A a: a exercise room in a and completed exer- extremities, but did resident. -At 2:00 p.m. RA-A seated in the wheel nurses' station. RA- juice next to R16 at -At 2:45 p.m. NA-G remained seated at R16 and asked R16 nodded his head, N from the area. NA-G offer/attempt to ass toileting needs. -At 3:01 p.m. R16 w wheelchair at the ta staff were observed offer/attempt to ass toileting needs. -At 3:27 p.m. R16 w wheelchair at the ta NA-G and NA-D wa observed to attemp repositioning to toile -At 3:49 p.m. R16 w seated in a wheelch station. NA- was ob resident and greete	ssisted R16 in a wheelchair to an unused hall of the facility rcises to both of R16's lower not offload or reposition the assisted R16, who remained lchair, to a table by the Pines -A placed a cup of coffee and t the table, and exited the area. briefly approached R16 who t the table. NA-G stood near 6 if he was alright. When R16 IA-G immediately walked away G was not observed to sist R16 with repositioning or was observed seated in a able by the nurses' station. No d during that time to sist R16 with repositioning of continued to be seated in a able by the nurses' station. Alked past R16 and were not totoffer to assist R16 with eting needs. was observed to continue to be hair at the table by the nurses perved to walk over to ed R16. NA-G proceeded to 6 without offering or de assistance with	F 3	12			

Facility ID: 00113

If continuation sheet Page 14 of 36

		AND HUMAN SERVICES			FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245435	B. WING		12/ [.]	10/2015
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	IELSON			20 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 312	Continued From pa -At 3:51 p.m. R16 v wheelchair, NA-D a questioned how he response and NA-D NA-D was not obse R16 with reposition -At 4:02 p.m. R16 r wheelchair at the ta C approached R16 give him a ride. R10 head and NA-C wa seated in the wheel -At 4:06 p.m. NA-G continued to be sea asked R16 how he non-verbal respons R16 she was check from R16. NA-G dia R16 with reposition -At 4:14 p.m. the nu notified by the surver repositioned or offe for a total of 3 hours approached R16 ar bring him to his roo no, NM-A asked R1 to his room to chan nodded affirmativel him to his room via the assistance of N -At 4:17 p.m. NM-A mechanical lift to tra	age 14 was observed to be seated in a approached R16 and was. R16 gave no verbal D walked away from R16. erved to offer/attempt to assist ing or toileting needs. remained seated in a able by the nurses station, NA- 5 and asked R16 if she could 6 was observed to shake his lked away. R16 remained lchair. approached R16, who ated in the wheelchair, and was. R16 gave no verbal or se to NA-G. NA-G stated to king on him and walked away d not offer or attempt to assist ing or toileting needs. urse manager (NM)-A was eyor that R16 had not been pred assistance with toileting s and 4 minutes. NM-A nd asked R16 if she could om. R16 initially shook his head 16 again if she could bring him ige his position, R16 then y and allowed NM-A to assist wheelchair. NM-A requested IA-C to aid in R16's cares.	TAG F 312		RATE	DATE
	area of the pants w	the transfer, R16's bottom rere noted to be wet. The wet ately 12 centimeters (cm) by				

If continuation sheet Page 15 of 36

TATEMENT	RS FOR MEDICAR OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		IDENTIFICATION NOMBER.	A. BUILDIN	NG			
		245435	B. WING _			2/10/2015	
NAME OF F	PROVIDER OR SUPPLIEF	1		STREET ADDRESS, CITY, STATE, ZIP C	ODE		
	IELSON			420 12TH AVENUE EAST ALEXANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 312	Continued From p	age 15	F 31	12			
		r in shape. NA-C and NM-A					
		d assisted R16 to move side to					
		move his sweat pants. R16 was continent brief which upon					
		d to be saturated with blood					
		ored urine. NM-A confirmed					
		turated with urine and					
		ncontinence had saturated his sweat pants. R16 was then					
		to his right side towards NA-C					
		C. R16 was observed to have a					
		thesive dressing consisting of a					
		oven top layer and a orbent pad,) dressing on his					
		eal fold. NM-A removed R16's					
		g, which was wet with urine on					
		16 was observed to have an					
		right side of his coccyx. A confirmed R16 had a stage 2					
		oss of dermis presenting as a					
		r with a red-pink wound bed,					
		ay also present as an intact or ter,) on his coccyx. NM-A					
		current urinary tract infection					
		's skin under the Primapore					
		NM-A changed gloves and					
		essure ulcer. NM-A confirmed					
		ssure ulcer measured 1.8 cm x rcular in shape. NM-A also					
		ound bed was covered with					
		(red tissue with " cobblestone "					
		nce, bleeds easily with injured) depth. NM-A then applied					
		d R16's wound with a new					
	dressing. After per	ricares were completed and a					
	clean brief applied	l, R16 was assisted to turn onto					
		bbed wound was observed on a. NM-A stated the scab on					

Facility ID: 00113

If continuation sheet Page 16 of 36

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
		245435	B. WING _		12/	10/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	/	
KNUTE I	NELSON			420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 312	was left open to air hip measured appre- had no redness. R16 had not been of offered to reposition changed for a total On 12/9/15, at 4:32 needed extensive a included reposition stated R16 was on schedule and was s changed for urinary frequently incontine was not aware of the repositioned or che stated she had atte around 4:00 p.m. b however R16 refus unable to offer toile R16 as he would refus was often more cor to go for a ride. NA had a pressure ulos developed pressure buttocks crease. Nu been on an every 2 and there had been often would increas repositioning of res ulcers though R16's not changed. NA-C make his needs kn anticipate R16's ne repositioning. On 12/9/15, at 5:01 current care plan at when R16 was last	The pressure ulcer on R16's oximately 0.5 cm x 0.5 cm and observed to be assisted or n/offload or to be checked and of 3 hours and 7 minutes. p.m. NA-C stated R16 assistance with all cares which ing and toileting needs. NA-C an every 2 hour repositioning supposed to be checked and v incontinence as R16 was ent of urine. NA-C stated she he last time R16 was cked and changed. NA-C mpted to care for R16 at y asking him to go for a ride, ed. NA-C stated the staff was ting or repositioning directly to fuse cares. NA-C stated R16 mpliant when they asked him -C stated she was aware R16 er on his right hip and a newly e ulcer on the right side of the A-C stated R16 had always hour repositioning schedule in o change. NA-C stated they	F 31			

If continuation sheet Page 17 of 36

	FORM	01/21/2016 APPROVED 0938-0391				
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245435	B. WING	·····	12/ [.]	10/2015
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	NELSON			20 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	she thought R16 ha p.m. NM-A stated F ulcers, one on his ri one on his right glur on 12/7/15. NM-A s place at the time th developed was to la his left side or back onto his right side in stated she expected repositioning at leas R16 was often resis staff were also expec- change R16 for urin stated R16 was no void and was freque NM-A confirmed R1 breakdown. On 12/09/15, at 5:0 unaware of when R or assisted with inc- he had not attempter repositioning or ince arrived on shift, aro R16 was dependen was on a every 2 he current pressure ule was on a check and which was to correl stated R16 was ofter to ileting and reposit not able to verbalize to anticipate needs. On 12/10/15, at 10: offered cares to R1 however was not of	ad refused assistance at 1:30 R16 had 2 current pressure ight hip which was healing and teal fold which was first noted stated the intervention put in re new stage 2 pressure ulcer ay R16 in bed after meals on X. NM-A stated R16 often rolled independently in bed. NM-A d R16 to be assisted with st every 2 hours, and indicated stive with cares. NM-A stated ected at that time to check and nary incontinence. NM-A longer able to feel the urge to ently incontinent of urine. 16 was at high risk for skin 08 p.m. NA-D stated he was R16 had last been repositioned ontinence cares. NA-D stated ed to assist R16 with ontinence cares since he'd bund 2:00 p.m. NA-D stated at on staff for his needs and our repositioning plan and had cers. NA-D also stated R16 d change plan for incontinence late with repositioning. NA-D en resistive with cares such as tioning. NA-D stated R16 was e his needs and staff needed				

If continuation sheet Page 18 of 36

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/21/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245435	B. WING		12/	10/2015
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KNUTE N	IELSON			420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312 F 314 SS=G	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 18 which included repositioning and check and changing every 2 hours. NA-E stated R16 was at high risk for skin breakdown and at present had 2 pressure ulcers, one on the right hip and right buttocks (gluteal fold.) NA-E stated the last time R16 was assisted with cares on 12/9/15 day shift was 11:00 a.m., prior to the noon meal. NA-E stated R16 was frequently incontinent of urine and was not able to verbalize the need to void or other need. NA-E stated staff needed to anticipate R16's needs A facility policy titled, Urinary Incontinence revised 1/2015, revealed the purpose of the policy was for staff to provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections. The policy directed facility staff to complete urinary assessments of residents and based on the assessment a plan was to be implemented to provide residents with incontinence management. The policy directed facility staff to follow the residents individualized care plan to maintain comfort and skin integrity. A facility policy titled, Perineal Care for incontinence revised 1/2015, revealed a statement which identified the facility used incontinent products designed to pull moisture away form the skin. The statement further revealed prolonged exposure to urine could compromise skin integrity. The policy directed facility staff to provide complete perineal cares after each incontinence. 483.25(c) TREATMENT/SVCS TO		F 312			1/7/16
SS=G	PREVENT/HEAL P	RESSURE SORES				

If continuation sheet Page 19 of 36

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		יחד			0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245435		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/10/2015		
							NAME OF PROVIDER OR SUPPLIER KNUTE NELSON
	4 A						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 314	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely interventions of repositioning for 1 of 3 (R16) residents reviewed for pressure ulcers. This deficient practice resulted in actual harm for R16 identified with recurrent or multiple stage 2 pressure ulcers. Findings include: R16's annual Minimum Data Set (MDS) dated 9/30/15, indicated R16 had severe cognitive impairment and had diagnoses which included dementia, arthritis and anxiety. The MDS also indicated R16 needed extensive assistance with activities of daily (ADL's), was frequently incontinent of urine, and was at risk for pressure ulcers. The MDS also indicated R16 was on a repositioning program to prevent pressure ulcers, but did not have a pressure ulcer at the time of the assessment.		F 3	:14		are ement vill be sident re. tted to those nent of this. , times the last d to lurses se ce. All aining ng	
	9/30/15, also identit included dementia,	fied R16 had diagnoses which arthritis and depression. The had severe cognitive			education on pressure ulcer preven care of pressure ulcers and repositi policy will be reviewed with nursing	tion, oning	

Facility ID: 00113

If continuation sheet Page 20 of 36

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245435		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			MB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		NAME OF PROVIDER OR SUPPLIER 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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
F 314	impairment, neede assistance for ADL of urine and was at ulcers. The CAA in assistance with rep care plan. Review of R16's ca R16 was at high ris urinary incontinence right hip. R16's car assist R16 with rep in bed and chair. R lying down R16 afte indicated R16 was longer aware of the incontinent brief. In directed facility stat needed. On 12/09/15, durin from 1:10 p.m. to 4 seated in a wheelc assisted, to reposit - At 1:10 p.m. R16 pants and a shirt, s Pines unit dining ro assistant (NA)-F wa and wheeled R16 t located across from common area was openings in which sat briefly in the co himself with his fee	d extensive physical 's, was frequently incontinent t risk for developing pressure dicated R16 was to receive positioning as indicated on the are plan dated 5/7/15, identified sk for pressure ulcers related to be and an open area on the e plan directed facility staff to positioning every 2 hours while 16's care plan did not address er meals. The care plan also incontinent of urine and no e urge to void so wore an interventions on the care plan ff to check and change R16 as g continuous observations E:17 p.m., R16 was observed hair without being offered, or	F 314	In-service will be on 12/30/15. d. Quality Assurance audits will be ensure compliance of following the residents care plan for timely repositioning, following care plan resident down in bed after meals audit the compliance and complet the repositioning logs. Audits will for the treatment of current press ulcers as well as interventions fo prevention of future skin breakdo. These audits will be done weekly weeks, then randomly by Directo Nursing and/or designee. Results audits will be taken to the Quality Assurance Committee for further recommendations. e. completion date January 7, 20	to lay and tion of be done ture wn. for 4 r of s of the		

		AND HUMAN SERVICES			FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245435	B. WING		12/ [.]	10/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KNUTE I	NELSON			420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	R16, who had conti feet around the con bring him to exercise exercises of active both lower extremit stated R16 needed and was unable to assistance. RA-A a a exercise room in and completed exe extremities, but did resident. -At 2:00 p.m. RA-A seated in the wheel nurses' station. RA- juice next to R16 at -At 2:45 p.m. NA-G remained seated at R16 and asked R16 nodded his head, N from the area. NA-G offer/attempt to ass toileting needs. -At 3:01 p.m. R16 v wheelchair at the ta staff were observed offer/attempt to ass toileting needs. -At 3:27 p.m. R16 v wheelchair at the ta NA-G and NA-D wa observed to attemp repositioning to toile	inued to propel himself with his mons area, and offered to ses. RA-A stated R16 received range of motion (AROM) to ies 5-6 times a week. RA-A a mechanical lift for transfers reposition himself without staff ssisted R16 in a wheelchair to an unused hall of the facility rcises to both of R16's lower not offload or reposition the assisted R16, who remained lchair, to a table by the Pines -A placed a cup of coffee and t the table, and exited the area. I briefly approached R16 who t the table. NA-G stood near 6 if he was alright. When R16 IA-G immediately walked away G was not observed to sist R16 with repositioning or was observed seated in a able by the nurses' station. No d during that time to sist R16 with repositioning of	F 314			

If continuation sheet Page 22 of 36

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245435	B. WING		12/ [.]	10/2015
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
KNUTE I	NELSON			20 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	seated in a wheelol station. NA- was ob resident and greete walk away from R1 attempting to provid repositioning or toil -At 3:51 p.m. R16 w wheelchair, NA-D a questioned how he response and NA-D NA-D was not obse R16 with reposition -At 4:02 p.m. R16 r wheelchair at the ta C approached R16 give him a ride. R10 head and NA-C wa seated in the wheel -At 4:06 p.m. NA-G continued to be sea asked R16 how he non-verbal respons R16 she was check from R16. NA-G dia R16 with reposition -At 4:14 p.m. the nu notified by the survi repositioned or offer for a total of 3 hour approached R16 ar bring him to his roo no, NM-A asked R1 to his room to chan nodded affirmativel	hair at the table by the nurses beerved to walk over to ed R16. NA-G proceeded to 6 without offering or de assistance with eting needs. was observed to be seated in a approached R16 and was. R16 gave no verbal D walked away from R16. erved to offer/attempt to assist ing or toileting needs. remained seated in a able by the nurses station, NA- 5 and asked R16 if she could 6 was observed to shake his liked away. R16 remained	F 314			

Facility ID: 00113

If continuation sheet Page 23 of 36

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED		
			A. BUILDIN	G				
		245435	B. WING _		12/10/2015			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
	IELSON			420 12TH AVENUE EAST ALEXANDRIA, MN 56308				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE		
F 314		-	F 31	4				
		IA-C to aid in R16's cares.						
	-At 4:17 p.m. NM-A and NA-C utilized a mechanical lift to transfer R16 out of the wheelchair. During the transfer, R16's bottom							
	area was approxim 12 cm and circular	vere noted to be wet. The wet ately 12 centimeters (cm) by in shape. NA-C and NM-A						
	side in order to rem wearing a white inc	l assisted R16 to move side to nove his sweat pants. R16 was continent brief which upon						
	tinged, amber colo	to be saturated with blood red urine. NM-A confirmed turated with urine and						
	brief and onto his s	continence had saturated his weat pants. R16 was then b his right side towards NA-C						
	by NM-A and NA-C Primapore (an ad	C. R16 was observed to have a hesive dressing consisting of a						
	low-adherent abso	ven top layer and a rbent pad,) dressing on his al fold. NM-A removed R16's						
	Primapore dressing the outside, and R	g, which was wet with urine on 16 was observed to have an ght side of his coccyx.						
	-At 4:26 p.m. NM-A (partial thickness lo	A confirmed R16 had a stage 2 poss of dermis presenting as a						
	without slough. Ma	with a red-pink wound bed, y also present as an intact or er,) on his coccyx. NM-A						
	stated R16 had a c and indicated R16	urrent urinary tract infection s skin under the Primapore NM-A changed gloves and						
	cleansed R16's pre R16's stage 2 pres	essure ulcer. NM-A confirmed sure ulcer measured 1.8 cm x						
		cular in shape. NM-A also ound bed was covered with						

If continuation sheet Page 24 of 36

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		245435	B. WING		12	/10/2015	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-		
KNUTE I	NELSON		420 12TH AVENUE EAST ALEXANDRIA, MN 56308				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
F 314	and had very little of cream and dressed dressing. After peri- clean brief applied, his left side. A scab R16's right hip area R16's right hip was was left open to air hip measured appre- had no redness. R16 had not been of offered to reposition and 7 minutes. On 12/9/15, at 4:32 needed extensive a included reposition stated R16 was on schedule and was a changed for urinary frequently incontine was not aware of the repositioned or che stated she had atter around 4:00 p.m. b however R16 refus unable to offer toile R16 as he would refuse was often more cor to go for a ride. NA had a pressure ulca developed pressure buttocks crease. Na been on an every 2 and there had beer often would increas repositioning of res ulcers though R16's not changed. NA-C	depth. NM-A then applied I R16's wound with a new cares were completed and a R16 was assisted to turn onto obed wound was observed on a. NM-A stated the scab on a stage 2 pressure ulcer and . The pressure ulcer on R16's oximately 0.5 cm x 0.5 cm and observed to be assisted or n/offload for a total of 3 hours ? p.m. NA-C stated R16 assistance with all cares which ing and toileting needs. NA-C an every 2 hour repositioning supposed to be checked and v incontinence as R16 was ent of urine. NA-C stated she he last time R16 was cked and changed. NA-C impted to care for R16 at y asking him to go for a ride, ed. NA-C stated the staff was ting or repositioning directly to fuse cares. NA-C stated R16 mpliant when they asked him -C stated she was aware R16 er on his right hip and a newly e ulcer on the right side of the A-C stated R16 had always ? hour repositioning schedule in o change. NA-C stated they	F 3				

Facility ID: 00113

If continuation sheet Page 25 of 36

		AND HUMAN SERVICES				FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY IPLETED
		245435	B. WING _			12/ [.]	10/2015
NAME OF F	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	NELSON				20 12TH AVENUE EAST LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ige 25	F 31	14			
	anticipate R16's ne repositioning.	eds such as toileting and					
	current care plan at when R16 was last assistance with inco- she thought R16 ha p.m. NM-A stated F ulcers, one on his r one on his right glu on 12/7/15. NM-A s place at the time th developed was to la his left side or back onto his right side in stated she expected repositioning at lease R16 was often resis staff were also expo- change R16 for urin stated R16 was no void and was freque NM-A confirmed R16	p.m. NM-A confirmed R16's nd stated she was unaware of repositioned and had ontinence care. NM-A stated ad refused assistance at 1:30 R16 had 2 current pressure ight hip which was healing and teal fold which was first noted stated the intervention put in e new stage 2 pressure ulcer ay R16 in bed after meals on k. NM-A stated R16 often rolled independently in bed. NM-A d R16 to be assisted with st every 2 hours, and indicated stive with cares. NM-A stated ected at that time to check and nary incontinence. NM-A longer able to feel the urge to ently incontinent of urine. 16 was at high risk for skin					
	unaware of when R or assisted with inc he had not attemptor repositioning or inco arrived on shift, aro R16 was dependen was on a every 2 ho current pressure un was on a check and which was to correl stated R16 was ofte	8 p.m. NA-D stated he was 816 had last been repositioned ontinence cares. NA-D stated ed to assist R16 with ontinence cares since he'd ound 2:00 p.m. NA-D stated at on staff for his needs and our repositioning plan and had cers. NA-D also stated R16 d change plan for incontinence late with repositioning. NA-D en resistive with cares such as tioning. NA-D stated R16 was					

Facility ID: 00113

If continuation sheet Page 26 of 36

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		045405	B. WING				
	PROVIDER OR SUPPLIER	245435		TREET ADDRESS, CITY, STATE, ZIP CODE	12/10/2015		
	NELSON		4 A				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 314	not able to verbaliz to anticipate needs On 12/10/15, at 9:4 (DON) stated R16 so staff were encou approaches for coo take R16 for a ride continued to lose w increased his risk f she thought R16's unavoidable. In add R16 resisted cares assist R16 with rep checking/changing hours. The DON va a newly developed gluteal fold and hav increase R16's rep R16's continued re stated they were lu R16 every 2 hours The DON again co risk for skin breakd condition was decli R16 had developed hip 10/27/15, which present had anothe gluteal fold. On 12/10/15, at 10 offered cares to R1 however was not o stated R16 require which included rep changing every 2 h	e his needs and staff needed a. 49 a.m. the director of nursing was often resistive with cares uraged to use alternative operation such as offering to . The DON stated R16 had veight and refuse cares which or pressure ulcers. She stated pressure ulcers may be dition, the DON stated although at times, she expected staff to	F 314				

Facility ID: 00113

If continuation sheet Page 27 of 36

		AND HUMAN SERVICES				FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245435	B. WING			12/ ⁻	10/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KNUTE I	NELSON				20 12TH AVENUE EAST LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	R16 was assisted w was 11:00 a.m., pro- stated R16 was free and was not able to other need. NA-E s anticipate R16's new Review of R16's pro- 12/10/15 revealed t -A skin assessment was at high risk for Braden scale (a too developing pressur- activity, nutrition, m identified R16 was a development of pre- identified R16 requi staff with reposition pressure areas. The preventative measu- time of the note incl reduction cushion in pressure reduction not indicate R16 had of the assessment. -A weekly skin cheor revealed R16 had at the right hip. The no- was caused by R16 implemented a an a daily dressing chan and Allevyn. The no-	with cares on 12/9/15 day shift or to the noon meal. NA-E quently incontinent of urine overbalize the need to void or tated staff needed to eds ogress notes from 10/06/15 to the following: t dated 10/6/15, revealed R16 skin breakdown based on a of used to identify risk for e ulcers based on mobility, aceration and friction) at moderate risk for essure ulcers. The assessment ired assistance of 2 facility ing every 2 hours to prevent e assessment identified ures that were in place at the luding; repositioning, pressure n wheelchair and a standard mattress. The summary did ad pressure ulcers at the time	F 3	;14			

If continuation sheet Page 28 of 36

		AND HUMAN SERVICES			FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245435	B. WING		12/ ⁻	10/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	IELSON			420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	R16's right hip treat changes, and to ke when in bed. R16's kept clean and dry. measured 1 cm x 0 -A wound measurer identified R16's righ pressure ulcer, mea cm. The note revea ulcer had 75% epith granulation tissue p	ote dated 10/28/15, revealed tment included daily dressing tep R16 repositioned off the hip right hip dressing was to be R16's right hip wound 0.5 cm. ment note dated 11/2/15, ht hip wound was a stage 2 asured 0.9 cm x 0.7 cm x 0.0 aled R16's stage 2 pressure helial tissue and 25% present at the time of the	F 314			
	in R16's dressing to every 3 days until h -A weekly skin note new skin issues.	e dated 11/3/15, revealed no				
	identified R16 had a inner thigh under th scratching the groin The note revealed r	nd note dated 11/9/15, an open area on the upper ne scrotum due to R16 n area throughout the night. monitoring would be initiated aff was to keep R16's finger				
	identified R16's star 1 cm x 0.5 cm x 0.0 tissue and 25% gra	ment note dated 11/9/15, ge 2 pressure ulcer measured 0 cm, had 75% epithelial anulation tissue. The note es in treatment and indicated er was healing.				
	R16's open area or	ote dated 11/9/15, identified In the scrotum measured 0.5 ad no signs of infection.				

If continuation sheet Page 29 of 36

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245435	B. WING		12/ [.]	10/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	NELSON			20 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	 A skin follow up no R16's open area or measure 0.5 cm x 0 infection. The note receive a thera shie the area. A wound measured identified R16's stat 1.5 cm x 0.5 cm x 0 tissue and 25% gra revealed the wound had no other signs revealed no treatmo pressure ulcer. A weekly skin note had no new skin iss A skin/wound initia identified R16 had a and had been deter A wound measured identified R16's stat 0.9 cm x 0.5 cm x 0 tissue and 25% gra identified R16's stat 0.9 cm x 0.5 cm x 0 tissue and 25% gra identified R16's righulcer which was he A weekly skin note had no new skin iss A wound measured identified R16's righulcer which was he A wound measured identified R16's stat 0.7 cm x 0.5 cm x 0 tissue. The note rev 	ote dated 11/10/15, revealed in the scrotum continued to 0.5 cm and had no signs of further revealed R16 was to add and Primapore dressing to ment note dated 11/16/15, ige 2 pressure ulcer measured 0.0 cm, had 75% epithelial anulation tissue. The note d was slightly inflamed though of infection. The note further ent change to R16's stage 2 e dated 11/18/15, revealed R16 sues. al note dated 11/21/15, an open area to the right knee rmined to be caused by injury. ment note dated 11/23/15, ige 2 pressure ulcer measured 0.0 cm, had 75% epithelial anulation tissue. The note ht hip had a stage 2 pressure e dated 11/24/15, revealed R16	F 314			

If continuation sheet Page 30 of 36

	-	AND HUMAN SERVICES				FORM	APPROVED
						OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED
			A. BOILDI		•		
		245435	B. WING			12/ [.]	10/2015
NAME OF F	PROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				4	420 12TH AVENUE EAST		
					ALEXANDRIA, MN 56308		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
			1				
F 314	Continued From pa	.ge 30	F 3	14	k l		
	A weakly akin nata	detect 10/0/15 revealed D10					
	had no new skin iss	dated 12/2/15, revealed R16					
		I note dated 12/7/15, identified					
		en area on the right lower					
		d which measured 1.8 cm x 1 s assessed to have 100%					
		note revealed an analysis					
		6 had declined and lost weight.					
		a new intervention for R16 of					
		to bed after meals on his left					
	side or back.						
	-A wound measure	ment note dated 12/7/15,					
		ge 2 right hip pressure ulcer,					
		1.0 cm and had 100%					
		The pressure ulcers ssessed as red and measured					
		rrounding the open area. No					
		were indicated on the note.					
		essment note dated 12/7/15,					
		a 1.8 cm x 1 cm open area on d of inner buttocks. The note					
		an overall decline in condition					
		t. The assessment further					
		o be assisted to lay down after					
		de or back for pressure relief.					
	The open area was	left open to air.					
	-A skin follow up no	te dated 12/7/15, revealed					
		the right lower gluteal fold					
		1.0 cm, had no signs of					
	intection and had b	een left open to air.					
	-A skin follow up no	ote dated 12/8/15, at 4:48 a.m.					
		en area to the right lower					
		ed 1.8 cm x 1.0 cm, had					

PRINTED: 01/21/2016

		AND HUMAN SERVICES			FORM	01/21/2016 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245435	B. WING		12/	10/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
KNUTE	NELSON			420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	yellow slough noted bed. The note furth was left open to air R16 on the left side roll over to the right - An MD note dated open area to the rig pressure ulcer and increase R16's nutr times a day. -A skin follow up no revealed R16's stag gluteal fold was ten measurements. The was to be encourage tolerated reposition A physician progress revealed R16 had a right hip and staff w repositioning. Review of R16's un printed 12/10/15, re date of 11/7/15, to of (right) hip, change/a every 3 days until h lacked an order for pressure ulcer to th Review of the faciliti Bed and in a Chair/ 4/2015, revealed th included prevention providing pressure directed facility staf	d in the center of the wound er revealed R16's open area and staff attempts to position e was ineffective as R16 would t side. d 12/8/15, identified R16's ght lower gluteal fold was a had received an order to ritional supplement to four ote dated 12/8/15, at 1:28 p.m. ge 2 pressure ulcer to the right ider, had no change in e note further indicated R16 ged to reposition and had ing at the present time. es note dated 11/6/15, a stage 2 pressure ulcer to the vere to encourage asigned physician orders evealed an order with a start cleanse OA (open area) to R) apply Primapore dressing healed. R16's physician orders a dressing on R16's stage 2	F 31			

If continuation sheet Page 32 of 36

		AND HUMAN SERVICES			FORM	: 01/21/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245435	B. WING		12/	10/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	IELSON			420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa a chair.	ge 32	F 314	ł		
F 441 SS=D	Skin Care policy, re statement which inc pressure sore was treatment and servi prevent infection and developing. The pol provide skin care to policy also directed repositioning press care plan. 483.65 INFECTION SPREAD, LINENS	ty policy titled, Comprehensive evised 7/1/15, revealed a policy cluded, a resident who had a to receive the necessary ices to promote healing, ad prevent new sores from licy directed facility staff to b keep skin clean and dry. The facility staff to provide ure relief per the residents	F 441			1/7/16
	Infection Control Pr safe, sanitary and c	tablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction.				
	Program under whit (1) Investigates, con in the facility; (2) Decides what pr should be applied to	tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective				
	determines that a re prevent the spread isolate the resident.	tion Control Program esident needs isolation to of infection, the facility must				

If continuation sheet Page 33 of 36

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 01/21/2016 APPROVED . 0938-0391
STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245435	B. WING		12	/10/2015
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
KNUTE NE	LSON				20 12TH AVENUE EAST LEXANDRIA, MN 56308	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
ofid()hhp ()Ftrii Tblrnirrted F F9irMirateFa () o	rom direct contact will tra a) The facility must ands after each direct and washing is indor rofessional practic c) Linens Personnel must har ransport linens so a fiection. This REQUIREMEN by: Based on observat eview, the facility far fection control pra- elated to proper glo echniques for 1 of a luring personal car findings include: R81's quarterly Mini- /30/15, identified Far holuded diabetes a MDS identified R81 mpairment and req issistance for all ac pileting and hygien R81 was frequently lways incontinent of COn 12/10/2015, fro ontinual observation	ase or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their rect resident contact for which licated by accepted e. adle, store, process and as to prevent the spread of IT is not met as evidenced ion, interview and document ailed to ensure proper actices were implemented ove and handwashing 3 residents (R81) observed es. imum Data Set (MDS) dated 81 had diagnoses which and Alzheimer dementia. The had severe cognitive uired extensive to total staff ctivities of daily living including e. The MDS further identified incontinent of urine and	F 4	141	F 441 a. The facility will have an infection control program which it investigates, controls and monitors that proper procedures are used to prevent infections within the facility. For R81 proper infectior control procedures which include proper hand washing and glove use during the delivery of care will be used and enforced at all times. b. All resident have the potential to be affected by this, due to the risk of infections in a health care facility and continual contact with staff. c. All nursing staff will be instructed on proper hand washing and glove use when providing direct resident care. Hand washing and glove use policy will be reviewed during scheduled in-service on 12/30/15 for all nursing staff. d. Quality assurance audits will be done to ensure that the facility policy and	

Facility ID: 00113

If continuation sheet Page 34 of 36

		AND HUMAN SERVICES				FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245435	B. WING			12/ [.]	10/2015
NAME OF I	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	NELSON				20 12TH AVENUE EAST LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	disposable gloves of and dried R81's arr to both legs and fee for R81's bedside s room, assisted R81 removed R81's inco performed perineal soft,brown stool wa on R81's bottom. W removed the stool f perineal area. Sme observed on NA-A personal cares wer the soiled wipes, br garbage bag. After with the same soile picked up the lotion her gloved hands a bottom. With the sa returned the lotion b dresser. NA-A proceeded to to R81's bathroom, applied fresh dispo- R81's bedside with washed R81's eyes cloth and dried thes reach into R81's be soiled lotion bottle f squeezed lotion on her hands together cheeks and face. On 12/10/2015, at the usual practice of R81 laying in bed, a	ge 34 NA)-A at the bedside, and wore on both hand. NA-A washed ns and legs, and applied lotion et from a bottle NA-A removed tand. NA-B entered R81's to position on the side, ontinent brief and NA-A cares. A large amount of s observed in R81's brief and Vith gloved hands, NA-A rom R81's bottom, and ars of brown stool were right gloved hand after e completed. NA-A picked up ief and placed the items in a NA-A cleansed R81's bottom, d gloves, NA-A immediately bottle, squeezed lotion onto nd applied lotion to R81's ame soiled gloves, NA-A cottle to R81's bedside remove the bathing supplies removed both gloves and sable gloves. NA-A returned to fresh water in a basin and a, face and ears with and wash as areas. NA-A proceeded to diside dresser, remove the from the dresser. NA-A to both gloved hands, rubbed and applied the lotion to R81's	F 4	.41	procedure on hand washing and g use is being followed, by interview and observing cares. These audit done weekly for 4 weeks, then ran by Director of Nursing and/or desig Results of the audits will be taken Quality Assurance Committee for f recommendation. e. Completion date January 7, 201	ing staff s will be domly gnee. to the urther	

If continuation sheet Page 35 of 36

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	01/21/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245435	B. WING			12/	10/2015
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	NELSON				20 12TH AVENUE EAST LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	her soiled gloves an apply lotion to R81' On 12/10/2015, at nursing (DON) com- practice was for sta hands when the glo The DON identified when proper handw should be complete bowel movement (R assisting with toileti course" anything ha provide pericare/too contaminated. The undated facility identified the Purpo	ottle into R81's dresser with nd used the same bottle to 's face. 3:33 p.m. the director of firmed the usual facility aff to change gloves and wash oves become contaminated. 4 the following as examples washing and glove change ed; when dealing with urine, a BM), providing pericare, and ing. The DON stated, "of andled with gloves used to uch BM would be considered y form titled Hand Hygiene, ose: Hand hygiene continues to ans of preventing the	F 4	41			

Facility ID: 00113

If continuation sheet Page 36 of 36

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(* /	CONSTRUCTION - MAIN BUILDING 01) ´coi	TE SURVEY MPLETED 8/15
		245435	B. WING			/09/2015
NAME OF F	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP	CODE	
	IELSON			12TH AVENUE EAST EXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K 000			
	Minnesota Departm Fire Marshal Divisio Knute Nelson Mem substantial complia participation in Meo Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, orial Home was found not in nce with the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection Standard 101, Life Safety er 19 Existing Health Care.				
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	R THE FIRE SAFETY		EPC		
	HEALTH CARE FIF STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 551	SHAL DIVISION STREET, SUITE 145		EPU		
	By e-mail to: Marian.Whitney@s	tate.mn.us				
ABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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.

Constant of

			AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	01/04/2016 PPROVED 0938-0391
	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` <i>'</i>	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	((X3) DATE COMF	SURVEY
21 新			245435	B. WING _			12/0	9/2015
Ľ.	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
		IELSON			420 12TH AVENUE EAST ALEXANDRIA, MN 56308			
Statute .	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD I	BE	(X5) COMPLETION DATE
2	K 000	Continued From pa	ige 1	K 00	00			
		or Angela.kappenmar	n@state.mn.us					
			RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
		1. A description of to correct the defici	what has been, or will be, done ency.					1 5.m 1
1.8		2. The actual, or pr	oposed, completion date.					
A DATE OF		responsible for cor	r title of the person rection and monitoring to ence of the deficiency.					
		building with a part constructed at 5 dif building was constr determined to be o 1961, an addition w determined to be o	orial Home is a 1-story ial basement. The building was ferent times. The original ructed in 1958 and was f Type II(111) construction. In vas added to the east was f Type II(111)construction. f the facility are separated by					6
		2-hour fire resistive administration purp included in this sur added to the south Type II(000) constr added to to the sou Type V(111) constr added to the east a to be Type V(111) constr original building an	e construction and are used for boses only and were no vey. In 1970 and addition was that was determined to be uction. In 1976 an addition was ith that was determined to be uction. In 1980 additions were and south that were determined construction. Because the d the additions meet the llowed for existing buildings,		27 (²⁷ ma <u>n</u> 17 18 19			
1.1		the facility was sur	veyed as one building.					

Facility ID: 00113

If continuation sheet Page 2 of 7

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/04/2016 APPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			E SURVEY IPLETED
		245435	B, WING		12/	09/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	
	IELSON				0 12TH AVENUE EAST LEXANDRIA, MN 56308	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000 K 014 SS=D	The entire facility is sprinkler system. The alarm system with s corridors and space monitored for autom notification. The face 85 beds and had a survey. The requirement at NOT MET as evide NFPA 101 LIFE SA Interior finish for co exposed interior su fixed or movable wa	protected by a complete fire the facility has a complete fire smoke detection in the es open to the corridor that is natic fire department cility has a licensed capacity of census of 72 at the time of the 42 CFR Subpart 483.70(a) is nced by: FETY CODE STANDARD rridors and exitways, including rfaces of buildings such as alls, partitions, columns, and e spread rating of Class A or	К 0 К 0			12/30/15
	Based on observat found that the facilit documentation for interior finishes per deficiency could res staff and visitors to flame spread and s finishes in the spac maximum amounts Findings include: During the facility to PM on 12/8/2015 it	s not met as evidenced by: ions and staff interview it was ty failed to maintain the proper the flame spread ratings of LSC (2000) 19.3.3.1. This sult in a failure of residents, safely exit due to unknown moke development of the wall es affected, if they exceed the			The interior finish for corridors, ceilings and hallways with fixed walls that have exposed interior finish product, known as FRP, to exit ways of our building are to meet flame spread rating. We have a Fire rating notebook of products from the past renovation projects. In November of 2003 we had installed a NUDO product Fiber-Lite Liner Panel with a class A flame spread Fire Rating on the corridor exiting outside near the Environmental Service Office. The fiberglass panels were installed on the lower half, approximately 48 inches up from the floor, with Manufacturers moldings, fasteners and	

6.Z

· sale and the second second

Facility ID: 00113

If continuation sheet Page 3 of 7

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01 - MAIN BUILDING 01	COM	PLETED
		245435	B. WING		12/0	09/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	IELSON			420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIOI DATE
K 014	finish 48 inches up This deficient cond	reinforced plastic as a wall	K 014	non-flammable FRP adhesive. T complies with Life Safety Code (19.3.3.1 to minimize flame sprea smoke impeding a safe exit of re staff and visitors. Responsible Person: Thomas S Director of Environmental Service	2000) ad and sidents,	
K 025 SS=D	K 025 SS=D Smoke barriers are constructed to provid least a one half hour fire resistance ratin accordance with 8.3. Smoke barriers ma terminate at an atrium wall. Windows ar protected by fire-rated glazing or by wire panels and steel frames. A minimum of separate compartments are provided on floor. Dampers are not required in duct penetrations of smoke barriers in fully du heating, ventilating, and air conditioning 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4		K 025			12/29/15
	Based on observa facility failed to mai construction that m NFPA 101 - 2000 e 8.3. This deficient staff and visitors by from one smoke co Findings include: On facility tour betw	s not met as evidenced by: tion and staff interview, the ntain smoke barrier wall eets the requirements of dition, Sections 19.3.7.3 and practice could affect residents, allowing smoke to propagate ompartment to another.		The smoke barrier wall above the barrier doors on the 500 hall near 514 had a hole penetration that allow smoke to propagate from a smoke compartment to another compartment. The Maintenance the hole with Fire Rated calking smoke from transferring to another compartment. Maintenance staff of Environmental Services or Administrative Representative we instructions for all contractors to	ar room could one smoke staff filled to prevent ner f, Director vill provide	

Facility ID: 00113

If continuation sheet Page 4 of 7

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG 01 - MAIN BUILDING 01	COM	PLETED
	z.	245435	B. WING			09/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
	IELSON			420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 025	a 1 inch diameter p smoke barrier wall barrier doors by res	enetration passing through the above the corridor smoke sident room 514.	КO	25 sure Fire caulking is used at when breaking the integrity of barrier while running any pro one smoke compartment to the building.	of the smoke oducts from	
K 029 SS=D	Maintenance Super Administrator [AU]. NFPA 101 LIFE SA One hour fire rated	ition was verified by the rvisor (TS) and the Facility FETY CODE STANDARD construction (with ¾ hour an approved automatic fire	κo	Responsible Person: Thom Director of Environmental So 29	as Storer, ervices	12/29/15
	extinguishing syste and/or 19.3.5.4 pro the approved autom option is used, the other spaces by sm doors. Doors are s field-applied protec	m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are				
	Based on observative revealed that the far proper protection frareas located throug accordance with NF section 19.3.2.1. The event of a first spread throughout areas making them.	PA Life Safety Code 101 (00) his deficient conditions could e, allow smoke and flames to the effected corridors and untenable, which could e exiting capabilities for	0	The smoke barrier compart mechanical room across the the Beauty Shop had severa could allow smoke and flam and affect the corridors. Thi the areas untenable and effe staff and visitors from exiting The Maintenance staff insta appropriate sheet rock on th and Fire Rated calking in ot areas of the mechanical room	e corridor by al holes that es to spread s could make ect residents, g capabilities. lied ne large hole her needed	

Contraction of the local division of the loc

から北部についていた

Event ID: J71M21

Facility ID: 00113

If continuation sheet Page 5 of 7

		AND HUMAN SERVICES & MEDICAID SERVICES				APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245435	B. WING		12/0	9/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST		
	NELSON			ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 029 K 056 SS=E	Findings include: On facility tour betw 12/8/2015, observa penetration found in mechanical room n This deficient cond Maintenance Supe Administrator [AU] NFPA 101 LIFE SA If there is an autom installed in accorda for the Installation of provide complete of building. The syste accordance with NI Inspection, Testing Water-Based Fire f	veen 9:00 AM to 12:30 PM on tion revealed that there was a in the corridor wall of the ear the beauty shop. ition was verified by the rvisor (TS) and the Facility FETY CODE STANDARD natic sprinkler system, it is ince with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the em is properly maintained in FPA 25, Standard for the , and Maintenance of Protection Systems. It is fully is a reliable, adequate water	K 02	that compartment if in the event of Maintenance staff, Director of Environmental Services or Admin representative will provide instruct contractors to make sure Fire call used at all times when breaking the integrity of the smoke barrier whill running any products from one smoke compartment to another smoke compartment within the building.	istrative tions all king is าe e	1/16/16
	supply for the syste systems are equipp switches, which are building fire alarm s This STANDARD i Based on observa found that the auto installed and maint NFPA 13 the Stand Sprinkler Systems	m. Required sprinkler bed with water flow and tamper e electrically connected to the		The sprinkler heads located on t station in the TV Lounge compar- area were standard response and match the adjoining corridor quict response sprinkler heads. That c affect the fire protection systems	ment d didn't <	

Facility ID: 00113

If continuation sheet Page 6 of 7

PRINTED: 01/04/2016

					1. Ang	FORM	01/04/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	
		245435	B. WING			12/0	9/2015
NAME OF F	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
				4	20 12TH AVENUE EAST		
	IELSON			A	LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 056	service causing a d system capability in that would affect the of the facility. Findings include: On facility tour betw 12/8/2015, observa- two different types the Pines Lounge a compartment, cons response and quick This deficient cond	veen 9:00 AM to 12:30 PM on ations revealed that there are of sprinkler heads located in area, which is one sisting of both standard k response heads. ition was verified by the rvisor (TS) and the Facility	K	056		actor, nuary neads ds and nencies. de equired ject is be	
FORM CMS-25	567(02-99) Previous Versions	s Obsolete Event ID: J71M2	1	Fa	cility ID: 00113 If continu	lation she	et Page 7 of

Real In

No. of Concession, Name

いたになっていた



Electronically delivered December 24, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5435026

Dear Ms. Urman:

The above facility was surveyed on December 7, 2015 through December 10, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 <u>only a suggestion</u> 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 Gail Anderson at: (218) 332-5140** or email: gail.anderson@state.mn.us.

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 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 meeth

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

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00113	B. WING		12/1	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE I	NELSON		AVENUE EA DRIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 12/30/15

Electronically Signed STATE FORM

If continuation sheet 1 of 36

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00113	B. WING		12/	10/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	NELSON		I AVENUE EAS DRIA, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically.	- Ith orders being submitted to Although no plan of correction	2 000			
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.						
	On December 7th, to December 10th, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.					
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow	umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		.E CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		00113	B. WING		12/10/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE	
	IELSON		I AVENUE EA DRIA, MN 56		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 000	Continued From pa	ge 2	2 000		
	THIS WILL APPEA	R ON EACH PAGE.			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		1/7/16
		omprehensive plan of care I personnel involved in the 			
	by: Based on observati review the facility fa interventions for toi	ent is not met as evidenced on, interview and document ailed to implement care plan leting and positioning for 1 of 1 iewed for urinary incontinence s.		Corrected	
	Findings include:				
	R16 was at high ris urinary incontinence right hip. R16's care assist R16 with rep in bed and chair. R lying down R16 afte indicated R16 was longer aware of the incontinent brief. In	re plan dated 5/7/15, identified k for pressure ulcers related to e and an open area on the e plan directed facility staff to ositioning every 2 hours while 16's care plan did not address er meals. The care plan also incontinent of urine and no urge to void so wore an nterventions on the care plan f to check and change R16 as			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00113	B. WING		12/	10/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	NELSON		I AVENUE EAS DRIA, MN 563	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 565	Continued From pa	ge 3	2 565			
	from 1:10 p.m. to 4 seated in a wheelch	On 12/09/15, during continuous observations from 1:10 p.m. to 4:17 p.m., R16 was observed seated in a wheelchair without being offered, or assisted, to reposition or toilet.				
	- At 1:10 p.m. R16 was observed wearing sweat pants and a shirt, seated in a wheelchair in the Pines unit dining room next to the table. Nursing assistant (NA)-F walked up to R16's wheelchair and wheeled R16 to the Pines common area, located across from the nurses' station. The common area was observed to have two openings in which to enter and exit the area. R16 sat briefly in the commons area prior to propelling himself with his feet around in a circle in one opening of the common area and out the other opening.					
	R16, who had contine feet around the contine bring him to exercise exercises of active both lower extremit stated R16 needed and was unable to assistance. RA-A a a exercise room in and completed exe	orative aid (RA)-A approached nued to propel himself with his nmons area, and offered to ses. RA-A stated R16 received range of motion (AROM) to ies 5-6 times a week. RA-A a mechanical lift for transfers reposition himself without staff ssisted R16 in a wheelchair to an unused hall of the facility rcises to both of R16's lower not offload or reposition the	5			
	seated in the wheel nurses' station. RA	assisted R16, who remained Ichair, to a table by the Pines A placed a cup of coffee and the table, and exited the area				
	remained seated at	briefly approached R16 who the table. NA-G stood near 6 if he was alright. When R16				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00113	B. WING		12/	10/2015
	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		10,2010
	IELSON		AVENUE EAS			
			DRIA, MN 563			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ige 4	2 565			
	from the area. NA-0	IA-G immediately walked away G was not observed to sist R16 with repositioning or	,			
	wheelchair at the ta staff were observed	vas observed seated in a able by the nurses' station. No d during that time to sist R16 with repositioning of				
	wheelchair at the ta NA-G and NA-D wa	continued to be seated in a able by the nurses' station. alked past R16 and were not ot/offer to assist R16 with eting needs.				
	seated in a wheelch station. NA- was ob resident and greete					
	wheelchair, NA-D a questioned how he response and NA-D NA-D was not obse	vas observed to be seated in a approached R16 and was. R16 gave no verbal D walked away from R16. erved to offer/attempt to assist ing or toileting needs.				
	wheelchair at the ta C approached R16 give him a ride. R10	emained seated in a able by the nurses station, NA- and asked R16 if she could 6 was observed to shake his lked away. R16 remained lchair.				
	-At 4:06 p.m. NA-G	approached R16, who				

STATE FORM

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00113	B. WING		12/	10/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST							
KNUTE I	NELSON		AVENUE EAS ORIA, MN 563				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 565	continued to be sea asked R16 how he non-verbal respons R16 she was check from R16. NA-G dia R16 with reposition -At 4:14 p.m. the nu notified by the surve repositioned or offe for a total of 3 hour approached R16 ar bring him to his roo no, NM-A asked R1 to his room to chan nodded affirmativel him to his room via the assistance of N -At 4:17 p.m. NM-A mechanical lift to tra wheelchair. During area of the pants w area was approxim 12 cm and circular donned gloves and side in order to rem wearing a white inc removal was noted tinged, amber color R16's brief was sat confirmed R16's ind brief and onto his s assisted to move to by NM-A and NA-C Primapore (an adl breathable non-wow	ated in the wheelchair, and was. R16 gave no verbal or se to NA-G. NA-G stated to king on him and walked away d not offer or attempt to assist ing or toileting needs. urse manager (NM)-A was eyor that R16 had not been ered assistance with toileting s and 4 minutes. NM-A nd asked R16 if she could m. R16 initially shook his head 16 again if she could bring him uge his position, R16 then y and allowed NM-A to assist wheelchair. NM-A requested IA-C to aid in R16's cares. and NA-C utilized a ansfer R16 out of the the transfer, R16's bottom rere noted to be wet. The wet ately 12 centimeters (cm) by in shape. NA-C and NM-A assisted R16 to move side to nove his sweat pants. R16 was ontinent brief which upon to be saturated with blood red urine. NM-A confirmed urated with urine and continence had saturated his weat pants. R16 was then o his right side towards NA-C . R16 was observed to have a hesive dressing consisting of a ven top layer and a		DEFICIENC			
linnesota D	bring him to his roo no, NM-A asked R1 to his room to chan nodded affirmativel him to his room via the assistance of N -At 4:17 p.m. NM-A mechanical lift to tr wheelchair. During area of the pants w area was approxim 12 cm and circular donned gloves and side in order to rem wearing a white inc removal was noted tinged, amber color R16's brief was sat confirmed R16's inc brief and onto his s assisted to move to by NM-A and NA-C Primapore (an adl breathable non-woy low-adherent absor right buttocks glute	m. R16 initially shook his head 6 again if she could bring him ige his position, R16 then y and allowed NM-A to assist wheelchair. NM-A requested A-C to aid in R16's cares. A and NA-C utilized a ansfer R16 out of the the transfer, R16's bottom rere noted to be wet. The wet ately 12 centimeters (cm) by in shape. NA-C and NM-A assisted R16 to move side to nove his sweat pants. R16 was ontinent brief which upon to be saturated with blood red urine. NM-A confirmed urated with urine and continence had saturated his weat pants. R16 was then o his right side towards NA-C . R16 was observed to have a hesive dressing consisting of a					

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00113	B. WING		12/	10/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	NELSON		I AVENUE EAS DRIA, MN 563			
(X4) ID	ALEXANDRIA, MN 56308) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION					(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
2 565	Continued From pa	ige 6	2 565			
	the outside, and R1	6 was observed to have an				
		ght side of his coccyx.				
	-At 4:26 p.m. NM-A	confirmed R16 had a stage 2				
		ess of dermis presenting as a				
		with a red-pink wound bed,				
		without slough. May also present as an intact or				
		er,) on his coccyx. NM-A				
		urrent urinary tract infection skin under the Primapore				
		IM-A changed gloves and				
	cleansed R16's pressure ulcer. NM-A confirmed					
	R16's stage 2 pressure ulcer measured 1.8 cm x					
	1.0 cm and was circular in shape. NM-A also					
	confirmed R16's wound bed was covered with					
	granulation tissue (red tissue with " cobblestone "					
		nce, bleeds easily with injured)				
		lepth. NM-A then applied				
		R16's wound with a new				
		cares were completed and a R16 was assisted to turn onto				
		bed wound was observed on				
		a. NM-A stated the scab on				
		a stage 2 pressure ulcer and				
		. The pressure ulcer on R16's				
		oximately 0.5 cm x 0.5 cm and				
	had no redness.	-				
		observed to be assisted or				
		n/offload and not checked and				
		of 3 hours and 7 minutes.				
		p.m. NA-C stated R16				
		assistance with all cares which ing and toileting needs. NA-C				
		an every 2 hour repositioning				
		supposed to be checked and				
		incontinence as R16 was				
		ent of urine. NA-C stated she				
		ne last time R16 was				
	repositioned or che	cked and changed. NA-C				
	stated she had atte	mpted to care for R16 at				
	around 4.00 p m by	y asking him to go for a ride,				1

STATEME	<u>ota Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			_			
		00113	B. WING		12/	10/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
KNUTE	NELSON		I AVENUE EAS DRIA, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	ige 7	2 565		,	
	unable to offer toile R16 as he would re was often more cor to go for a ride. NA- had a pressure ulce developed pressure buttocks crease. Na- been on an every 2 and there had been often would increas repositioning of res ulcers though R16's not changed. NA-C make his needs know	ed. NA-C stated the staff was ting or repositioning directly to afuse cares. NA-C stated R16 mpliant when they asked him -C stated she was aware R16 er on his right hip and a newly e ulcer on the right side of the A-C stated R16 had always hour repositioning schedule in o change. NA-C stated they see the frequency of idents when they had pressure is repositioning schedule had stated R16 was unable to own and staff needed to eds such as toileting and				
	current care plan au when R16 was last assistance with inco she thought R16 ha p.m. NM-A stated F ulcers, one on his r one on his right glu on 12/7/15. NM-A s place at the time th developed was to la his left side or back onto his right side in stated she expected repositioning at leas R16 was often resis staff were also expe change R16 for urin stated R16 was no void and was freque	p.m. NM-A confirmed R16's nd stated she was unaware of repositioned and had ontinence care. NM-A stated ad refused assistance at 1:30 R16 had 2 current pressure ight hip which was healing and teal fold which was first noted stated the intervention put in e new stage 2 pressure ulcer ay R16 in bed after meals on x. NM-A stated R16 often rolled independently in bed. NM-A d R16 to be assisted with st every 2 hours, and indicated stive with cares. NM-A stated ected at that time to check and hary incontinence. NM-A longer able to feel the urge to ently incontinent of urine. 16 was at high risk for skin				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED		
		00113	B. WING		12/	10/2015		
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S					
	NELSON		I AVENUE EAS DRIA, MN 563					
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE		
2 565	Continued From pa	ige 8	2 565					
	unaware of when F or assisted with inc he had not attempt repositioning or inc arrived on shift, arc R16 was depender was on a every 2 h current pressure ul was on a check and which was to correl stated R16 was off toileting and reposi not able to verbaliz to anticipate needs On 12/10/15, at 9:4	9 a.m. the director of nursing						
	so staff were encou approaches for coo take R16 for a ride. continued to lose w increased his risk for she thought R16's unavoidable. In ado R16 resisted cares assist R16 with rep checking/changing	was often resistive with cares uraged to use alternative operation such as offering to . The DON stated R16 had reight and refuse cares which or pressure ulcers. She stated pressure ulcers may be dition, the DON stated although at times, she expected staff to ositioning and for incontinence every 2 erified she was aware R16 had						
	a newly developed gluteal fold and had increase R16's rep R16's continued res stated they were lu R16 every 2 hours The DON again con risk for skin breakd condition was decli	pressure ulcer to the right d decided at that time to not ositioning frequency due to sistance with cares. The DON cky if they could reposition as R16 was unpredictable. nfirmed R16 was at very high own and stated R16's overall ning. The DON confirmed d a pressure ulcer on the right						

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00113	B. WING		12/	10/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST							
	NELSON		I AVENUE EAS DRIA, MN 563				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 565	Continued From pa	ige 9	2 565				
		n was almost healed and at the er pressure ulcer on the right					
	offered cares to R1 however was not of stated R16 required which included repor- changing every 2 h high risk for skin br pressure ulcers, on buttocks (gluteal fo R16 was assisted w was 11:00 a.m., prio- stated R16 was free and was not able to	18 a.m. NA-E stated she had 6 on 12/9/15, at 1:30 p.m., this bserved by the surveyor. NA-E d assistance with all cares ositioning and check and ours. NA-E stated R16 was at eakdown and at present had 2 te on the right hip and right ld.) NA-E stated the last time with cares on 12/9/15 day shift or to the noon meal. NA-E quently incontinent of urine o verbalize the need to void or tated staff needed to eds					
	1/2015, revealed th staff to provide app treatment to help re bladder function an infections. The polic complete urinary as based on the asses implemented to pro incontinence manage facility staff to follow	d, Urinary Incontinence revised re purpose of the policy was for ropriate services and esidents restore or improve d prevent urinary tract cy directed facility staff to assessments of residents and asment a plan was to be ovide residents with gement. The policy directed w the residents individualized in comfort and skin integrity.					
	3/2015, revealed a facility staff to deve comprehensive car policy further revea responsibility to foll	e plan for each resident. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00113	B. WING		12/	10/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	NELSON		H AVENUE EAS IDRIA, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 565	Continued From pa	ge 10	2 565			
	member from follov	ving the care plan.				
	The director of nurs develop and implem related to following designee, could pro staff related to the t implementation. Th	HOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures the care plan. The DON or ovide training for all nursing imeliness of care plan e quality assessment and ee could perform random mpliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 900	MN Rule 4658.0528 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			1/7/16
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which	r			
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent veloping.				

	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00113	B. WING		12/	10/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	NELSON		AVENUE E			
			DRIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 11	2 900			
	by: Based on observation review the facility for the facility facility facility for the facility facility facility for the facility facility facility for the facility faci	ent is not met as evidenced ion, interview and document ailed to provide timely positioning for 1 of 3 (R16) for pressure ulcers. This esulted in actual harm for R16 rrent or multiple stage 2		Corrected		
	Findings include:	Findings include:				
	9/30/15, indicated F impairment and had dementia, arthritis a indicated R16 need activities of daily (A incontinent of urine ulcers. The MDS a repositioning progra	num Data Set (MDS) dated R16 had severe cognitive d diagnoses which included and anxiety. The MDS also ded extensive assistance with DL's), was frequently and was at risk for pressure also indicated R16 was on a am to prevent pressure ulcers, pressure ulcer at the time of				
	9/30/15, also identi included dementia, CAA identified R16 impairment, needer assistance for ADL of urine and was at ulcers. The CAA inc	Area Assessment dated fied R16 had diagnoses which arthritis and depression. The had severe cognitive d extensive physical 's, was frequently incontinent risk for developing pressure dicated R16 was to receive positioning as indicated on the				
	R16 was at high ris urinary incontinenc	are plan dated 5/7/15, identified of for pressure ulcers related to e and an open area on the e plan directed facility staff to				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00113	B. WING	B. WING		12/10/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
		420 12TH	AVENUE EAS	ST			
KNUTEI	NELSON	ALEXAN	DRIA, MN 563	808			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	assist R16 with rep in bed and chair. R lying down R16 afte indicated R16 was longer aware of the incontinent brief. Ir directed facility staf needed. On 12/09/15, during from 1:10 p.m. to 4 seated in a wheelch assisted, to repositi - At 1:10 p.m. R16 y pants and a shirt, s Pines unit dining ro assistant (NA)-F wa and wheeled R16 to located across from common area was openings in which t sat briefly in the com himself with his fee opening of the com opening.	ositioning every 2 hours while 16's care plan did not address er meals. The care plan also incontinent of urine and no urge to void so wore an aterventions on the care plan f to check and change R16 as g continuous observations :17 p.m., R16 was observed hair without being offered, or fon or toilet. was observed wearing sweat eated in a wheelchair in the om next to the table. Nursing alked up to R16's wheelchair o the Pines common area, in the nurses' station. The observed to have two o enter and exit the area. R16 mmons area prior to propelling t around in a circle in one mon area and out the other					
	R16, who had conti feet around the con bring him to exercis exercises of active both lower extremit stated R16 needed and was unable to assistance. RA-A a a exercise room in and completed exe	orative aid (RA)-A approached nued to propel himself with his nmons area, and offered to ses. RA-A stated R16 received range of motion (AROM) to ies 5-6 times a week. RA-A a mechanical lift for transfers reposition himself without staff ssisted R16 in a wheelchair to an unused hall of the facility rcises to both of R16's lower not offload or reposition the	3				

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00113	B. WING		12/10/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	NELSON		HAVENUE EAS DRIA, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE
2 900	Continued From pa	ige 13	2 900			
	seated in the whee nurses' station. RA juice next to R16 at -At 2:45 p.m. NA-G remained seated at R16 and asked R10 nodded his head, N from the area. NA-G offer/attempt to ass toileting needs. -At 3:01 p.m. R16 w wheelchair at the ta staff were observed	assisted R16, who remained lchair, to a table by the Pines -A placed a cup of coffee and t the table, and exited the area briefly approached R16 who t the table. NA-G stood near 6 if he was alright. When R16 IA-G immediately walked away G was not observed to sist R16 with repositioning or was observed seated in a able by the nurses' station. No d during that time to sist R16 with repositioning of				
	wheelchair at the ta NA-G and NA-D wa	continued to be seated in a able by the nurses' station. alked past R16 and were not t/offer to assist R16 with eting needs.				
	seated in a wheelch station. NA- was ob resident and greete		•			
	wheelchair, NA-D a questioned how he response and NA-E NA-D was not obse	vas observed to be seated in a approached R16 and was. R16 gave no verbal D walked away from R16. erved to offer/attempt to assist ing or toileting needs.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00113	B. WING	B. WING		10/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
KNUTE I	NELSON		I AVENUE EAS DRIA, MN 563			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ge 14	2 900			
	 -At 4:02 p.m. R16 remained seated in a wheelchair at the table by the nurses station, NA-C approached R16 and asked R16 if she could give him a ride. R16 was observed to shake his head and NA-C walked away. R16 remained seated in the wheelchair. -At 4:06 p.m. NA-G approached R16, who continued to be seated in the wheelchair, and asked R16 how he was. R16 gave no verbal or non-verbal response to NA-G. NA-G stated to 					
	R16 she was check from R16. NA-G did R16 with reposition	king on him and walked away d not offer or attempt to assist ing or toileting needs.				
	notified by the surver repositioned or offer for a total of 3 hours approached R16 ar bring him to his roo no, NM-A asked R1 to his room to chan nodded affirmativel him to his room via	urse manager (NM)-A was eyor that R16 had not been red assistance with toileting s and 4 minutes. NM-A nd asked R16 if she could m. R16 initially shook his head 6 again if she could bring him ge his position, R16 then y and allowed NM-A to assist wheelchair. NM-A requested A-C to aid in R16's cares.				
	mechanical lift to tra wheelchair. During area of the pants w area was approxim 12 cm and circular donned gloves and side in order to rem wearing a white inc removal was noted	and NA-C utilized a ansfer R16 out of the the transfer, R16's bottom ere noted to be wet. The wet ately 12 centimeters (cm) by in shape. NA-C and NM-A assisted R16 to move side to love his sweat pants. R16 was ontinent brief which upon to be saturated with blood red urine. NM-A confirmed				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00113	B. WING		12/10/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
KNUTE	NELSON		HAVENUE EAS DRIA, MN 563			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ge 15	2 900			
	brief and onto his s assisted to move to by NM-A and NA-C Primapore (an add breathable non-wow low-adherent absor- right buttocks glute- Primapore dressing the outside, and R1 open area on the ri- At 4:26 p.m. NM-A (partial thickness lo shallow open ulcer without slough. May open/ruptured blists stated R16 had a c and indicated R16's dressing was dry. N cleansed R16's press 1.0 cm and was circ confirmed R16's wo granulation tissue (or bumpy appearar and had very little of cream and dressed dressing. After perio- clean brief applied, his left side. A scab R16's right hip was was left open to air hip measured appro- had no redness. R16 had not been co offered to reposition and 7 minutes. On 12/9/15, at 4:32	continence had saturated his weat pants. R16 was then o his right side towards NA-C . R16 was observed to have a hesive dressing consisting of a ven top layer and a bent pad,) dressing on his al fold. NM-A removed R16's g, which was wet with urine on 6 was observed to have an ght side of his coccyx. a confirmed R16 had a stage 2 bes of dermis presenting as a with a red-pink wound bed, y also present as an intact or er,) on his coccyx. NM-A urrent urinary tract infection a skin under the Primapore IM-A changed gloves and soure ulcer. NM-A confirmed sure ulcer measured 1.8 cm x cular in shape. NM-A also bund bed was covered with red tissue with " cobblestone in ce, bleeds easily with injured) lepth. NM-A then applied I R16's wound with a new cares were completed and a R16 was assisted to turn onto bed wound was observed on a stage 2 pressure ulcer and . The pressure ulcer on R16's oximately 0.5 cm x 0.5 cm and observed to be assisted or n/offload for a total of 3 hours				

STATEME	Dta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00113	B. WING		12/	10/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	NELSON	420 12TH	AVENUE EAS	ST		
		ALEXAN	DRIA, MN 563	808		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 16	2 900			
	included repositioni stated R16 was on schedule and was schanged for urinary frequently incontine was not aware of the repositioned or che stated she had atte around 4:00 p.m. by however R16 refuse unable to offer toile R16 as he would re was often more con- to go for a ride. NA- had a pressure ulce developed pressure buttocks crease. NA- been on an every 2 and there had been often would increas repositioning of resi- ulcers though R16's not changed. NA-C make his needs kno- anticipate R16's ne- repositioning. On 12/9/15, at 5:01 current care plan ar- when R16 was last assistance with inco- she thought R16 ha p.m. NM-A stated F- ulcers, one on his right glut on 12/7/15. NM-A s	ng and toileting needs. NA-C an every 2 hour repositioning supposed to be checked and rincontinence as R16 was ent of urine. NA-C stated she le last time R16 was cked and changed. NA-C mpted to care for R16 at y asking him to go for a ride, ed. NA-C stated the staff was ting or repositioning directly to fuse cares. NA-C stated R16 npliant when they asked him -C stated she was aware R16 er on his right hip and a newly e ulcer on the right side of the A-C stated R16 had always hour repositioning schedule no change. NA-C stated they				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00113	B. WING		12/	12/10/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
	NELSON	420 12TH	AVENUE EAS	ST			
KNUTET	NELSON	ALEXAN	DRIA, MN 563	308			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				TION SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	ige 17	2 900				
	repositioning at lear R16 was often resis staff were also expe- change R16 for urin stated R16 was no void and was frequi NM-A confirmed R breakdown. On 12/09/15, at 5:0 unaware of when R or assisted with inc he had not attempter repositioning or inc arrived on shift, aro R16 was dependen was on a every 2 h current pressure ul- was on a check and which was to correl stated R16 was ofter to illeting and reposit not able to verbalize to anticipate needs On 12/10/15, at 9:4 (DON) stated R16 was os staff were encou	9 a.m. the director of nursing was often resistive with cares uraged to use alternative					
	take R16 for a ride. continued to lose w increased his risk for	peration such as offering to The DON stated R16 had reight and refuse cares which or pressure ulcers. She stated pressure ulcers may be					
	unavoidable. In add R16 resisted cares assist R16 with rep checking/changing	dition, the DON stated although at times, she expected staff to ositioning and for incontinence every 2					
nnoncto D		erified she was aware R16 had pressure ulcer to the right					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00113	B. WING		12/10/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
KNUTE	NELSON		HAVENUE EAS DRIA, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	gluteal fold and had increase R16's rep R16's continued re- stated they were lu R16 every 2 hours The DON again co- risk for skin breakd condition was decli R16 had developed hip 10/27/15, which present had anothe gluteal fold. On 12/10/15, at 10 offered cares to R1 however was not of stated R16 required which included rep- changing every 2 h high risk for skin br pressure ulcers, or buttocks (gluteal fo R16 was assisted w was 11:00 a.m., pri stated R16 was fre and was not able to other need. NA-E s anticipate R16's ne Review of R16's pr 12/10/15 revealed fo -A skin assessmen was at high risk for Braden scale (a too developing pressur activity, nutrition, m identified R16 was development of pre-	d decided at that time to not ositioning frequency due to sistance with cares. The DON cky if they could reposition as R16 was unpredictable. Infirmed R16 was at very high lown and stated R16's overall ning. The DON confirmed d a pressure ulcer on the right to was almost healed and at the er pressure ulcer on the right the was almost healed and at the er pressure ulcer on the right the same stated she had 6 on 12/9/15, at 1:30 p.m., this beserved by the surveyor. NA-E d assistance with all cares ositioning and check and ours. NA-E stated R16 was at reakdown and at present had 2 te on the right hip and right Id.) NA-E stated the last time with cares on 12/9/15 day shift or to the noon meal. NA-E quently incontinent of urine to verbalize the need to void or stated staff needed to reds				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00113	B. WING		12/10/2015		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
	NELSON		AVENUE EAS				
	1		DRIA, MN 563		000000000		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	ige 19	2 900				
	pressure areas. The preventative measure time of the note income reduction cushion in pressure reduction not indicate R16 had of the assessment. -A weekly skin cheorerevealed R16 had -An initial skin/wour revealed R16 had athe right hip. The new was caused by R16 implemented a an a daily dressing chan and Allevyn. The new tissue type that the -A skin follow-up no R16's right hip treat changes, and to ke when in bed. R16's kept clean and dry. measured 1 cm x 0 -A wound measured identified R16's right pressure ulcer, mea- cm. The note revea- ulcer had 75% epith	ck note dated 10/14/15, no pressure ulcers. ad note dated 10/27/15, a 1.0 cm x 0.5 cm open area to be identified R16's open area b laying on the right side and air mattress on R16's bed. A ge was ordered of thera shield ote lacked information of the ulcer had at the time of origin. be dated 10/28/15, revealed tment included daily dressing ep R16 repositioned off the hip right hip dressing was to be R16's right hip wound					
	in R16's dressing to every 3 days until h	ote further revealed a change o a Primafore dressing change ealed. dated 11/3/15, revealed no					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00113	B. WING		12/	12/10/2015	
AME OF PRO	VIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
NUTE NEI	SON		I AVENUE EAS DRIA, MN 563				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 900 C	ontinued From pa	ge 20	2 900				
id in so T u	lentified R16 had a ner thigh under th cratching the groir he note revealed i	nd note dated 11/9/15, an open area on the upper le scrotum due to R16 n area throughout the night. monitoring would be initiated iff was to keep R16's finger					
id 1 tis re	entified R16's sta cm x 0.5 cm x 0.0 ssue and 25% gra	ment note dated 11/9/15, ge 2 pressure ulcer measured 0 cm, had 75% epithelial nulation tissue. The note es in treatment and indicated er was healing.					
R	16's open area or	ote dated 11/9/15, identified the scrotum measured 0.5 ad no signs of infection.					
R m in re	16's open area or leasure 0.5 cm x (fection. The note	ote dated 11/10/15, revealed the scrotum continued to 0.5 cm and had no signs of further revealed R16 was to eld and Primapore dressing to					
id 1. tis re ha re	entified R16's sta 5 cm x 0.5 cm x 0 ssue and 25% gra evealed the wound ad no other signs	ment note dated 11/16/15, ge 2 pressure ulcer measured 0.0 cm, had 75% epithelial nulation tissue. The note d was slightly inflamed though of infection. The note further ent change to R16's stage 2					
	A weekly skin note ad no new skin iss	dated 11/18/15, revealed R16 sues.					
-4	A skin/wound initia	l note dated 11/21/15,					

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00113	B. WING	B. WING		12/10/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	_		
		420 12TH	AVENUE EAS	ST			
KNUTEI	NELSON	ALEXAN	DRIA, MN 563	808			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	ge 21	2 900				
	identified R16 had a	an open area to the right knee rmined to be caused by injury.					
	identified R16's sta 0.9 cm x 0.5 cm x 0 tissue and 25% gra	ment note dated 11/23/15, ge 2 pressure ulcer measured 0.0 cm, had 75% epithelial nulation tissue. The note nt hip had a stage 2 pressure aling.					
	-A weekly skin note had no new skin iss	dated 11/24/15, revealed R16 sues.					
	identified R16's stat 0.7 cm x 0.5 cm x 0 tissue. The note rev	ment note dated 12/1/15, ge 2 pressure ulcer measured 0.0 cm, had 100% epithelial vealed R16's pressure ulcer o treatment changes were					
	-A weekly skin note had no new skin iss	dated 12/2/15, revealed R16 sues.					
	R16 had a new ope buttocks gluteal fold cm. The wound was slough tissue. The which identified R10 The note identified	I note dated 12/7/15, identified on area on the right lower d which measured 1.8 cm x 1 s assessed to have 100% note revealed an analysis 6 had declined and lost weight a new intervention for R16 of to bed after meals on his left					
	identified R16's sta measured 0.5 cm x granulation tissue. surrounding skin as 2.5 cm x 2.0 cm su	ment note dated 12/7/15, ge 2 right hip pressure ulcer, a 1.0 cm and had 100% The pressure ulcers assessed as red and measured rrounding the open area. No were indicated on the note.					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00113	B. WING		12/	12/10/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
	NELSON		HAVENUE EAS IDRIA, MN 563				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 22	2 900				
	revealed R16 had a the right gluteal fold identified R16 had and had lost weigh revealed R16 was	sessment note dated $12/7/15$, a 1.8 cm x 1 cm open area on d of inner buttocks. The note an overall decline in condition t. The assessment further to be assisted to lay down afte de or back for pressure relief. s left open to air.	r				
	R16's open area to measured 1.8 cm x	ote dated 12/7/15, revealed the right lower gluteal fold (1.0 cm, had no signs of een left open to air.					
	revealed R16's ope gluteal fold measur yellow slough noted bed. The note furth was left open to air	ote dated 12/8/15, at 4:48 a.m. en area to the right lower red 1.8 cm x 1.0 cm, had d in the center of the wound her revealed R16's open area and staff attempts to position e was ineffective as R16 would t side.					
	open area to the rig pressure ulcer and	d 12/8/15, identified R16's ght lower gluteal fold was a had received an order to ritional supplement to four					
	revealed R16's star gluteal fold was ter measurements. Th was to be encourag	ote dated 12/8/15, at 1:28 p.m. ge 2 pressure ulcer to the right nder, had no change in e note further indicated R16 ged to reposition and had ning at the present time.					
		ss note dated 11/6/15, a stage 2 pressure ulcer to the vere to encourage					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00113	B. WING		12/10/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	NELSON		HAVENUE EAS DRIA, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	age 23	2 900		.,	
	repositioning.	-				
	printed 12/10/15, re date of 11/7/15, to o (right) hip, change/ every 3 days until h	nsigned physician orders evealed an order with a start cleanse OA (open area) to R) apply Primapore dressing nealed. R16's physician orders a dressing on R16's stage 2 ne right gluteal fold.				
	Bed and in a Chair, 4/2015, revealed the included prevention providing pressure directed facility state	ty policy titled, Repositioning in /Appling (sp) lift sheets dated ne purpose of the policy n of skin breakdown and relief for residents. The policy ff to follow the residents care positioning needs in bed and in				
	Skin Care policy, re statement which in pressure sore was treatment and serv prevent infection and developing. The po provide skin care to policy also directed	ty policy titled, Comprehensive evised 7/1/15, revealed a policy cluded, a resident who had a to receive the necessary ices to promote healing, nd prevent new sores from olicy directed facility staff to b keep skin clean and dry. The I facility staff to provide oure relief per the residents	/			
	The director of nurs review/revise polici	THOD OF CORRECTION: sing (DON) or designee could es/procedures for pressure id care, educate staff, and ther nsure compliance.				
	TIME PERIOD FOI (21) days. epartment of Health	R CORRECTION: Twenty One				

	NT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00113	B. WING		12/10/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
KNUTE I	NELSON		I AVENUE EA DRIA, MN 56	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLET DATE
2 920	Subp. 6. Activities of comprehensive resistence B. a resident who activities of daily livit services to maintain and personal and of This MN Requirement by: Based on observation review the facility far incontinence cares program for 1 of 1 m urinary incontinence Findings include: Review of R16's an (MDS) dated 9/30/1 cognitive impairment included dementia, MDS also identified assistance with action frequently incontine identified R16 was a was on a reposition pressure ulcers. Review of R16's an for assessment refer identified R16 had a required extensive for ADL's and was for requiring staff to as	is unable to carry out ing receives the necessary n good nutrition, grooming, ral hygiene. ent is not met as evidenced on, interview and document illed to provide timely for a check and change esidents (R16) reviewed for	2 920	Corrected		1/7/16

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00113	B. WING		12/10/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	NELSON	420 12TH	AVENUE EAS	ST		
KNUTEI	NELSON	ALEXAN	DRIA, MN 563	308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ge 25	2 920			
	and had recurrent urinary tract infections (UTI's.) The CAA summary further revealed R16 was resistive to cares and non-compliant with medications which included antibiotics for UTI's.					
	9/30/15, identified F moderate to large a assessment also id cognitive impairmen staff for transfers w The assessment re assistance with toile 0500-0600 daily. Th revealed R16 wore	ladder Assessment dated R16 was incontinent of a amount of urine. The lentified R16 had severe int and required assistance of 2 with use of a full mechanical lift. wealed R16 was to receive eting between 2300-2400 and ne assessment further an incontinent brief and tance with incontinence cares.				
	R16 was at high ris urinary incontinence R16's care plan dire with repositioning e chair. R16's care pl incontinent of urine of the urge to void.	re plan dated 5/7/15, identified k for pressure ulcers related to e and open area on right hip. ected facility staff to assist R16 very 2 hours while in bed and an also revealed R16 was and R16 was no longer aware R16's care plan also revealed tinent brief and directed facility change as needed.				
	from 1:10 p.m. to 4	g continuous observations :17 p.m., R16 was observed nair without being offered, or ion or toilet.				
	pants and a shirt, s Pines unit dining ro assistant (NA)-F wa and wheeled R16 to located across from	was observed wearing sweat eated in a wheelchair in the om next to the table. Nursing alked up to R16's wheelchair o the Pines common area, n the nurses' station. The observed to have two				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00113	B. WING		12/	12/10/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
	IELSON		I AVENUE EAS DRIA, MN 563				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE	
2 920	Continued From pa	ge 26	2 920				
	sat briefly in the cor himself with his fee	o enter and exit the area. R16 mmons area prior to propelling t around in a circle in one mon area and out the other					
	-At 1:35 p.m. a restorative aid (RA)-A approache R16, who had continued to propel himself with h feet around the commons area, and offered to bring him to exercises. RA-A stated R16 receiver exercises of active range of motion (AROM) to both lower extremities 5-6 times a week. RA-A stated R16 needed a mechanical lift for transfers and was unable to reposition himself without stat assistance. RA-A assisted R16 in a wheelchair to a exercise room in an unused hall of the facility and completed exercises to both of R16's lower extremities, but did not offload or reposition the resident.						
	seated in the wheel nurses' station. RA	assisted R16, who remained chair, to a table by the Pines A placed a cup of coffee and the table, and exited the area.					
	remained seated at R16 and asked R16 nodded his head, N from the area. NA-0	briefly approached R16 who the table. NA-G stood near if he was alright. When R16 IA-G immediately walked away G was not observed to sist R16 with repositioning or					
	wheelchair at the ta staff were observed	vas observed seated in a ble by the nurses' station. No d during that time to ist R16 with repositioning of					
	-At 3:27 p.m. R16 c	continued to be seated in a					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00113	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	NELSON		HAVENUE EAS DRIA, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE
2 920	Continued From pa	age 27	2 920			
	NA-G and NA-D wa	able by the nurses' station. alked past R16 and were not ot/offer to assist R16 with eting needs.				
	seated in a wheeld station. NA- was ob resident and greete		•			
	wheelchair, NA-D a questioned how he response and NA-I NA-D was not obse	was observed to be seated in a approached R16 and was. R16 gave no verbal D walked away from R16. erved to offer/attempt to assist ing or toileting needs.				
	wheelchair at the ta C approached R16 give him a ride. R1	remained seated in a able by the nurses station, NA- 5 and asked R16 if she could 6 was observed to shake his Iked away. R16 remained Ichair.				
	continued to be sea asked R16 how he non-verbal respons R16 she was check from R16. NA-G dia	approached R16, who ated in the wheelchair, and was. R16 gave no verbal or se to NA-G. NA-G stated to king on him and walked away d not offer or attempt to assist ing or toileting needs.				
	notified by the surv repositioned or offe for a total of 3 hour	urse manager (NM)-A was eyor that R16 had not been ered assistance with toileting s and 4 minutes. NM-A nd asked R16 if she could				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
		00113	B. WING		12/10/2015		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
KNUTE NELSON 420 12TH AVENUE EAST ALEXANDRIA, MN 56308							
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)	
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLETI DATE	
2 920	Continued From pa	ge 28	2 920				
	 bring him to his room. R16 initially shook his head no, NM-A asked R16 again if she could bring him to his room to change his position, R16 then nodded affirmatively and allowed NM-A to assist him to his room via wheelchair. NM-A requested the assistance of NA-C to aid in R16's cares. -At 4:17 p.m. NM-A and NA-C utilized a mechanical lift to transfer R16 out of the wheelchair. During the transfer, R16's bottom area of the pants were noted to be wet. The wet area was approximately 12 centimeters (cm) by 12 cm and circular in shape. NA-C and NM-A donned gloves and assisted R16 to move side to side in order to remove his sweat pants. R16 was wearing a white incontinent brief which upon removal was noted to be saturated with blood tinged, amber colored urine. NM-A confirmed R16's brief was saturated with urine and confirmed R16's incontinence had saturated his brief and onto his sweat pants. R16 was then assisted to move to his right side towards NA-C 						
	Primapore (an adh breathable non-wow low-adherent absor right buttocks glutes Primapore dressing	bent pad,) dressing on his al fold. NM-A removed R16's y, which was wet with urine on					
	open area on the rig -At 4:26 p.m. NM-A (partial thickness lo shallow open ulcer	6 was observed to have an ght side of his coccyx. confirmed R16 had a stage 2 ss of dermis presenting as a with a red-pink wound bed,					
	open/ruptured bliste stated R16 had a c and indicated R16's	y also present as an intact or er,) on his coccyx. NM-A urrent urinary tract infection s skin under the Primapore					
	cleansed R16's pre	IM-A changed gloves and ssure ulcer. NM-A confirmed sure ulcer measured 1.8 cm x					

/innesota Department of He STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
IND FLAN OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:	·····	COM	FLETED
	00113	B. WING		- 12/10/2015	
IAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NUTE NELSON		I AVENUE EAS DRIA, MN 563			
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 920 Continued From pa	age 29	2 920			
confirmed R16's w granulation tissue or bumpy appearat and had very little of cream and dressed dressing. After per clean brief applied his left side. A scal R16's right hip area R16's right hip area R16's right hip was was left open to ain hip measured appr had no redness. R16 had not been offered to reposition changed for a total On 12/9/15, at 4:32 needed extensive a included reposition stated R16 was on schedule and was changed for urinary frequently incontine was not aware of the repositioned or che stated she had atte around 4:00 p.m. b however R16 refus unable to offer toile R16 as he would re was often more co to go for a ride. NA had a pressure uld developed pressur buttocks crease. N been on an every 2	cular in shape. NM-A also ound bed was covered with (red tissue with " cobblestone" hce, bleeds easily with injured) depth. NM-A then applied d R16's wound with a new icares were completed and a , R16 was assisted to turn onto bed wound was observed on a. NM-A stated the scab on a stage 2 pressure ulcer and c. The pressure ulcer on R16's foximately 0.5 cm x 0.5 cm and observed to be assisted or n/offload or to be checked and of 3 hours and 7 minutes. 2 p.m. NA-C stated R16 assistance with all cares which ing and toileting needs. NA-C an every 2 hour repositioning supposed to be checked and y incontinence as R16 was ent of urine. NA-C stated she he last time R16 was ecked and changed. NA-C empted to care for R16 at by asking him to go for a ride, ied. NA-C stated the staff was being or repositioning directly to efuse cares. NA-C stated R16 mpliant when they asked him a-C stated she was aware R16 er on his right hip and a newly e ulcer on the right side of the A-C stated R16 had always 2 hour repositioning schedule in no change. NA-C stated they asking him to go for a ride, end the right side of the a-C stated R16 had always 2 hour repositioning schedule in no change. NA-C stated they asted to care for R16 at always 2 hour repositioning schedule				

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
	00113	B. WING		12/	10/2015
PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
NELSON					
SUMMARY STATEMENT OF DEFICIENCIES ID PRO (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH			PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ge 30	2 920			
ulcers though R16's repositioning schedule had not changed. NA-C stated R16 was unable to make his needs known and staff needed to anticipate R16's needs such as toileting and repositioning.					
repositioning. On 12/9/15, at 5:01 p.m. NM-A confirmed R16's current care plan and stated she was unaware of when R16 was last repositioned and had assistance with incontinence care. NM-A stated she thought R16 had refused assistance at 1:30 p.m. NM-A stated R16 had 2 current pressure ulcers, one on his right hip which was healing and one on his right gluteal fold which was first noted on 12/7/15. NM-A stated the intervention put in place at the time the new stage 2 pressure ulcer developed was to lay R16 in bed after meals on his left side or back. NM-A stated R16 often rolled onto his right side independently in bed. NM-A stated she expected R16 to be assisted with repositioning at least every 2 hours, and indicated R16 was often resistive with cares. NM-A stated					
unaware of when R or assisted with inc he had not attempte repositioning or ince arrived on shift, aro R16 was dependen	16 had last been repositioned ontinence cares. NA-D stated ed to assist R16 with ontinence cares since he'd und 2:00 p.m. NA-D stated it on staff for his needs and				
	OF CORRECTION PROVIDER OR SUPPLIER JELSON SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa ulcers though R16's not changed. NA-C make his needs kn anticipate R16's ne repositioning. On 12/9/15, at 5:01 current care plan at when R16 was last assistance with incu- she thought R16 ha p.m. NM-A stated F ulcers, one on his r one on his right glu on 12/7/15. NM-A s place at the time th developed was to la his left side or back onto his right side in stated she expecter repositioning at lea: R16 was often resis staff were also expi- change R16 for urind stated R16 was no void and was freque NM-A confirmed R ⁻¹ breakdown. On 12/09/15, at 5:01 unaware of when Floor or assisted with incu- he had not attemptor repositioning or incu- arrived on shift, arco R16 was depender	OF CORRECTION IDENTIFICATION NUMBER: 00113 00113 PROVIDER OR SUPPLIER STREET AL SELSON 420 12Th ALEXAN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 30 ulcers though R16's repositioning schedule had not changed. NA-C stated R16 was unable to make his needs known and staff needed to anticipate R16's needs such as toileting and repositioning. On 12/9/15, at 5:01 p.m. NM-A confirmed R16's current care plan and stated she was unaware of when R16 was last repositioned and had assistance with incontinence care. NM-A stated she thought R16 had refused assistance at 1:30 p.m. NM-A stated R16 had 2 current pressure ulcers, one on his right pluteal fold which was first noted on 12/7/15. NM-A stated the intervention put in place at the time the new stage 2 pressure ulcer developed was to lay R16 in bed after meals on his left side or back. NM-A stated R16 often rolled onto his right side independently in bed. NM-A stated she expected R16 to be assisted with repositioning at least every 2 hours, and indicated R16 was often resistive with cares. NM-A stated staff were also expected at that time to check and change R16 for urinary incontinence. NM-A stated staff were also expected at that time to check and change R16 for urinary incontinence. NM-A stated staff were also expected at that time to check and change R16 for urinary incontinence cares. NA-D stated he had not attempted to assist R16 with repositioning or incontinence cares since he'd arrived on shift, around 2:00 p.m. NA-D stated he had not attempted to assist R16 with <td>OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00113 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S IELSON 420 12TH AVENUE EAS ALEXANDRIA, MN 563 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENC WUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 30 2 920 ulcers though R16's repositioning schedule had not changed. NA-C stated R16 was unable to make his needs known and staff needed to anticipate R16's needs such as toileting and repositioning. 2 920 On 12/9/15, at 5:01 p.m. NM-A confirmed R16's current care plan and stated she was unaware of when R16 was last repositioned and had assistance with incontinence care. NM-A stated she thought R16 had refused assistance at 1:30 p.m. NM-A stated R16 had 2 current pressure ulcers, one on his right hip which was healing and one on his right gluteal fold which was first noted on 12/7/15. NM-A stated the intervention put in place at the time the new stage 2 pressure ulcer developed was to lay R16 in bed after meals on his left side or back. NM-A stated R16 often rolled onto his right side independently in bed. NM-A stated she expected R16 to be assisted with repositioning at least every 2 hours, and indicated R16 was often resistive with cares. NM-A stated staff were also expected at that time to check and change R16 for urinary incontinence. NM-A stated R16 was no longer able to feel the urge to void and was frequently incontinent of urine. NM-A confirmed R16 was at high risk for skin breakdown. On 12/09/15, at 5:08 p.m. NA-D stated he was unaware of when R16 had last been repositioned or assisted</td> <td>OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00113 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE #ELSON 420 12TH AVENUE EAST ALEXANDRIA, MN 56308 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIDE BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDERS PLAN OF CROSS-REFERENCED TO DEFICIENC Continued From page 30 2 920 Ulcers though R16's repositioning schedule had not changed. NA-C stated R16 was unable to make his needs known and staff needed to anticipate R16's needs such as toileting and repositioning. 2 920 On 12/9/15, at 5:01 p.m. NM-A confirmed R16's current care plan and stated she was unaware of when R16 was last repositioned and had assistance with incontinence care. NM-A stated she thought R16 had refused assistance at 1:30 p.m. NM-A stated R16 had 2 current pressure ulcers, one on is right pluteal fold which was freat noted on 12/7/15. NM-A stated R16 often rolled on this left side independently in bed. NM-A stated Staff were also expected R16 to be assisted with repositioning at least every 2 hours, and indicated R16 was often resistive with cares. NM-A stated staff were also expected R16 to the alt time to check and change R16 for urinary incontinence Cares. NA-D stated R16 was dependent to assist R16 with repositioning or incontinence cares. SiA-D stated he had not attempted to assist R16 with repositioning or incontinence cares. SiA-D stated he had not attempted to assist R16 with repositioning or incontinence cares. SiA-D stated R16 was dep</td> <td>OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: 12/ 00113 B. WING 12/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308 12/ SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION AUDU D BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 30 2 920 Ucers though R16's repositioning schedule had not changed. NA-C stated R16 was unable to make his needs known and staff needed to anticipate R16's needs such as toileting and repositioning. 2 920 On 12/9/15, at 5:01 p.m. NM-A confirmed R16's current care plan and stated she was unaware of when R16 was last repositioned and had assistance with incontinence care. NM-A stated she though R16 had 2 current pressure ulcers, one on his right hip which was healing and one on his right gluteal for the ad assistance at 1:30 p.m. NM-A stated R16 had 2 current pressure ulcers, one on his right fib ded after meals on his left side or back. NM-A stated staff ware also expected R16 to be assisted with repositioning at least very 2 hours, and indicated R16 was often resistive with cares. NM-A stated staff ware also expected R16 to feel the urge to void and was frequently incontinence cares. NM-A stated R16 was na high risk for skin breakdown. On 12/09/15, at 5:08 p.m. NA-D stated he was unaware of when R16 had last been repositioned or assisted with incontinence cares since he'd arrived on shift, around 2:00 p.m. NA-D stated he had not attempted to assist R16 with repositioning or incontinence cares since he'd arrived on shift, around 2:00 p.m. NA-D stated he had non</td>	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00113 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S IELSON 420 12TH AVENUE EAS ALEXANDRIA, MN 563 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENC WUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 30 2 920 ulcers though R16's repositioning schedule had not changed. NA-C stated R16 was unable to make his needs known and staff needed to anticipate R16's needs such as toileting and repositioning. 2 920 On 12/9/15, at 5:01 p.m. NM-A confirmed R16's current care plan and stated she was unaware of when R16 was last repositioned and had assistance with incontinence care. NM-A stated she thought R16 had refused assistance at 1:30 p.m. NM-A stated R16 had 2 current pressure ulcers, one on his right hip which was healing and one on his right gluteal fold which was first noted on 12/7/15. NM-A stated the intervention put in place at the time the new stage 2 pressure ulcer developed was to lay R16 in bed after meals on his left side or back. NM-A stated R16 often rolled onto his right side independently in bed. NM-A stated she expected R16 to be assisted with repositioning at least every 2 hours, and indicated R16 was often resistive with cares. NM-A stated staff were also expected at that time to check and change R16 for urinary incontinence. NM-A stated R16 was no longer able to feel the urge to void and was frequently incontinent of urine. NM-A confirmed R16 was at high risk for skin breakdown. On 12/09/15, at 5:08 p.m. NA-D stated he was unaware of when R16 had last been repositioned or assisted	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00113 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE #ELSON 420 12TH AVENUE EAST ALEXANDRIA, MN 56308 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIDE BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDERS PLAN OF CROSS-REFERENCED TO DEFICIENC Continued From page 30 2 920 Ulcers though R16's repositioning schedule had not changed. NA-C stated R16 was unable to make his needs known and staff needed to anticipate R16's needs such as toileting and repositioning. 2 920 On 12/9/15, at 5:01 p.m. NM-A confirmed R16's current care plan and stated she was unaware of when R16 was last repositioned and had assistance with incontinence care. NM-A stated she thought R16 had refused assistance at 1:30 p.m. NM-A stated R16 had 2 current pressure ulcers, one on is right pluteal fold which was freat noted on 12/7/15. NM-A stated R16 often rolled on this left side independently in bed. NM-A stated Staff were also expected R16 to be assisted with repositioning at least every 2 hours, and indicated R16 was often resistive with cares. NM-A stated staff were also expected R16 to the alt time to check and change R16 for urinary incontinence Cares. NA-D stated R16 was dependent to assist R16 with repositioning or incontinence cares. SiA-D stated he had not attempted to assist R16 with repositioning or incontinence cares. SiA-D stated he had not attempted to assist R16 with repositioning or incontinence cares. SiA-D stated R16 was dep	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: 12/ 00113 B. WING 12/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308 12/ SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION AUDU D BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 30 2 920 Ucers though R16's repositioning schedule had not changed. NA-C stated R16 was unable to make his needs known and staff needed to anticipate R16's needs such as toileting and repositioning. 2 920 On 12/9/15, at 5:01 p.m. NM-A confirmed R16's current care plan and stated she was unaware of when R16 was last repositioned and had assistance with incontinence care. NM-A stated she though R16 had 2 current pressure ulcers, one on his right hip which was healing and one on his right gluteal for the ad assistance at 1:30 p.m. NM-A stated R16 had 2 current pressure ulcers, one on his right fib ded after meals on his left side or back. NM-A stated staff ware also expected R16 to be assisted with repositioning at least very 2 hours, and indicated R16 was often resistive with cares. NM-A stated staff ware also expected R16 to feel the urge to void and was frequently incontinence cares. NM-A stated R16 was na high risk for skin breakdown. On 12/09/15, at 5:08 p.m. NA-D stated he was unaware of when R16 had last been repositioned or assisted with incontinence cares since he'd arrived on shift, around 2:00 p.m. NA-D stated he had not attempted to assist R16 with repositioning or incontinence cares since he'd arrived on shift, around 2:00 p.m. NA-D stated he had non

STATEMEN	DIT DEPARTMENT OF HE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00113	B. WING		12/10/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
	NELSON		I AVENUE EAS DRIA, MN 563	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ige 31	2 920			
	toileting and reposi	en resistive with cares such as tioning. NA-D stated R16 was e his needs and staff needed				
	offered cares to R1 however was not of stated R16 required which included report changing every 2 h high risk for skin br pressure ulcers, on buttocks (gluteal fo R16 was assisted w was 11:00 a.m., pri stated R16 was fre- and was not able to other need. NA-E s	On 12/10/15, at 10:18 a.m. NA-E stated she had offered cares to R16 on 12/9/15, at 1:30 p.m., this however was not observed by the surveyor. NA-E stated R16 required assistance with all cares which included repositioning and check and changing every 2 hours. NA-E stated R16 was at high risk for skin breakdown and at present had 2 pressure ulcers, one on the right hip and right buttocks (gluteal fold.) NA-E stated the last time R16 was assisted with cares on 12/9/15 day shift was 11:00 a.m., prior to the noon meal. NA-E stated R16 was frequently incontinent of urine and was not able to verbalize the need to void or other need. NA-E stated staff needed to anticipate R16's needs				
	1/2015, revealed th staff to provide app treatment to help re bladder function an infections. The poli complete urinary as based on the asses implemented to pro- incontinence mana facility staff to follow	d, Urinary Incontinence revised re purpose of the policy was for ropriate services and esidents restore or improve d prevent urinary tract cy directed facility staff to assessments of residents and asment a plan was to be ovide residents with gement. The policy directed w the residents individualized in comfort and skin integrity.				
	Incontinence revise statement which ide incontinent product	d, Perineal Care for ed 1/2015, revealed a entified the facility used s designed to pull moisture . The statement further				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00113	B. WING		12/10	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
KNUTE I	NELSON		HAVENUE EA IDRIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ge 32	2 920			
	compromise skin in	exposure to urine could tegrity. The policy directed de complete perineal cares ence.				
	The DON or design as necessary the per regarding the need of daily living includ and change program could provide training these policies and p designee (s) could	HOD OF CORRECTION: tee(s) could review and revise olicies and procedures for assistance with activities ing repositioning and check ms. The DON or designee (s) ng for all appropriate staff on procedures. The DON or monitor to assure all residents uate and appropriate care.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			1/7/16
	home must establis	on control program. A nursing th and maintain an infection signed to provide a safe and nt.				
	by: Based on observati review, the facility fa infection control pra related to proper glo	ent is not met as evidenced on, interview and document ailed to ensure proper actices were implemented ove and handwashing 3 residents (R81) observed es.		Corrected		

STATE FORM

J71M11

If continuation sheet 33 of 36

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	of connection	IDENTITION TON NOMBER.	A. BUILDING: _			
		00113	B. WING		12/10/2015	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
	IELSON		AVENUE EAS DRIA, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 33	21375			
	Findings include:					
	9/30/15, identified R included diabetes a MDS identified R81 impairment and rec assistance for all ac toileting and hygien R81 was frequently always incontinent On 12/10/2015, fro continual observation was conducted. R8 nursing assistant (N disposable gloves of and dried R81's arr to both legs and fee for R81's bedside s room, assisted R81 removed R81's inco- performed perineal soft,brown stool wa on R81's bottom. W removed the stool f perineal area. Sme observed on NA-A personal cares wer the soiled wipes, br garbage bag. After with the same soile picked up the lotion her gloved hands a bottom. With the same	and Alzheimer dementia. The had severe cognitive quired extensive to total staff ctivities of daily living including he. The MDS further identified v incontinent of urine and of bowel. om 10:47 a.m. to 11:11 a.m. on of personal cares for R81 of was lying in bed, with NA)-A at the bedside, and wore on both hand. NA-A washed ms and legs, and applied lotion et from a bottle NA-A removed stand. NA-B entered R81's I to position on the side, ontinent brief and NA-A cares. A large amount of its observed in R81's brief and Vith gloved hands, NA-A from R81's bottom, and ears of brown stool were right gloved hand after e completed. NA-A picked up rief and placed the items in a NA-A cleansed R81's bottom, ad gloves, NA-A immediately n bottle, squeezed lotion onto and applied lotion to R81's ame soiled gloves, NA-A bottle to R81's bedside				
		remove the bathing supplies				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00113	B. WING		12/10/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	· · · ·	
	IELSON		I AVENUE EAS DRIA, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	applied fresh dispo R81's bedside with washed R81's eyes cloth and dried thes reach into R81's be soiled lotion bottle f squeezed lotion on her hands together cheeks and face. On 12/10/2015, at the usual practice of R81 laying in bed, a moving towards the had returned the bother soiled gloves at apply lotion to R81' On 12/10/2015, at nursing (DON) com- practice was for stathands when the glo The DON identified when proper handw should be complete bowel movement (fa assisting with toiletit course" anything ha provide pericare/too contaminated.	removed both gloves and sable gloves. NA-A returned to fresh water in a basin and s, face and ears with and wash se areas. NA-A proceeded to edside dresser, remove the from the dresser. NA-A to both gloved hands, rubbed and applied the lotion to R81's 11:31 a.m. NA-A confirmed of providing morning cares with and starting with the feet and e head. NA-A confirmed she ottle into R81's dresser with and used the same bottle to	5			
	identified the Purpo be the primary mea transmission of infe	ose: Hand hygiene continues to ins of preventing the ection.				
	SUGGESTED MET	HOD OF CORRECTION:				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COM	E SURVEY PLETED
					-	
		00113	B. WING		12/	10/2015
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
	IELSON		I AVENUE EAS DRIA, MN 563			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 35	21375			
	The director of nursi infection control pra and educate staff. designee, could con delivery of care to e services are impler risk of infection.	sing or designee, could review actices during personal care The director of nursing or induct random audits of the ensure appropriate care and mented in order to reduce the R CORRECTION: Twenty-one				
nesota De	epartment of Health					