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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O9DB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00113

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

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

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

4. TYPE OF ACTION: **7**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/05/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **93** (L18)
13.Total Certified Beds **93** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	93			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 01/11/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/18/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245435

January 11, 2018

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

Dear Ms. Solwold:

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

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

Effective December 31, 2017 the above facility is or recommended for:

93 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2018

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

RE: Project Number S5435028

Dear Ms. Solwold:

On December 6, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 17, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 5, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 3, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 17, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 31, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 17, 2017, effective December 31, 2017 and therefore remedies outlined in our letter to you dated December 6, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: O9DB

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(L3) **KNUTE NELSON**
(L4) **420 12TH AVENUE EAST**
(L5) **ALEXANDRIA, MN** (L6) **56308**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/17/2017** (L34)

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

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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

12.Total Facility Beds **93** (L18)
13.Total Certified Beds **93** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	93			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Beth Nowling, HFE - NE II 12/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/09/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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3. Both of the Above :
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02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
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25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 6, 2017

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

RE: Project Number S5435028

Dear Ms. Solwold:

On November 17, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
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 December 27, 2017, 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 December 27, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 17, 2018 (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 May 17, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 11/17/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On November 13, 2017 to November 17, 2017, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePoC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the PoC will be used as verification of compliance.	F 000		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect,	F 225		12/20/17

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

Electronically Signed | 12/14/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 11/17/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1	F 225		

exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 11/17/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the administrator and failed to report within 24 hours to the State agency (SA) and thoroughly investigate, for 1 of 1 resident (R105) with injuries of unknown source(extensive bruising) and failed to report to SA within 2 hours and thoroughly investigate for 1 of 1 resident (R105) when they had knowledge of R105's injury of unknown source (hip fracture). In addition, the facility failed to immediately report to the administrator, and report to the SA within 2 hours an allegation of abuse, and failed to protect residents while investigating a second allegation of abuse for 1 of 1 resident (R163)with allegations of abuse. Further, the facility failed to immediately notify the administrator and timely report to the SA an allegation of misappropriation of resident's property for 1 of 3 residents (R153) reviewed for abuse prohibition. Findings include: R105 R105's significant change MDS dated 10/10/17, identified R105 had moderately impaired cognition, a diagnosis of hemiplegia and required extensive assistance for bed mobility, dressing, toilet and personal care, and required total assistance with transfers and locomotion, but did	F 225	F 000 Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Knute Nelson of the truth of the facts alleged in this statement of deficiency and plan of correction is submitted exclusively to comply with state and federal law. Knute Nelson reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. This statement of deficiencies will be taken to Knute Nelson□s Quality Assurance Performance Improvement Committee. We are in full compliance as of December 20, 2017 and respectfully request a desk review in lieu of a post survey revisit. F 225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS It is the practice of Knute Nelson to promote care for residents in a manner and in an environment that is free from alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. What corrective action(s) will be accomplished for those residents to have	

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F 225	Continued From page 3 not walk. R105's current care plan reviewed 10/20/17, included various problems which included the potential for injury related to dementia, related to CVA (cerebrovascular accident) with right side hemiplegia, use of psychotropic medications, poor safety awareness, visual field cut, the potential for injury related to falls, and a risk for being abused by other individuals. Review of R105's progress notes from 9/22/17 to 10/2/17 identified the following: -9/23/17, R105 was hollering out, anxious, disorientated and unable to speak clearly. When able to speak normally, R105 complained of left side body pain. -9/23/17, in the evening, had continued pain, anxiousness and difficulty speaking and no memory recall of the previous night. -9/28/17, R105 left anterior thigh bruise which measured 1.24 cm (centimeter) by 10 cm, yellow in color with patches of purple/green located on the left anterior thigh, which wrapped around to the medial thigh with scant edema, moderate/severe pain noted. Left lateral thigh bruise measured 35 cm by 19 cm, light yellow in color with 13 cm purple center, and 1 plus edema noted and moderate/severe pain. -9/30/17, sent to emergency room for displaced subcapital left femoral neck fracture and admitted to hospital -R105's record and facility VA reports lacked evidence R105's unexplained significant bruising nor the knowledge of the fractured hip had been reported to the SA. Review of the hospital record with admit date	F 225	been found affected by the deficient practice? Residents 105, 163 and 153 suffered no adverse effects as a result of this practice. Resident 105 was interviewed by the Director of Nursing and resident stated she has never felt abused, nor was her hip fracture caused by anyone. Resident 163 was interviewed by the Director of Nursing and resident stated he did not feel abused by any of the staff, he felt safe at the community. No corrective actions could be made for Resident 153 since the resident was discharged from the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken? All residents have the potential to be affected by the alleged deficient practice. Interviews were conducted by the Director of Nursing and designees to assure that no other residents were affected. No other concerns were identified. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? The community has a policy regarding abuse prohibition and immediately reporting suspected/alleged abuse, neglect, and injuries of unknown origin to the designated state agency/common entry point. Re-Education has been conducted by the Administrator on Tuesday, December 19, 2017, on immediate reporting for all care center staff. Staff will be educated during orientation and will also be educated	

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F 225	Continued From page 4 9/30/17, identified the following: Chief complaint: left hip pain, last Saturday when daughters visited their mother they noticed that she was acting strange. She was appearing to have spasms. The nursing home staff thought she was having a seizure. Since last Saturday 9/23/17, she had been having trouble with moving in a wheel chair and with transferring she appears to be having spasms and hip pain. She does have a history of right femoral neck fracture (hip) with hemi-hip arthroplasty (surgical joint repair) last year. She also has a history of a stroke with complete right-sided hemiparesis. The X-ray identified a displaced left femoral neck fracture. On 11/15/2017, at 11:30 a.m. R105 verified she had recently broken her hip. R105 could not recall details but stated she had fallen. On 11/15/2017, at 2:46 p.m. nursing assistant (NA)A indicated R105 had a hip fracture a month or two ago. NA-A indicated they had no idea how the fracture occurred, and stated one day she was fine, the next she had excruciating pain and she didn't know what happened. On 11/15/2017, at 2:56 p.m. the CM-C indicated R105 did not have any incident reports on file and had not had a fall for nine months. CM-C indicated R105 was last hospitalized due to failure of the hip repair completed the previous year. On 11/16/2017, at 9:33 a.m. NA-B verified R105 had recently broken her hip and was now back to her normal abilities. NA-B stated staff were not entirely sure how R105's broken hip occurred. On 11/16/2017, at 11:25 a.m. licensed practical	F 225	yearly with an abuse prohibition in-service. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Audits will be conducted on all incident reports by the Administrator or designee to monitor timeliness of reporting and the allegations are correct. Results will be brought to the Quality Assurance Performance Improvement committee for further recommendations. Completion date: December 20, 2017	

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nurse (LPN)-H indicated R105 would at times attempt to self-transfer. LPN-H indicated R105 had been more confused around the time of her recent hip fracture. LPN-H indicated R105 did not fall when she broke her hip, but stated I don't think it was ever determined how it happened.

On 11/16/2017, at 2:40 p.m. CM-C indicated R105 did not have any falls, however; did have osteoporosis. With review of the computerized charting, CM-C verified R105 had pain on 9/23/17, was not aware why she had pain, and confirmed the record also indicated bruising to the left hip noted 9/28/17, which was colored yellow and green. CM-C indicated R105 had a history of seizures, strokes, had osteoporosis and was "acting peculiar." CM-C questioned if R105 possibly fractured her hip during a seizure.

On 11/16/2017, at 3:05 p.m. the DON reviewed R105's electronic chart and verified R105 presented with pain on the 23rd, and was confused. The DON indicated R105 possibly had a seizure resulting in the hip fracture. The DON stated she had not reported R105's hip fracture to the SA as she had nothing identifying that it was caused by abuse.

On 11/16/17, at 3:15 p.m. the administrator verified the facility staff discussed R105's hip fracture and did not feel it needed to be reported.

On 11/16/2017, at 3:34 p.m. the medical director was interviewed by phone. The medical director identified a person with a diagnosis of Osteoporosis would be at risk for hip fracture and stated he did not feel a VA report would be appropriate.

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F 225	Continued From page 6 R163 R163's admission Minimum Data Set Assessment (MDS) dated 10/24/17, identified R163 had intact cognition and had diagnoses which included quadriplegia. The MDS listed R163 required total assistance with all activities of daily living (ADL's). On 11/13/2017, at 11:36 a.m. R163 stated approximately two weeks ago he had requested multiple times for nursing assistants to go slow during cares and to tell him what they were going to do with him. R163 stated staff did not honor this request and continued to quickly move his body causing him pain. R163 indicated he had informed his family of the incident. R163 further stated he believed the facility had removed these two nursing assistants from the schedule because they had not worked with him for a while. R163 stated one of the nursing assistants had worked with him again today and she did not slow down when moving him, causing pain and repeatedly stated she was sorry when he complained about her treatment but continued to cause pain. He stated he believed the apology to be self serving and the treatment was abuse. He stated he had not reported today's occurrence to anyone; however, planned to if it continued. On 11/13/2017, at 12:00 p.m. the director of nursing (DON) was notified of R163's current allegation of abuse by the nursing assistant. The DON indicated she was not aware of R163's past or present concerns of potential abuse. The DON indicated the family had requested a specific nursing assistant no longer work with R163, however had not given a reason and the request was honored. The DON indicated she and the	F 225		

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clinical manager (CM)-A spoke with the family regarding personal cares, therapy and the request of one nursing assistant to no longer work with R163, however stated the family had not used the word abuse.

On 11/14/2017, at 3:07 p.m. R163 indicated the DON had brought nursing assistant (NA-C) into R163's room. R163 indicated he was able to verify this was the nursing assistant that mistreated him.

On 11/15/2017, at 3:15 p.m. via telephone interview, FM-G stated two weeks ago on a Sunday, she had become aware of concerns and had then spoken with the social worker regarding R163's allegation of abuse. FM-G stated [R163] specifically stated there were two night staff that would move him too quickly causing him pain and they would disregard his wishes. FM-G stated she felt that if staff were told to slow down and don't, then it is abuse.

On 11/15/2017, at 3:50 p.m. the DON verified NA-C was currently working independently with residents. The DON indicated she was working on the investigative report, and did not believe the allegation of abuse to be true. The DON indicated if the investigation proved NA-C had abused R163, she would have to be terminated but at this time there was no proof.

On 11/16/2017, at 7:09 a.m. NA-C indicated on 11/13/17, the nurse manager had instructed her to no longer go into R163's room due to a report of abuse. NA-C she had worked independently with other residents on the unit until the morning of 11/16/17, when she been informed by the DON that she could no longer work alone with

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residents.

On 11/16/2017, at 3:05 p.m. the DON verified she had spoken with R163 on 11/13/17, and the complaint was regarding staff moving him fast, and that it hurt him when they moved him. The DON stated she talked to staff and did not consider it abuse.

On 11/16/2017, at 10:05 a.m. CM-A indicated she was not aware of any problems R163 had with the night nursing assistants. CM-A indicated reports of abuse were reported to the DON who would submit a report to the SA and begin an investigation. CM-A indicated DON and the clinical managers were able to submit the reports to the SA and the administrator then followed up with the reports. CM-A indicated the social worker assisted with these reports but was not responsible for them.

On 11/16/2017, at 12:29 p.m. the licensed social worker (LSW) identified she was not aware of a past abuse allegation for R163. The LSW indicated abuse allegations were the DON's responsibility and her role was to assist with gathering information and documenting as needed.

On 11/16/2017, at 2:00 p.m. the administrator indicated she was not aware of the allegation regarding R163 . The administrator indicated concerns were immediately reported to the administrator or the DON who then informed the administrator. The administrator stated she felt the problem two weeks ago was not a vulnerable adult situation. The administrator indicated she felt the DON had handled the situation appropriately, she had no reason to believe it was

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F 225	Continued From page 9 abuse, and had educated staff at that time. Review of R163's computerized progress notes revealed an entry dated 11/7/17, which indicated a care conference was held per family member (FM)-G's request. The notes indicated nursing and social service staff participated in the call with the daughter regarding questions and concerns. The record did not identify what the family's questions or concerns were. R153 R153's admission MDS dated 6/20/17, indicated R153 had diagnoses which included pelvic fracture and hypertension. The MDS identified R153 was cognitively intact and had no difficulty with understanding communication and ability to express, understand or hear information. R153 required extensive staff assistance for ADL's with the exception of eating. Review of R153's SA draft incident form with a print date of 6/19/17, indicated on 6/17/17, at 5:30 p.m. R153 reported to the charge nurse that her wallet was missing from her purse. Review of the investigative report submitted to the SA on 6/22/17, indicated R153 reported her wallet was missing on 6/17/17, staff assisted R153 with a complete room search several times. R153 did not have any visitors since admission. R153 reported to staff her wallet was in her purse on Friday, 6/16/17 when she had written a receipt in her checkbook ledger, then put her wallet back in her purse. R153 was alert and orientated times three, and reported she had $120.00 in her wallet,	F 225		

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a debit card and a credit card along with her social security card. Staff assisted R153 to cancel her debit and credit card, family was called, admitting hospital called to see if wallet was with them, it was not. Police were notified on 6/19/17 to report R153's missing wallet.

On 11/16/17, at 11:36 a.m. LPN-A indicated if a resident reported missing money staff were expected to report that to the nurse manager and director of nursing, call family and start searching for reported missing money. LPN-A verified if a resident reports missing money, the allegation would need to be reported to the SA within 24 hours.

On 11/16/17, at 3:04 p.m. CM-B stated staff were expected to report allegations of missing money to the SA immediately, as soon as staff find out. CM-B verified 2 days after the report of missing money would be too late.

On 11/17/17, at 10:48 a.m. DON confirmed R153 reported her wallet and money missing on 6/17/17. The DON stated R153 reported the allegation on 6/17/17 during the weekend. The DON verified she was not made aware of the situation until Monday, 6/19/19, and at that time she reported the allegation to the SA and the police on 6/19/17, and staff continued to look for the wallet.

On 11/17/17, at 10:49 a.m. the administrator verified she was not updated on R153's allegation immediately, nor was an incident report filed to the SA immediately. The administrator stated she believed that kind of stuff happens, the resdient had just been admitted to the facility and staff thought maybe R153 had misplaced the wallet.

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F 225	Continued From page 11 The administrator stated once administration determined the wallet was lost, on Monday 6/19/17, they reported the incident to the SA and contacted police at that time. The administrator stated administration reported the incident immediately when they "deemed" it was misappropriation of resident property, because that is when we decided it was missing and we could not find the wallet and missing money. Review of the facility's Vulnerable Adult Abuse/Neglect Prevention policy, revised 9/1/16, indicated all injuries of unknown cause or injuries from accident/incident must be reported immediately to the state agency at the time the injury is discovered. The policy directed all suspected violations and all substantiated incidents of abuse would be immediately reported to the SA. In addition, the policy directed incidents of suspected resident abuse, or injury of unknown source to be reported to the administrator immediately and the administrator would appoint a member of management to investigate the alleged incident. Further, the policy directed residents shall be protected from harm during an investigation and employees accused of participating in the alleged abuse would be immediately reassigned to duties that do not involve resident contact or would be suspended until the findings of the investigation had been reviewed by the administrator. If the employee was reassigned to non-resident care duties, the assignment would not be in any part of the building which the resident frequented.	F 225		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3)	F 226		12/20/17

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F 226	Continued From page 12 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the abuse prohibition polices to immediately report to administrator and report within 2 hours to State agency (SA), and thoroughly investigate injuries of unknown source and allegations of abuse. In addition, the facility	F 226	F 226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES It is the practice of Knute Nelson to promote care for residents in a manner and in an environment that is free from alleged violations involving abuse,	

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F 226	Continued From page 13 failed to implement abuse prohibition policies for protection of residents during the investigation of allegations of abuse. Further, the facility failed to immediately report to the adminstrator, timely report to the SA, an allegation of misappropriation of resident property. Findings include: Review of the facility's Vulnerable Adult Abuse/Neglect Prevention policy, revised 9/1/16, indicated all injuries of unknown cause or injuries from accident/incident must be reported immediately to the state agency at the time the injury is discovered. The policy directed all suspected violations and all substantiated incidents of abuse would be immediately reported to the SA. In addition, the policy directed incidents of suspected resident abuse, or injury of unknown source to be reported to the administrator immediately and the administrator would appoint a member of management to investigate the alleged incident. Further, the policy directed residents shall be protected from harm during an investigation and employees accused of participating in the alleged abuse would be immediately reassigned to duties that do not involve resident contact or would be suspended until the findings of the investigation had been reviewed by the administrator. If the employee was reassigned to non-resident care duties, the assignment would not be in any part of the building which the resident frequented. R105 R105's significant change MDS dated 10/10/17, identified R105 had moderately impaired cognition, a diagnosis of hemiplegia and required	F 226	neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. What corrective action(s) will be accomplished for those residents to have been found affected by the deficient practice? Residents 105, 163 and 153 suffered no adverse effects as a result of this practice. Resident 105 was interviewed by the Director of Nursing and resident stated she has never felt abused, nor was her hip fracture caused by anyone. Resident 163 was interviewed by the Director of Nursing and resident stated he did not feel abused by any of the staff, he felt safe at the community. No corrective actions could be made for Resident 153 since the resident was discharged from the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken? All residents have the potential to be affected by the alleged deficient practice. Interviews were conducted by the Director of Nursing and designees to assure that no other residents were affected. No other concerns were identified. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? The community has a policy regarding abuse prohibition and immediately reporting suspected/alleged abuse, neglect, and injuries of unknown origin to the designated state agency/common entry point. The Administrator reviewed	

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F 226	Continued From page 14 extensive assistance for bed mobility, dressing, toilet and personal care, and required total assistance with transfers and locomotion, but did not walk. R105's current care plan reviewed 10/20/17, included various problems which included the potential for injury related to dementia, related to CVA (cerebrovascular accident) with right side hemiplegia, use of psychotropic medications, poor safety awareness, visual field cut, the potential for injury related to falls, and a risk for being abused by other individuals. Review of R105's progress notes from 9/22/17 to 10/2/17 identified the following: -9/23/17, R105 was hollering out, anxious, disorientated and unable to speak clearly. When able to speak normally, R105 complained of left side body pain. -9/23/17, in the evening, had continued pain, anxiousness and difficulty speaking and no memory recall of the previous night. -9/28/17, R105 left anterior thigh bruise which measured 1.24 cm (centimeter) by 10 cm, yellow in color with patches of purple/green located on the left anterior thigh, which wrapped around to the medial thigh with scant edema, moderate/severe pain noted. Left lateral thigh bruise measured 35 cm by 19 cm, light yellow in color with 13 cm purple center, and 1 plus edema noted and moderate/severe pain. -9/30/17, sent to emergency room for displaced subcapital left femoral neck fracture and admitted to hospital -R105's record and facility VA reports lacked evidence R105's unexplained significant bruising nor the knowledge of the fractured hip had been	F 226	and updated the facilities policy. Re-Education has been conducted to all care center staff by the Administrator on Tuesday, December 19, 2017, on the revised abuse prohibition policy. Staff will be educated during orientation and will also be educated yearly with an abuse prohibition in-service. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Audits will be conducted on all incident reports by the Administrator or designee to monitor that staff are following the abuse prohibition policy. Results will be brought to the Quality Assurance Performance Improvement committee for further recommendations. Completion date: December 20, 2017	

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reported to the SA.

Review of the hospital record with admit date 9/30/17, identified the following: Chief complaint: left hip pain, last Saturday when daughters visited their mother they noticed that she was acting strange. She was appearing to have spasms. The nursing home staff thought she was having a seizure. Since last Saturday 9/23/17, she had been having trouble with moving in a wheel chair and with transferring she appears to be having spasms and hip pain. She does have a history of right femoral neck fracture (hip) with hemi-hip arthroplasty (surgical joint repair) last year. She also has a history of a stroke with complete right-sided hemiparesis. The X-ray identified a displaced left femoral neck fracture.

On 11/15/2017, at 11:30 a.m. R105 verified she had recently broken her hip. R105 could not recall details but stated she had fallen.

On 11/15/2017, at 2:46 p.m. nursing assistant (NA)A indicated R105 had a hip fracture a month or two ago. NA-A indicated they had no idea how the fracture occurred, and stated one day she was fine, the next she had excruciating pain and she didn't know what happened.

On 11/15/2017, at 2:56 p.m. the CM-C indicated R105 did not have any incident reports on file and had not had a fall for nine months. CM-C indicated R105 was last hospitalized due to failure of the hip repair completed the previous year.

On 11/16/2017, at 9:33 a.m. NA-B verified R105 had recently broken her hip and was now back to her normal abilities. NA-B stated staff were not

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F 226	Continued From page 16 entirely sure how R105's broken hip occurred. On 11/16/2017, at 11:25 a.m. licensed practical nurse (LPN)-H indicated R105 would at times attempt to self-transfer. LPN-H indicated R105 had been more confused around the time of her recent hip fracture. LPN-H indicated R105 did not fall when she broke her hip, but stated I don't think it was ever determined how it happened. On 11/16/2017, at 2:40 p.m. CM-C indicated R105 did not have any falls, however; did have osteoporosis. With review of the computerized charting, CM-C verified R105 had pain on 9/23/17, was not aware why she had pain, and confirmed the record also indicated bruising to the left hip noted 9/28/17, which was colored yellow and green. CM-C indicated R105 had a history of seizures, strokes, had osteoporosis and was "acting peculiar." CM-C questioned if R105 possibly fractured her hip during a seizure. On 11/16/2017, at 3:05 p.m. the DON reviewed R105's electronic chart and verified R105 presented with pain on the 23rd, and was confused. The DON indicated R105 possibly had a seizure resulting in the hip fracture. The DON stated she had not reported R105's hip fracture to the SA as she had nothing identifying that it was caused by abuse. On 11/16/17, at 3:15 p.m. the administrator verified the facility staff discussed R105's hip fracture and did not feel it needed to be reported. On 11/16/2017, at 3:34 p.m. the medical director was interviewed by phone. The medical director identified a person with a diagnosis of Osteoporosis would be at risk for hip fracture and	F 226		

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F 226	Continued From page 17 stated he did not feel a VA report would be appropriate. R163 R163's admission Minimum Data Set Assessment (MDS) dated 10/24/17, identified R163 had intact cognition and had diagnoses which included quadriplegia. The MDS listed R163 required total assistance with all activities of daily living (ADL's). On 11/13/2017, at 11:36 a.m. R163 stated approximately two weeks ago he had requested multiple times for nursing assistants to go slow during cares and to tell him what they were going to do with him. R163 stated staff did not honor this request and continued to quickly move his body causing him pain. R163 indicated he had informed his family of the incident. R163 further stated he believed the facility had removed these two nursing assistants from the schedule because they had not worked with him for a while. R163 stated one of the nursing assistants had worked with him again today and she did not slow down when moving him, causing pain and repeatedly stated she was sorry when he complained about her treatment but continued to cause pain. He stated he believed the apology to be self serving and the treatment was abuse. He stated he had not reported today's occurrence to anyone; however, planned to if it continued. On 11/13/2017, at 12:00 p.m. the director of nursing (DON) was notified of R163's current allegation of abuse by the nursing assistant. The DON indicated she was not aware of R163's past or present concerns of potential abuse. The DON indicated the family had requested a specific	F 226		

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nursing assistant no longer work with R163, however had not given a reason and the request was honored. The DON indicated she and the clinical manager (CM)-A spoke with the family regarding personal cares, therapy and the request of one nursing assistant to no longer work with R163, however stated the family had not used the word abuse.

On 11/14/2017, at 3:07 p.m. R163 indicated the DON had brought nursing assistant (NA-C) into R163's room. R163 indicated he was able to verify this was the nursing assistant that mistreated him.

On 11/15/2017, at 3:15 p.m. via telephone interview, FM-G stated two weeks ago on a Sunday, she had become aware of concerns and had then spoken with the social worker regarding R163's allegation of abuse. FM-G stated [R163] specifically stated there were two night staff that would move him too quickly causing him pain and they would disregard his wishes. FM-G stated she felt that if staff were told to slow down and don't, then it is abuse.

On 11/15/2017, at 3:50 p.m. the DON verified NA-C was currently working independently with residents. The DON indicated she was working on the investigative report, and did not believe the allegation of abuse to be true. The DON indicated if the investigation proved NA-C had abused R163, she would have to be terminated but at this time there was no proof.

On 11/16/2017, at 7:09 a.m. NA-C indicated on 11/13/17, the nurse manager had instructed her to no longer go into R163's room due to a report of abuse. NA-C she had worked independently

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with other residents on the unit until the morning of 11/16/17, when she been informed by the DON that she could no longer work alone with residents.

On 11/16/2017, at 3:05 p.m. the DON verified she had spoken with R163 on 11/13/17, and the complaint was regarding staff moving him fast, and that it hurt him when they moved him. The DON stated she talked to staff and did not consider it abuse.

On 11/16/2017, at 10:05 a.m. CM-A indicated she was not aware of any problems R163 had with the night nursing assistants. CM-A indicated reports of abuse were reported to the DON who would submit a report to the SA and begin an investigation. CM-A indicated DON and the clinical managers were able to submit the reports to the SA and the administrator then followed up with the reports. CM-A indicated the social worker assisted with these reports but was not responsible for them.

On 11/16/2017, at 12:29 p.m. the licensed social worker (LSW) identified she was not aware of a past abuse allegation for R163. The LSW indicated abuse allegations were the DON's responsibility and her role was to assist with gathering information and documenting as needed.

On 11/16/2017, at 2:00 p.m. the administrator indicated she was not aware of the allegation regarding R163 . The administrator indicated concerns were immediately reported to the administrator or the DON who then informed the administrator. The administrator stated she felt the problem two weeks ago was not a vulnerable

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adult situation. The administrator indicated she felt the DON had handled the situation appropriately, she had no reason to believe it was abuse, and had educated staff at that time.

Review of R163's computerized progress notes revealed an entry dated 11/7/17, which indicated a care conference was held per family member (FM)-G's request. The notes indicated nursing and social service staff participated in the call with the daughter regarding questions and concerns. The record did not identify what the family's questions or concerns were.

R153

R153's admission MDS dated 6/20/17, indicated R153 had diagnoses which included pelvic fracture and hypertension. The MDS identified R153 was cognitively intact and had no difficulty with understanding communication and ability to express, understand or hear information. R153 required extensive staff assistance for ADL's with the exception of eating.

Review of R153's SA draft incident form with a print date of 6/19/17, indicated on 6/17/17, at 5:30 p.m. R153 reported to the charge nurse that her wallet was missing from her purse. Review of the investigative report submitted to the SA on 6/22/17, indicated R153 reported her wallet was missing on 6/17/17, staff assisted R153 with a complete room search several times. R153 did not have any visitors since admission. R153 reported to staff her wallet was in her purse on Friday, 6/16/17 when she had written a receipt in her checkbook ledger, then put her wallet back in

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her purse. R153 was alert and orientated times three, and reported she had $120.00 in her wallet, a debit card and a credit card along with her social security card. Staff assisted R153 to cancel her debit and credit card, family was called, admitting hospital called to see if wallet was with them, it was not. Police were notified on 6/19/17 to report R153's missing wallet.

On 11/16/17, at 11:36 a.m. LPN-A indicated if a resident reported missing money staff were expected to report that to the nurse manager and director of nursing, call family and start searching for reported missing money. LPN-A verified if a resident reports missing money, the allegation would need to be reported to the SA within 24 hours.

On 11/16/17, at 3:04 p.m. CM-B stated staff were expected to report allegations of missing money to the SA immediately, as soon as staff find out. CM-B verified 2 days after the report of missing money would be too late.

On 11/17/17, at 10:48 a.m. DON confirmed R153 reported her wallet and money missing on 6/17/17. The DON stated R153 reported the allegation on 6/17/17 during the weekend. The DON verified she was not made aware of the situation until Monday, 6/19/19, and at that time she reported the allegation to the SA and the police on 6/19/17, and staff continued to look for the wallet.

On 11/17/17, at 10:49 a.m. the administrator verified she was not updated on R153's allegation immediately, nor was an incident report filed to the SA immediately. The administrator stated she believed that kind of stuff happens, the resdient

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F 226	Continued From page 22 had just been admitted to the facility and staff thought maybe R153 had misplaced the wallet. The administrator stated once administration determined the wallet was lost, on Monday 6/19/17, they reported the incident to the SA and contacted police at that time. The administrator stated administration reported the incident immediately when they "deemed" it was misappropriation of resident property, because that is when we decided it was missing and we could not find the wallet and missing money.	F 226		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs.	F 329		12/20/17

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F 329	Continued From page 23 Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure parameters were identified for range orders and use of dual analgesics for 1 of 5 residents (R112) reviewed for unnecessary medications. Findings include: R112's admission nursing assessment dated 11/3/17, revealed R112 had cognitive impairment and diagnoses which included dementia, weakness, gout, congestive heart failure (CHF), osteopenia and diabetes mellitus(DM) type II. The admission assessment also indicated R112 required extensive assistance from facility staff with activities of daily living (ADL's). The admission note dated 11/3/17, indicated R112 denied pain, and R112's pain had not interfered with sleep. R112's care plan dated 11/10/17, indicated R112 had arthritis and directed staff to monitor for signs and symptoms of pain, monitor fatigue and	F 329	F 329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS It is the practice of Knute Nelson to ensure parameters are identified for range orders and use of dual analgesics. What corrective action(s) will be accomplished for those residents to have been found affected by the deficient practice? Resident 112 suffered no adverse effects as a result of this practice. Resident 112□s Tylenol order was changed from 1-2 tabs to 2 tabs for a pain rating of 1-5/10, Ibuprofen is 600mg for a pain rating of 6-10/10. How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken? All residents have the potential to be affected by this practice. No other current residents in the facility have range orders and use of dual analgesics.	

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F 329	Continued From page 24 monitor for any side effects of medications. Review of R112's physician orders signed 11/3/17, revealed orders for Tylenol (acetaminophen) 325 milligrams (mg), give 1-2 tablets by mouth every 4 hours for pain. Review of R112's physician order dated 11/15/17, revealed an order for ibuprofen 600 mg, give by mouth every 8 hours as needed for severe pain. R112's physician orders lacked guidance for what level of pain was indicated to use the Tylenol 1-2 tablets and when to use the ibuprofen for pain. Review of R112's medication administration records (MAR) from November 3, 2017, to November 17, 2017, revealed the following: -R112 had received acetaminophen 13 times for pain levels that ranged from a 2 to 7 on a numeric pain scale (0 being no pain and 10 being the worst pain imaginable.) The MAR did not indicate if R112 received 1 or 2 tablets when the acetaminophen was given. The MAR further revealed R112 had received ibuprofen 600 mg 3 times from 11/15/2017 to 11/17/2017, for pain levels ranging from a 4 to 8. The MAR revealed all but 5 doses of acetaminophen administrations were effective in relieving R112's pain, and all 3 doses of ibuprofen were effective in relieving R112's pain. On 11/16/17, at 2:17 p.m. trained medication aide (TMA)-B confirmed R112 had physician orders for both acetaminophen and ibuprofen. TMA-B confirmed R112's physician orders lacked indications on when to use 1 or 2 tablets of	F 329	What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? Licensed Nursing staff received education on orders that are not clear or do not have parameters, the orders must be clarified with the prescribing provider upon receiving the order. If prescribing provider wishes to keep a range order the nursing staff have been educated on the need to document what dose was given on the electronic medication administration sheet. This education will be completed on 12/19/2017. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Random audits will be done by the Director of Nursing/designee of the nursing hours to ensure that all residents who have more than one analgesic order have parameters within the order and that if there are range orders the staff are documenting what dose was given in the electronic medication administration record. Results of the audit will be taken to the QAPI committee for further recommendations. Completion date: December 20, 2017	

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acetaminophen and when to use which medication. TMA-B stated she had to ask the nurse responsible for the unit if 1 or 2 tablets should be given and when the ibuprofen was to be used. TMA-B indicated R112 was pleasantly confused and could not identify a number on the pain scale when asked, so staff used a tool for residents with dementia to identify how much pain R112 had. TMA-A stated she had only given R112 acetaminophen one time, when she asked the nurse how many tablets to give, the nurse directed her to give 2 tablets.

On 11/16/17, at 2:33 p.m. registered nurse (RN)-B confirmed R112 had physician orders for both acetaminophen and ibuprofen. RN-B indicated the usual practice was for the physician to include guidelines on how many tablets to give and when to use which medication. RN-B stated all trained medication aides were required to consult with the charge nurse prior to giving as needed medications for pain so the nurse could assess the resident's pain. RN-B stated both of R112's medication orders should have been clarified to include parameters.

On 11/16/17, at 2:39 p.m. licensed practical nurse (LPN)-A confirmed R112 had physician orders for both acetaminophen and ibuprofen without parameters. LPN-A was not aware R112's analgesic orders lacked the guidelines, and would have expected the prescriber to include them. LPN-A verified the staff should have sent out clarification to be added to both the acetaminophen and ibuprofen medication orders.

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F 329	Continued From page 26 On 11/16/17, at 2:47 p.m. clinical manager (CM)-B verified R112's physican orders for acetaminophen and ibuprofen lacked parameters. CM-B indicated staff should have contacted the doctor for clarification and parameters on when to use 1 or 2 tablets of acetaminophen and when to use the ibuprofen. On 11/17/17, at 10:10 a.m. the director of nursing (DON) stated she would expect parameters to be listed for R112's acetaminophen and ibuprofen. The DON reported R112 was new to the facility, but would have expected the nurse to send out a request to the physician for the order clarifications. The facility's Medication Range Order policy revised 7/2016, indicated range orders may be unclear and ambiguous and may also be a source for medication errors. Prescriber's should be encouraged to make range orders as specific and clear as possible (e.g., morphine 5 mg for a pain rating of 5 or less; morphine 10 mg for a pain rating of 6 or higher). Documentation must show the amount given for each range order dose.	F 329		
F 356 SS=C	POSTED NURSE STAFFING INFORMATION CFR(s): 483.35(g)(1)-(4) 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 356		12/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 11/17/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 27 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as	F 356		

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F 356	Continued From page 28 required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the nurse staffing information was posted on a daily basis. This had the potential to affect all visitors and all 79 residents who resided in the facility. Findings include: During the initial tour of the facility on 11/13/17, at 6:51 a.m. the untitled forms dated 10/31/17, to 11/6/17, were observed to be posted on the wall next to the entrance door. There were 7 forms hanging in clear plastic files. The forms include the facility name, dates, census of 75 to 79, and the number of licensed and unlicensed nursing staff scheduled for each shift. The nurse staffing information for the current date of 11/13/17, was not observed to be posted anywhere in the facility. During interview on 11/13/17, at 7:08 a.m. licensed practical nurse (LPN)-F confirmed the posting dated 11/06/17, had been the most recent nurse staffing information posted. LPN-F and surveyor reviewed the 7 forms posted and confirmed they were dated 10/31/17 to 11/6/17 and included the facility name, date, census and nursing staff scheduled for each shift including licensed and unlicensed staff. On 11/13/17, at 8:45 a.m. the director of nursing (DON) confirmed the most recent posting of staffing information was dated 11/6/17. DON and surveyor reviewed the forms posted and confirmed the 7 forms were dated 10/31/17 to 11/6/17 and included the facility name, date,	F 356	F 356 POSTED NURSE STAFFING INFROMATION It is the practice of Knute Nelson to ensure that the nurse staffing information is posted on a daily basis. What corrective action(s) will be accomplished for those residents to have been found affected by the deficient practice? No residents suffered adverse effects because of this practice. How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken? All visitors and residents in the facility have the potential to be affected by this practice. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? The staffing coordinator is responsible to post the nursing hours each day at the beginning of the day. These hours are changed as schedule changes occur. The policy was updated to reflect that when the staffing coordinator is not present the person who is responsible for staffing would make the changes on the nursing staffing hours as needed. On weekends the RN manager will make necessary changes to the posted hours. Staffing Coordinator was educated on the	

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F 356	Continued From page 29 census and licensed and unlicensed nursing staff scheduled for each shift. She reported the staffing coordinator (SC) was responsible for the completion and posting of the nurse staffing information. DON indicated her expectation was the forms would be posted daily. On 11/17/17, at 10:02 a.m. SC verified she was responsible for updating the nursing staff posting. SC indicated she made changes to the forms as needed. She indicated she posted them on Fridays and if changes during the weekend she would update them on Mondays. She verified if changes occurred during the weekend, the forms would not be accurate at that time. The facility's policy titled Posting of Nursing hours, undated, indicated that nursing staffing hours were posted daily and was to be completed by the staffing coordinator daily prior to the beginning of the first shift. The policy lacked direction for persons responsible when the staffing coordinator was not present to assure updates were made as needed.	F 356	importance of having the nursing hours posted timely on 12/19/2017. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Random audits will be done by the Director of Nursing/designee of the nursing hours to ensure that they are current and correct. Results of the audit will be taken to the QAPI committee for further recommendations. Completion date: December 20, 2017	
F 431 SS=E	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures	F 431		12/20/17

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F 431	Continued From page 30 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		

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F 431	Continued From page 31 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin pens were labeled with instructions for use for 4 of 4 insulin pens reviewed on medication carts in the facility. Findings include: On 11/13/17, at 8:02 a.m. the 700 wing medication cart was observed with licensed practical nurse (LPN)-D present. She verified R183's humalog (insulin lispro) and toujeo (insulin glargine) insulin pens, stored in the 700 wing medication cart had facility labels which included R183's name, date of birth, medical record number, room number and primary physician. She confirmed the pen lacked a pharmacy label with instructions. LPN indicated the pharmacy had not labeled the actual pens, so they applied a facility label on the pen. On 11/13/17, at 8:54 a.m. the 500 wing medication cart was observed with trained medication aide (TMA)- A present, who verified R30's Lantus insulin pen, stored in the 500 wing medication cart had a facility label with R30's name, room number, medical number, date of birth and primary physicians name, but lacked a pharmacy label with instructions for dose to be administered. On 11/13/17, at 8:41 a.m. the transitional care wing medication cart was observed with registered nurse (RN)-A present. R184's Novolog pen on the transitional care wing medication cart	F 431	F 431 DRUG RECORD, LABEL/STORE DRUGS AND BIOLOGICALS It is the practice of Knute Nelson to ensure insulin pens are properly labeled with instructions for use. What corrective action(s) will be accomplished for those residents to have been found affected by the deficient practice? Resident 183, 30, and 184 suffered no adverse affects as a result of this practice. R 183, R 30 and R 184□s insulin pens did not have pharmacy labels on them. At the time this was found, pharmacy labeled all affected insulin pens with proper labels. All insulin pens in facility have proper pharmacy labels on. How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken? All residents who have orders for insulin pens have the potential to be affected by this. No other current residents in the facility with insulin orders were found to have any concerns with their pens and not being properly labeled. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? Nursing staff will receive education that all insulin pens must have their own label on each pen, if a pen is found not to have a proper label on it, nursing staff will send	

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F 431	Continued From page 32 with surveyor. RN-A verified the pen's pharmacy label was partially worn off and had black areas over most of the label. This made it unable to read the resident name and instructions for dose to be administered. R183's signed physician orders dated 11/10/17, indicated R183 was prescribed Humalog solution 100 unit/ml (insulin lispro) inject 10 units subcutaneously with meals for DM (diabetes mellitus), with an ordered start date of 11/9/17, and Lantus 100 unit/ml (insulin glargine) inject 70 units subcutaneously in the morning for DM, with an ordered start date of 11/10/17. R30's signed physician orders dated 9/15/17, indicated R30 was prescribed Lantus Solution 100 unit/ml (insulin glargine) inject 26 units subcutaneously at bedtime for DM, with an order start date of 5/26/17. R184's signed physician orders dated 11/3/17, indicated R184 was prescribed Novolog solution 100 unit/ml (insulin aspart) inject 3 unit subcutaneously before meals for DM, hold for BS (blood sugar) <120, with an order start date of 11/1/17. On 11/16/17, 9:22 a.m. during a phone interview, pharmacy consultant (PC) indicated she was not aware that insulin pens in the facility were not labeled with pharmacy instructions. PC indicated she would recommend insulin pens would have pharmacy labels on them when not stored in boxes with pharmacy labels on the boxes. On 11/16/17, at 11:28 a.m. director of nursing (DON) confirmed the pharmacy labels on medications were used to compare the written	F 431	back to pharmacy for proper labeling. This education will be completed on 12/19/2017. Director of Nursing has spoken to the pharmacies involved that the requirement is each pen must be labeled individually, if the pharmacy is not able to comply with this the insulin pens will be obtained from another pharmacy that can meet this requirement. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Random audits will be done by Director of Nursing/designee of residents who use insulin pens to ensure that they have proper labels on them. Results of the audits will be taken to the QAPI committee for further recommendations. Completion date: 12/20/17	

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F 431	Continued From page 33 orders on the medication administration records to assure the 5 rights (the right route, medication, resident, time and dosage) were accurate. She indicated some pharmacies refused to put labels on the insulin pens. DON indicated she would expect the staff would call pharmacy for a new label if it became unreadable. The facility policy titled Pharmacy-Drug Labeling, dated 11/1/11, reviewed 11/16, indicated all medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations. The policy also indicated medication labels must be legible at all times. Insulin pens-original box that they come in would have the label, pens were labeled with facility label attached to them (this was for specific certain pharmacies). The policy also indicated only the dispensing pharmacy could label a medication container or package.	F 431		
F 456 SS=E	ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION CFR(s): 483.90(d)(2)(e) (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the water and ice machine was maintained in good repair for 1 of 3 kitchen areas. This practice had the	F 456	F 456 ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION It is the practice of Knute Nelson to procure maintain all mechanical,	12/20/17

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F 456	Continued From page 34 potential to affect all 16 residents who received water and ice from the machine on the short-term stay dining room. Findings include: On 11/13/17, at 6:55 a.m. the initial tour of the kitchen was completed with dietary cook (DC)-A. The following concerns were identified: - The water and ice machine located adjacent from the short- term dining room area was observed to have encrusted hard water lime scale build up under the ice and water dispenser area, behind the seams of the water tray, and running down the front right and left side of the machine in between the seams of the metal, which ran all the way to the floor. On 11/16/17, at 9:38 a.m. during follow up tour of the kitchen areas with the dietary manger (DM) the following concerns were noted: - The water and ice machine located adjacent from the short- term dining room area was observed to have encrusted hard water lime scale build up under the ice and water dispenser area, behind the seams of the water tray, and running down the front right and left side of the machine in between the seams of the metal, which ran all the way to the floor. -at 9:41 a.m. the DM confirmed the above finding and was able to pick off chunks of lime scale build up from underneath the ice and water dispenser area. The DM indicated the water and ice machine could be cleaned better due to the lime scale getting bad after a week. The DM indicated the ice and water machine appeared to	F 456	electrical, and patient care equipment in safe operating conditions. What corrective action(s) will be accomplished for those residents to have been found affected by the deficient practice? No residents suffered adverse effects as a result of this practice. How will you identify other residents having the potential to be affected by the same deficient practice and what correction actions will be taken? All residents in the facility have the potential to be affected by this practice. The ice machine was thoroughly deep cleaned and scrapped of all lime scale build up. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? The community has a policy regarding equipment being maintained in a safe, clean, functional, comfortable manner. All Care Center staff have been re-educated on this policy on Tuesday, December 19, 2017. Ice machines are deep cleaned monthly and as needed via audits. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Random audits will be done by Director of Dining Services or designee of the ice machine equipment to ensure it is safe, clean, functional, and in a comfortable manner. Results of the audits will be taken to the QAPI committee for further recommendations. Completion date:	

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F 456	Continued From page 35 be leaking to cause the lime scale build up on the seams of the machine. At 11:27 a.m. in a follow up interview with the DM, she indicated the ice and water machine was old, the water line should be replaced, the plastic ice dispenser should be replaced and stated could take a while to clean. The DM indicated ice machine was a problem and needed to be fixed. Review of the Monthly ice machine logs revealed the ice machines on the short term stay dining room area was cleaned on 9/1/17, 10/1/17, 10/25/17 and 11/1/17. No other information for cleaning and maintaining the water and ice machine was provided. Review of facility policy titled, Knute Nelson, undated, indicated the ice machine equipment would be cleaned on a regular basis to maintain a clean, sanitary condition. Cleaning and sanitation for the ice machine would be done monthly, recorded and replace parts of the ice machine as needed.	F 456	December 20, 2017	

Electronically delivered
December 6, 2017

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

Re: Project Number S5435028

Dear Ms. Solwold:

The above facility was surveyed on November 13, 2017 through November 17, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at 218-332-54140 or 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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00113	A. BUILDING: _____ B. WING _____	C 11/17/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 11/13/17 to 11/17/17, 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. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00113	A. BUILDING: _____ B. WING _____	C 11/17/2017

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 995	MN Rule 4658.0610 Subp. 3 Dietary Staff Requirements -Grooming. Subp. 3. Grooming. Dietary staff must wear clean outer garments. Hairnets or other hair restraints must be worn to prevent the contamination of food, utensils, and equipment. Hair spray is not an acceptable hair restraint. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure staff utilized a hair net properly to prevent contamination of food while serving food in the Pines kitchenette during 1 of 1 observation of food service in the Pines unit. This deficient practice had the potential to affect 33 of 33 residents in the facility who were served food from the Pines kitchenette. Findings include: During observation of the morning meal service on 11/13/2017, at 7:37 a.m. dietary aid (DA)A stood in the Pines Kitchenette in front of the steam table. A thin net type hair covering partially covered DA-A's hair leaving pieces of hair hanging down the back of DA-A's neck and all of her bangs uncovered. DA-A stood over the steam table with her hair partially uncovered and checked the temperature of the cooked cereal, omelets, and scrambled eggs. DA-A walked	2 995	Corrected	12/20/17

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2 995	Continued From page 3 through out the kitchenette with the hair net partially covering her hair as she prepared for the meal service, placed utensils near the steam table and toasted bread. At 7:48 a.m. DA-A scooped food items into bowls and onto plates with utensils and placed toast on plates with a gloved hand. At 8:39 a.m. the morning meal service observation was completed and DA-A's bangs and hair at the back of her neck remained uncovered. When interviewed on 11/13/2017, at 12:19 p.m. DA-A indicated her usual duties did include serving food items in the kitchenette for the morning meal. DA-A indicated although leaving her bangs uncovered and not contained by the hair net was a usual practice, she was aware all hair should be contained, however; stated the hair nets were not large enough to cover all of her hair. On 11/13/2017, at 12:21 p.m. the dining services manager (DSM)-A verified dietary staff were to have all of their hair completely covered when working with foods. On 11/13/2017, at 1:24 p.m. The DSM-B indicated staff were to cover all of their hair when working and should not purposely leave hair uncovered. The facilities policy titled Dietary Policy and Procedure revised May 21, 2008, identified: All employees shall: 1. Hair restraints are required at all times. SUGGESTED METHOD OF CORRECTION: The dietary director could provide education to staff regarding the facility policy on food safety	2 995		

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2 995	Continued From page 4 and sanitization, with focus on facial hair restraints. The dietary director/or designee could perform audits to ensure compliance and review and quality assurance meeting. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 995		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure parameters were identified	21540	Corrected	12/20/17

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21540	Continued From page 5 for range orders and use of dual analgesics for 1 of 5 residents (R112) reviewed for unnecessary medications. Findings include: R112's admission nursing assessment dated 11/3/17, revealed R112 had cognitive impairment and diagnoses which included dementia, weakness, gout, congestive heart failure (CHF), osteopenia and diabetes mellitus(DM) type II. The admission assessment also indicated R112 required extensive assistance from facility staff with activities of daily living (ADL's). The admission note dated 11/3/17, indicated R112 denied pain, and R112's pain had not interfered with sleep. R112's care plan dated 11/10/17, indicated R112 had arthritis and directed staff to monitor for signs and symptoms of pain, monitor fatigue and monitor for any side effects of medications. Review of R112's physician orders signed 11/3/17, revealed orders for Tylenol (acetaminophen) 325 milligrams (mg), give 1-2 tablets by mouth every 4 hours for pain. Review of R112's physician order dated 11/15/17, revealed an order for ibuprofen 600 mg, give by mouth every 8 hours as needed for severe pain. R112's physician orders lacked guidance for what level of pain was indicated to use the Tylenol 1-2 tablets and when to use the ibuprofen for pain. Review of R112's medication administration records (MAR) from November 3, 2017, to November 17, 2017, revealed the following:	21540		

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21540	Continued From page 6 -R112 had received acetaminophen 13 times for pain levels that ranged from a 2 to 7 on a numeric pain scale (0 being no pain and 10 being the worst pain imaginable.) The MAR did not indicate if R112 received 1 or 2 tablets when the acetaminophen was given. The MAR further revealed R112 had received ibuprofen 600 mg 3 times from 11/15/2017 to 11/17/2017, for pain levels ranging from a 4 to 8. The MAR revealed all but 5 doses of acetaminophen administrations were effective in relieving R112's pain, and all 3 doses of ibuprofen were effective in relieving R112's pain. On 11/16/17, at 2:17 p.m. trained medication aide (TMA)-B confirmed R112 had physician orders for both acetaminophen and ibuprofen. TMA-B confirmed R112's physician orders lacked indications on when to use 1 or 2 tablets of acetaminophen and when to use which medication. TMA-B stated she had to ask the nurse responsible for the unit if 1 or 2 tablets should be given and when the ibuprofen was to be used. TMA-B indicated R112 was pleasantly confused and could not identify a number on the pain scale when asked, so staff used a tool for residents with dementia to identify how much pain R112 had. TMA-A stated she had only given R112 acetaminophen one time, when she asked the nurse how many tablets to give, the nurse directed her to give 2 tablets. On 11/16/17, at 2:33 p.m. registered nurse (RN)-B confirmed R112 had physician orders for both acetaminophen and ibuprofen. RN-B indicated the usual practice was for the physician to include guidelines on how many tablets to give and when to use which medication. RN-B stated	21540		

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21540	Continued From page 7	21540		

all trained medication aides were required to consult with the charge nurse prior to giving as needed medications for pain so the nurse could assess the resident's pain. RN-B stated both of R112's medication orders should have been clarified to include parameters.

On 11/16/17, at 2:39 p.m. licensed practical nurse (LPN)-A confirmed R112 had physician orders for both acetaminophen and ibuprofen without parameters. LPN-A was not aware R112's analgesic orders lacked the guidelines, and would have expected the prescriber to include them. LPN-A verified the staff should have sent out clarification to be added to both the acetaminophen and ibuprofen medication orders.

On 11/16/17, at 2:47 p.m. clinical manager (CM)-B verified R112's physican orders for acetaminophen and ibuprofen lacked parameters. CM-B indicated staff should have contacted the doctor for clarification and parameters on when to use 1 or 2 tablets of acetaminophen and when to use the ibuprofen.

On 11/17/17, at 10:10 a.m. the director of nursing (DON) stated she would expect parameters to be listed for R112's acetaminophen and ibuprofen. The DON reported R112 was new to the facility, but would have expected the nurse to send out a request to the physician for the order clarifications.

The facility's Medication Range Order policy revised 7/2016, indicated range orders may be unclear and ambiguous and may also be a

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21540	Continued From page 8 source for medication errors. Prescriber's should be encouraged to make range orders as specific and clear as possible (e.g., morphine 5 mg for a pain rating of 5 or less; morphine 10 mg for a pain rating of 6 or higher). Documentation must show the amount given for each range order dose. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for unnecessary medications. Appropriate nursing staff could be educated on the systems. The DON or designee, could audit unnecessary medication systems to ensure ongoing compliance. The audit results could be brought to the quality assurance group for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin pens were labeled with instructions for use for 4 of 4 insulin pens reviewed on medication carts in the facility. Findings include:	21620	Corrected	12/20/17

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21620	Continued From page 9 On 11/13/17, at 8:02 a.m. the 700 wing medication cart was observed with licensed practical nurse (LPN)-D present. She verified R183's humalog (insulin lispro) and toujeo (insulin glargine) insulin pens, stored in the 700 wing medication cart had facility labels which included R183's name, date of birth, medical record number, room number and primary physician. She confirmed the pen lacked a pharmacy label with instructions. LPN indicated the pharmacy had not labeled the actual pens, so they applied a facility label on the pen. On 11/13/17, at 8:54 a.m. the 500 wing medication cart was observed with trained medication aide (TMA)- A present, who verified R30's Lantus insulin pen, stored in the 500 wing medication cart had a facility label with R30's name, room number, medical number, date of birth and primary physicians name, but lacked a pharmacy label with instructions for dose to be administered. On 11/13/17, at 8:41 a.m. the transitional care wing medication cart was observed with registered nurse (RN)-A present. R184's Novolog pen on the transitional care wing medication cart with surveyor. RN-A verified the pen's pharmacy label was partially worn off and had black areas over most of the label. This made it unable to read the resident name and instructions for dose to be administered. R183's signed physician orders dated 11/10/17, indicated R183 was prescribed Humalog solution 100 unit/ml (insulin lispro) inject 10 units subcutaneously with meals for DM (diabetes mellitus), with an ordered start date of 11/9/17, and Lantus 100 unit/ml (insulin glargine) inject 70 units subcutaneously in the morning for DM, with	21620		

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21620	Continued From page 10 an ordered start date of 11/10/17. R30's signed physician orders dated 9/15/17, indicated R30 was prescribed Lantus Solution 100 unit/ml (insulin glargine) inject 26 units subcutaneously at bedtime for DM, with an order start date of 5/26/17. R184's signed physician orders dated 11/3/17, indicated R184 was prescribed Novolog solution 100 unit/ml (insulin aspart) inject 3 unit subcutaneously before meals for DM, hold for BS (blood sugar) <120, with an order start date of 11/1/17. On 11/16/17, 9:22 a.m. during a phone interview, pharmacy consultant (PC) indicated she was not aware that insulin pens in the facility were not labeled with pharmacy instructions. PC indicated she would recommend insulin pens would have pharmacy labels on them when not stored in boxes with pharmacy labels on the boxes. On 11/16/17, at 11:28 a.m. director of nursing (DON) confirmed the pharmacy labels on medications were used to compare the written orders on the medication administration records to assure the 5 rights (the right route, medication, resident, time and dosage) were accurate. She indicated some pharmacies refused to put labels on the insulin pens. DON indicated she would expect the staff would call pharmacy for a new label if it became unreadable. The facility policy titled Pharmacy-Drug Labeling, dated 11/1/11, reviewed 11/16, indicated all medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations. The policy also indicated medication labels must be legible at all times.	21620		

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21620	Continued From page 11 Insulin pens-original box that they come in would have the label, pens were labeled with facility label attached to them (this was for specific certain pharmacies). The policy also indicated only the dispensing pharmacy could label a medication container or package. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to labeling medications when opened when necessary such as insulin. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21620		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the water and ice machine was maintained in good repair for 1 of 3 kitchen areas. This practice had the potential to affect all 16 residents who received water and ice from the machine on the short-term stay dining room.	21685	Corrected	12/20/17

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21685	Continued From page 12 Findings include: On 11/13/17, at 6:55 a.m. the initial tour of the kitchen was completed with dietary cook (DC)-A. The following concerns were identified: - The water and ice machine located adjacent from the short- term dining room area was observed to have encrusted hard water lime scale build up under the ice and water dispenser area, behind the seams of the water tray, and running down the front right and left side of the machine in between the seams of the metal, which ran all the way to the floor. On 11/16/17, at 9:38 a.m. during follow up tour of the kitchen areas with the dietary manger (DM) the following concerns were noted: - The water and ice machine located adjacent from the short- term dining room area was observed to have encrusted hard water lime scale build up under the ice and water dispenser area, behind the seams of the water tray, and running down the front right and left side of the machine in between the seams of the metal, which ran all the way to the floor. -at 9:41 a.m. the DM confirmed the above finding and was able to pick off chunks of lime scale build up from underneath the ice and water dispenser area. The DM indicated the water and ice machine could be cleaned better due to the lime scale getting bad after a week. The DM indicated the ice and water machine appeared to be leaking to cause the lime scale build up on the seams of the machine. At 11:27 a.m. in a follow up interview with the DM, she indicated the ice and water machine was old, the water line should	21685		

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21685	Continued From page 13 be replaced, the plastic ice dispenser should be replaced and stated could take a while to clean. The DM indicated ice machine was a problem and needed to be fixed. Review of the Monthly ice machine logs revealed the ice machines on the short term stay dining room area was cleaned on 9/1/17, 10/1/17, 10/25/17 and 11/1/17. No other information for cleaning and maintaining the water and ice machine was provided. Review of facility policy titled, Knute Nelson, undated, indicated the ice machine equipment would be cleaned on a regular basis to maintain a clean, sanitary condition. Cleaning and sanitation for the ice machine would be done monthly, recorded and replace parts of the ice machine as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop and implement policies and procedures and educate appropriate staff to ensure that the residents's equipment was maintained in a safe, clean, functional, comfortable manner. Ongoing monitoring and record keeping to ensure that the equipment is kept in good repair. Develop a system to audit the equipment on an ongoing basis to ensure compliance and monitor staff for adherence to these policies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21685		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults	21990		12/20/17

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21990	Continued From page 14 Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the administrator and failed to report within 24 hours to the State agency (SA) and thoroughly investigate, for 1 of 1 resident (R105) with injuries of unknown source(extensive bruising) and failed to report to SA within 2 hours and thoroughly investigate for 1 of 1 resident (R105) when they had knowledge of R105's injury of unknown source (hip fracture). In addition, the facility failed to immediately report to the administrator, and report to the SA within 2 hours an allegation of abuse, and failed to protect residents while investigating a second allegation of abuse for 1 of 1 resident (R163)with allegations of abuse. Further, the facility failed to immediately notify the administrator and timely report to the SA an allegation of misappropriation of resident's	21990	Corrected	

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21990	Continued From page 15 property for 1 of 3 residents (R153) reviewed for abuse prohibition. Findings include: R105 R105's significant change MDS dated 10/10/17, identified R105 had moderately impaired cognition, a diagnosis of hemiplegia and required extensive assistance for bed mobility, dressing, toilet and personal care, and required total assistance with transfers and locomotion, but did not walk. R105's current care plan reviewed 10/20/17, included various problems which included the potential for injury related to dementia, related to CVA (cerebrovascular accident) with right side hemiplegia, use of psychotropic medications, poor safety awareness, visual field cut, the potential for injury related to falls, and a risk for being abused by other individuals. Review of R105's progress notes from 9/22/17 to 10/2/17 identified the following: -9/23/17, R105 was hollering out, anxious, disorientated and unable to speak clearly. When able to speak normally, R105 complained of left side body pain. -9/23/17, in the evening, had continued pain, anxiousness and difficulty speaking and no memory recall of the previous night. -9/28/17, R105 left anterior thigh bruise which measured 1.24 cm (centimeter) by 10 cm, yellow in color with patches of purple/green located on the left anterior thigh, which wrapped around to the medial thigh with scant edema, moderate/severe pain noted. Left lateral thigh	21990		

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bruise measured 35 cm by 19 cm, light yellow in color with 13 cm purple center, and 1 plus edema noted and moderate/severe pain.
-9/30/17, sent to emergency room for displaced subcapital left femoral neck fracture and admitted to hospital

-R105's record and facility VA reports lacked evidence R105's unexplained significant bruising nor the knowledge of the fractured hip had been reported to the SA.

Review of the hospital record with admit date 9/30/17, identified the following: Chief complaint: left hip pain, last Saturday when daughters visited their mother they noticed that she was acting strange. She was appearing to have spasms. The nursing home staff thought she was having a seizure. Since last Saturday 9/23/17, she had been having trouble with moving in a wheel chair and with transferring she appears to be having spasms and hip pain. She does have a history of right femoral neck fracture (hip) with hemi-hip arthroplasty (surgical joint repair) last year. She also has a history of a stroke with complete right-sided hemiparesis. The X-ray identified a displaced left femoral neck fracture.

On 11/15/2017, at 11:30 a.m. R105 verified she had recently broken her hip. R105 could not recall details but stated she had fallen.

On 11/15/2017, at 2:46 p.m. nursing assistant (NA)A indicated R105 had a hip fracture a month or two ago. NA-A indicated they had no idea how the fracture occurred, and stated one day she was fine, the next she had excruciating pain and she didn't know what happened.

On 11/15/2017, at 2:56 p.m. the CM-C indicated

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R105 did not have any incident reports on file and had not had a fall for nine months. CM-C indicated R105 was last hospitalized due to failure of the hip repair completed the previous year.

On 11/16/2017, at 9:33 a.m. NA-B verified R105 had recently broken her hip and was now back to her normal abilities. NA-B stated staff were not entirely sure how R105's broken hip occurred.

On 11/16/2017, at 11:25 a.m. licensed practical nurse (LPN)-H indicated R105 would at times attempt to self-transfer. LPN-H indicated R105 had been more confused around the time of her recent hip fracture. LPN-H indicated R105 did not fall when she broke her hip, but stated I don't think it was ever determined how it happened.

On 11/16/2017, at 2:40 p.m. CM-C indicated R105 did not have any falls, however; did have osteoporosis. With review of the computerized charting, CM-C verified R105 had pain on 9/23/17, was not aware why she had pain, and confirmed the record also indicated bruising to the left hip noted 9/28/17, which was colored yellow and green. CM-C indicated R105 had a history of seizures, strokes, had osteoporosis and was "acting peculiar." CM-C questioned if R105 possibly fractured her hip during a seizure.

On 11/16/2017, at 3:05 p.m. the DON reviewed R105's electronic chart and verified R105 presented with pain on the 23rd, and was confused. The DON indicated R105 possibly had a seizure resulting in the hip fracture. The DON stated she had not reported R105's hip fracture to the SA as she had nothing identifying that it was caused by abuse.

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21990	Continued From page 18 On 11/16/17, at 3:15 p.m. the administrator verified the facility staff discussed R105's hip fracture and did not feel it needed to be reported. On 11/16/2017, at 3:34 p.m. the medical director was interviewed by phone. The medical director identified a person with a diagnosis of Osteoporosis would be at risk for hip fracture and stated he did not feel a VA report would be appropriate. R163 R163's admission Minimum Data Set Assessment (MDS) dated 10/24/17, identified R163 had intact cognition and had diagnoses which included quadriplegia. The MDS listed R163 required total assistance with all activities of daily living (ADL's). On 11/13/2017, at 11:36 a.m. R163 stated approximately two weeks ago he had requested multiple times for nursing assistants to go slow during cares and to tell him what they were going to do with him. R163 stated staff did not honor this request and continued to quickly move his body causing him pain. R163 indicated he had informed his family of the incident. R163 further stated he believed the facility had removed these two nursing assistants from the schedule because they had not worked with him for a while. R163 stated one of the nursing assistants had worked with him again today and she did not slow down when moving him, causing pain and repeatedly stated she was sorry when he complained about her treatment but continued to cause pain. He stated he believed the apology to be self serving and the treatment was abuse. He stated he had not reported today's occurrence to anyone; however, planned to if it continued.	21990		

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21990	Continued From page 19 On 11/13/2017, at 12:00 p.m. the director of nursing (DON) was notified of R163's current allegation of abuse by the nursing assistant. The DON indicated she was not aware of R163's past or present concerns of potential abuse. The DON indicated the family had requested a specific nursing assistant no longer work with R163, however had not given a reason and the request was honored. The DON indicated she and the clinical manager (CM)-A spoke with the family regarding personal cares, therapy and the request of one nursing assistant to no longer work with R163, however stated the family had not used the word abuse. On 11/14/2017, at 3:07 p.m. R163 indicated the DON had brought nursing assistant (NA-C) into R163's room. R163 indicated he was able to verify this was the nursing assistant that mistreated him. On 11/15/2017, at 3:15 p.m. via telephone interview, FM-G stated two weeks ago on a Sunday, she had become aware of concerns and had then spoken with the social worker regarding R163's allegation of abuse. FM-G stated [R163] specifically stated there were two night staff that would move him too quickly causing him pain and they would disregard his wishes. FM-G stated she felt that if staff were told to slow down and don't, then it is abuse. On 11/15/2017, at 3:50 p.m. the DON verified NA-C was currently working independently with residents. The DON indicated she was working on the investigative report, and did not believe the allegation of abuse to be true. The DON indicated if the investigation proved NA-C had abused R163, she would have to be terminated but at this	21990		

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21990	Continued From page 20 time there was no proof. On 11/16/2017, at 7:09 a.m. NA-C indicated on 11/13/17, the nurse manager had instructed her to no longer go into R163's room due to a report of abuse. NA-C she had worked independently with other residents on the unit until the morning of 11/16/17, when she been informed by the DON that she could no longer work alone with residents. On 11/16/2017, at 3:05 p.m. the DON verified she had spoken with R163 on 11/13/17, and the complaint was regarding staff moving him fast, and that it hurt him when they moved him. The DON stated she talked to staff and did not consider it abuse. On 11/16/2017, at 10:05 a.m. CM-A indicated she was not aware of any problems R163 had with the night nursing assistants. CM-A indicated reports of abuse were reported to the DON who would submit a report to the SA and begin an investigation. CM-A indicated DON and the clinical managers were able to submit the reports to the SA and the administrator then followed up with the reports. CM-A indicated the social worker assisted with these reports but was not responsible for them. On 11/16/2017, at 12:29 p.m. the licensed social worker (LSW) identified she was not aware of a past abuse allegation for R163. The LSW indicated abuse allegations were the DON's responsibility and her role was to assist with gathering information and documenting as needed. On 11/16/2017, at 2:00 p.m. the administrator indicated she was not aware of the allegation	21990		

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regarding R163 . The administrator indicated concerns were immediately reported to the administrator or the DON who then informed the administrator. The administrator stated she felt the problem two weeks ago was not a vulnerable adult situation. The administrator indicated she felt the DON had handled the situation appropriately, she had no reason to believe it was abuse, and had educated staff at that time.

Review of R163's computerized progress notes revealed an entry dated 11/7/17, which indicated a care conference was held per family member (FM)-G's request. The notes indicated nursing and social service staff participated in the call with the daughter regarding questions and concerns. The record did not identify what the family's questions or concerns were.

R153

R153's admission MDS dated 6/20/17, indicated R153 had diagnoses which included pelvic fracture and hypertension. The MDS identified R153 was cognitively intact and had no difficulty with understanding communication and ability to express, understand or hear information. R153 required extensive staff assistance for ADL's with the exception of eating.

Review of R153's SA draft incident form with a print date of 6/19/17, indicated on 6/17/17, at 5:30 p.m. R153 reported to the charge nurse that her wallet was missing from her purse. Review of the investigative report submitted to the SA on 6/22/17, indicated R153 reported her wallet was missing on 6/17/17, staff assisted R153 with a complete room search several times. R153 did not have any visitors since admission. R153 reported to staff her wallet was in her purse on

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Friday, 6/16/17 when she had written a receipt in her checkbook ledger, then put her wallet back in her purse. R153 was alert and orientated times three, and reported she had $120.00 in her wallet, a debit card and a credit card along with her social security card. Staff assisted R153 to cancel her debit and credit card, family was called, admitting hospital called to see if wallet was with them, it was not. Police were notified on 6/19/17 to report R153's missing wallet.

On 11/16/17, at 11:36 a.m. LPN-A indicated if a resident reported missing money staff were expected to report that to the nurse manager and director of nursing, call family and start searching for reported missing money. LPN-A verified if a resident reports missing money, the allegation would need to be reported to the SA within 24 hours.

On 11/16/17, at 3:04 p.m. CM-B stated staff were expected to report allegations of missing money to the SA immediately, as soon as staff find out. CM-B verified 2 days after the report of missing money would be too late.

On 11/17/17, at 10:48 a.m. DON confirmed R153 reported her wallet and money missing on 6/17/17. The DON stated R153 reported the allegation on 6/17/17 during the weekend. The DON verified she was not made aware of the situation until Monday, 6/19/19, and at that time she reported the allegation to the SA and the police on 6/19/17, and staff continued to look for the wallet.

On 11/17/17, at 10:49 a.m. the administrator verified she was not updated on R153's allegation immediately, nor was an incident report filed to the SA immediately. The administrator stated she

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21990	Continued From page 23 believed that kind of stuff happens, the resdient had just been admitted to the facility and staff thought maybe R153 had misplaced the wallet. The administrator stated once administration determined the wallet was lost, on Monday 6/19/17, they reported the incident to the SA and contacted police at that time. The administrator stated administration reported the incident immediately when they "deemed" it was misappropriation of resident property, because that is when we decided it was missing and we could not find the wallet and missing money. Review of the facility's Vulnerable Adult Abuse/Neglect Prevention policy, revised 9/1/16, indicated all injuries of unknown cause or injuries from accident/incident must be reported immediately to the state agency at the time the injury is discovered. The policy directed all suspected violations and all substantiated incidents of abuse would be immediately reported to the SA. In addition, the policy directed incidents of suspected resident abuse, or injury of unknown source to be reported to the administrator immediately and the administrator would appoint a member of management to investigate the alleged incident. Further, the policy directed residents shall be protected from harm during an investigation and employees accused of participating in the alleged abuse would be immediately reassigned to duties that do not involve resident contact or would be suspended until the findings of the investigation had been reviewed by the administrator. If the employee was reassigned to non-resident care duties, the assignment would not be in any part of the building which the resident frequented. SUGGESTED METHOD OF CORRECTION:	21990		

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21990	Continued From page 24 The administrator could in-service all staff on the need to immediately report suspected/alleged abuse, neglect, and injuries of unknown origin to the designated state agency/common entry point. The director of nursing could monitor incident reports for implementation of this requirement. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21990		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.	22000		12/20/17

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22000	Continued From page 25 (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement the abuse prohibition polices to immediately report to administrator and report within 2 hours to State agency (SA), and thoroughly investigate injuries of unknown source and allegations of abuse. In addition, the facility failed to implement abuse prohibition policies for protection of residents during the investigation of allegations of abuse. Further, the facility failed to immediately report to the adminstrator, timely report to the SA, an allegation of misappropriation of resident property. Findings include:	22000	Corrected	

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22000	Continued From page 26 Review of the facility's Vulnerable Adult Abuse/Neglect Prevention policy, revised 9/1/16, indicated all injuries of unknown cause or injuries from accident/incident must be reported immediately to the state agency at the time the injury is discovered. The policy directed all suspected violations and all substantiated incidents of abuse would be immediately reported to the SA. In addition, the policy directed incidents of suspected resident abuse, or injury of unknown source to be reported to the administrator immediately and the administrator would appoint a member of management to investigate the alleged incident. Further, the policy directed residents shall be protected from harm during an investigation and employees accused of participating in the alleged abuse would be immediately reassigned to duties that do not involve resident contact or would be suspended until the findings of the investigation had been reviewed by the administrator. If the employee was reassigned to non-resident care duties, the assignment would not be in any part of the building which the resident frequented. R105 R105's significant change MDS dated 10/10/17, identified R105 had moderately impaired cognition, a diagnosis of hemiplegia and required extensive assistance for bed mobility, dressing, toilet and personal care, and required total assistance with transfers and locomotion, but did not walk. R105's current care plan reviewed 10/20/17, included various problems which included the potential for injury related to dementia, related to CVA (cerebrovascular accident) with right side hemiplegia, use of psychotropic medications,	22000		

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22000	Continued From page 27 poor safety awareness, visual field cut, the potential for injury related to falls, and a risk for being abused by other individuals. Review of R105's progress notes from 9/22/17 to 10/2/17 identified the following: -9/23/17, R105 was hollering out, anxious, disorientated and unable to speak clearly. When able to speak normally, R105 complained of left side body pain. -9/23/17, in the evening, had continued pain, anxiousness and difficulty speaking and no memory recall of the previous night. -9/28/17, R105 left anterior thigh bruise which measured 1.24 cm (centimeter) by 10 cm, yellow in color with patches of purple/green located on the left anterior thigh, which wrapped around to the medial thigh with scant edema, moderate/severe pain noted. Left lateral thigh bruise measured 35 cm by 19 cm, light yellow in color with 13 cm purple center, and 1 plus edema noted and moderate/severe pain. -9/30/17, sent to emergency room for displaced subcapital left femoral neck fracture and admitted to hospital -R105's record and facility VA reports lacked evidence R105's unexplained significant bruising nor the knowledge of the fractured hip had been reported to the SA. Review of the hospital record with admit date 9/30/17, identified the following: Chief complaint: left hip pain, last Saturday when daughters visited their mother they noticed that she was acting strange. She was appearing to have spasms. The nursing home staff thought she was having a seizure. Since last Saturday 9/23/17, she had been having trouble with moving in a wheel chair and with transferring she appears to be having	22000		

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	00113	A. BUILDING: _____ B. WING _____	C 11/17/2017

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spasms and hip pain. She does have a history of right femoral neck fracture (hip) with hemi-hip arthroplasty (surgical joint repair) last year. She also has a history of a stroke with complete right-sided hemiparesis. The X-ray identified a displaced left femoral neck fracture.

On 11/15/2017, at 11:30 a.m. R105 verified she had recently broken her hip. R105 could not recall details but stated she had fallen.

On 11/15/2017, at 2:46 p.m. nursing assistant (NA)A indicated R105 had a hip fracture a month or two ago. NA-A indicated they had no idea how the fracture occurred, and stated one day she was fine, the next she had excruciating pain and she didn't know what happened.

On 11/15/2017, at 2:56 p.m. the CM-C indicated R105 did not have any incident reports on file and had not had a fall for nine months. CM-C indicated R105 was last hospitalized due to failure of the hip repair completed the previous year.

On 11/16/2017, at 9:33 a.m. NA-B verified R105 had recently broken her hip and was now back to her normal abilities. NA-B stated staff were not entirely sure how R105's broken hip occurred.

On 11/16/2017, at 11:25 a.m. licensed practical nurse (LPN)-H indicated R105 would at times attempt to self-transfer. LPN-H indicated R105 had been more confused around the time of her recent hip fracture. LPN-H indicated R105 did not fall when she broke her hip, but stated I don't think it was ever determined how it happened.

On 11/16/2017, at 2:40 p.m. CM-C indicated R105 did not have any falls, however; did have

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osteoporosis. With review of the computerized charting, CM-C verified R105 had pain on 9/23/17, was not aware why she had pain, and confirmed the record also indicated bruising to the left hip noted 9/28/17, which was colored yellow and green. CM-C indicated R105 had a history of seizures, strokes, had osteoporosis and was "acting peculiar." CM-C questioned if R105 possibly fractured her hip during a seizure.

On 11/16/2017, at 3:05 p.m. the DON reviewed R105's electronic chart and verified R105 presented with pain on the 23rd, and was confused. The DON indicated R105 possibly had a seizure resulting in the hip fracture. The DON stated she had not reported R105's hip fracture to the SA as she had nothing identifying that it was caused by abuse.

On 11/16/17, at 3:15 p.m. the administrator verified the facility staff discussed R105's hip fracture and did not feel it needed to be reported.

On 11/16/2017, at 3:34 p.m. the medical director was interviewed by phone. The medical director identified a person with a diagnosis of Osteoporosis would be at risk for hip fracture and stated he did not feel a VA report would be appropriate.

R163

R163's admission Minimum Data Set Assessment (MDS) dated 10/24/17, identified R163 had intact cognition and had diagnoses which included quadriplegia. The MDS listed R163 required total assistance with all activities of daily living (ADL's).

On 11/13/2017, at 11:36 a.m. R163 stated

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22000	Continued From page 30 approximately two weeks ago he had requested multiple times for nursing assistants to go slow during cares and to tell him what they were going to do with him. R163 stated staff did not honor this request and continued to quickly move his body causing him pain. R163 indicated he had informed his family of the incident. R163 further stated he believed the facility had removed these two nursing assistants from the schedule because they had not worked with him for a while. R163 stated one of the nursing assistants had worked with him again today and she did not slow down when moving him, causing pain and repeatedly stated she was sorry when he complained about her treatment but continued to cause pain. He stated he believed the apology to be self serving and the treatment was abuse. He stated he had not reported today's occurrence to anyone; however, planned to if it continued. On 11/13/2017, at 12:00 p.m. the director of nursing (DON) was notified of R163's current allegation of abuse by the nursing assistant. The DON indicated she was not aware of R163's past or present concerns of potential abuse. The DON indicated the family had requested a specific nursing assistant no longer work with R163, however had not given a reason and the request was honored. The DON indicated she and the clinical manager (CM)-A spoke with the family regarding personal cares, therapy and the request of one nursing assistant to no longer work with R163, however stated the family had not used the word abuse. On 11/14/2017, at 3:07 p.m. R163 indicated the DON had brought nursing assistant (NA-C) into R163's room. R163 indicated he was able to verify this was the nursing assistant that mistreated him.	22000		

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22000	Continued From page 31 On 11/15/2017, at 3:15 p.m. via telephone interview, FM-G stated two weeks ago on a Sunday, she had become aware of concerns and had then spoken with the social worker regarding R163's allegation of abuse. FM-G stated [R163] specifically stated there were two night staff that would move him too quickly causing him pain and they would disregard his wishes. FM-G stated she felt that if staff were told to slow down and don't, then it is abuse. On 11/15/2017, at 3:50 p.m. the DON verified NA-C was currently working independently with residents. The DON indicated she was working on the investigative report, and did not believe the allegation of abuse to be true. The DON indicated if the investigation proved NA-C had abused R163, she would have to be terminated but at this time there was no proof. On 11/16/2017, at 7:09 a.m. NA-C indicated on 11/13/17, the nurse manager had instructed her to no longer go into R163's room due to a report of abuse. NA-C she had worked independently with other residents on the unit until the morning of 11/16/17, when she been informed by the DON that she could no longer work alone with residents. On 11/16/2017, at 3:05 p.m. the DON verified she had spoken with R163 on 11/13/17, and the complaint was regarding staff moving him fast, and that it hurt him when they moved him. The DON stated she talked to staff and did not consider it abuse. On 11/16/2017, at 10:05 a.m. CM-A indicated she was not aware of any problems R163 had with the night nursing assistants. CM-A indicated	22000		

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22000	Continued From page 32 reports of abuse were reported to the DON who would submit a report to the SA and begin an investigation. CM-A indicated DON and the clinical managers were able to submit the reports to the SA and the administrator then followed up with the reports. CM-A indicated the social worker assisted with these reports but was not responsible for them. On 11/16/2017, at 12:29 p.m. the licensed social worker (LSW) identified she was not aware of a past abuse allegation for R163. The LSW indicated abuse allegations were the DON's responsibility and her role was to assist with gathering information and documenting as needed. On 11/16/2017, at 2:00 p.m. the administrator indicated she was not aware of the allegation regarding R163 . The administrator indicated concerns were immediately reported to the administrator or the DON who then informed the administrator. The administrator stated she felt the problem two weeks ago was not a vulnerable adult situation. The administrator indicated she felt the DON had handled the situation appropriately, she had no reason to believe it was abuse, and had educated staff at that time. Review of R163's computerized progress notes revealed an entry dated 11/7/17, which indicated a care conference was held per family member (FM)-G's request. The notes indicated nursing and social service staff participated in the call with the daughter regarding questions and concerns. The record did not identify what the family's questions or concerns were. R153	22000		

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R153's admission MDS dated 6/20/17, indicated R153 had diagnoses which included pelvic fracture and hypertension. The MDS identified R153 was cognitively intact and had no difficulty with understanding communication and ability to express, understand or hear information. R153 required extensive staff assistance for ADL's with the exception of eating.

Review of R153's SA draft incident form with a print date of 6/19/17, indicated on 6/17/17, at 5:30 p.m. R153 reported to the charge nurse that her wallet was missing from her purse. Review of the investigative report submitted to the SA on 6/22/17, indicated R153 reported her wallet was missing on 6/17/17, staff assisted R153 with a complete room search several times. R153 did not have any visitors since admission. R153 reported to staff her wallet was in her purse on Friday, 6/16/17 when she had written a receipt in her checkbook ledger, then put her wallet back in her purse. R153 was alert and orientated times three, and reported she had $120.00 in her wallet, a debit card and a credit card along with her social security card. Staff assisted R153 to cancel her debit and credit card, family was called, admitting hospital called to see if wallet was with them, it was not. Police were notified on 6/19/17 to report R153's missing wallet.

On 11/16/17, at 11:36 a.m. LPN-A indicated if a resident reported missing money staff were expected to report that to the nurse manager and director of nursing, call family and start searching for reported missing money. LPN-A verified if a resident reports missing money, the allegation would need to be reported to the SA within 24 hours.

On 11/16/17, at 3:04 p.m. CM-B stated staff were

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22000	Continued From page 34 expected to report allegations of missing money to the SA immediately, as soon as staff find out. CM-B verified 2 days after the report of missing money would be too late. On 11/17/17, at 10:48 a.m. DON confirmed R153 reported her wallet and money missing on 6/17/17. The DON stated R153 reported the allegation on 6/17/17 during the weekend. The DON verified she was not made aware of the situation until Monday, 6/19/19, and at that time she reported the allegation to the SA and the police on 6/19/17, and staff continued to look for the wallet. On 11/17/17, at 10:49 a.m. the administrator verified she was not updated on R153's allegation immediately, nor was an incident report filed to the SA immediately. The administrator stated she believed that kind of stuff happens, the resdient had just been admitted to the facility and staff thought maybe R153 had misplaced the wallet. The administrator stated once administration determined the wallet was lost, on Monday 6/19/17, they reported the incident to the SA and contacted police at that time. The administrator stated administration reported the incident immediately when they "deemed" it was misappropriation of resident property, because that is when we decided it was missing and we could not find the wallet and missing money. SUGGESTED METHOD OF CORRECTION: The administrator could review and update the facility's current abuse prohibition policy to include immediately reporting suspected/alleged abuse, neglect, and injuries of unknown origin to the designated state agency/common entry point. In addition, the adminimistrator or designee could	22000		

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22000	Continued From page 35 educate all staff on revised abuse prohibition policy. The administrator or designee could perform audits using incident reports to ensure staff are following the abuse prohibition policy. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	22000		

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Knute Nelson Memorial Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/15/2017

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

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

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K 000	Continued From page 2 sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 93 beds and had a census of 77 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms	K 321		12/31/17

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K 321	Continued From page 3 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one hazardous storage room and one combustible storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for the 77 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 11/15/2017,observations and staff interview revealed: 1) A combustible storage room in the dining room without the proper requirements for the room made of dividers. 2) A storage room constructed with plywood used for the walls on the otherside of the kitchen. This deficient condition was confirmed by the Environmental Services Supervisor.	K 321	K 321 NFPA 101 - 2012 Edition Life Safety Code Standard Section 19.3.6.3.1 Hazardous Areas - Enclosures We will have a licensed contractor remove the particle board wall and install sheetrock, tape, mud and paint to provide the 1 hour fire rating as required. We will also have a new door installed that is a 3/4 hour rated fire barrier. This is the Housekeeping supply room that has an inside room of more supplies. The wall and door that separates them is the area of where the work will be performed. It has the proper sprinkler system that was installed originally. In doing this work, it should minimize fire or smoke entering into the corridor for passage of residents, visitors and staff to exit in the event of an emergency. Completion Date: To be completed December of 2017 Responsible Person: Thomas Storer - Lead Maintenance	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in	K 345		11/16/17

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K 345	Continued From page 4 accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. The deficient practice could affect 77 out of 77 residents. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25. Findings include: On facility tour between 8:00 AM and 12:00 PM on 11/15/2017, documentation reviewed revealed there were discrepancies in the amount of Manual Fire Alarm Boxes, Photo detectors, Duct detectors, Heat Detectors and Supervisory Switches from the Fire alarm report 2016 to the	K 345	K 345 NFPA 70, NFPA 72 section 9.7.5, 9.7.7, 9.7.8 and NFPA 25 Fire Alarm System □ Testing and Maintenance The Fire Alarm System testing and maintenance in compliance with NFPA 70 and NFPA 72. Summit Companies who does our Fire Panel inspection was notified about a discrepancy in 2 reports from 2016 and 2017 of the total number of devices. The devices were Manual Fire Alarm boxes, Photo detectors, Heat detectors and Supervisory switches. On 11/16/17 Summit Companies sent out Greg Sorell to verify on the total number of devices. Summit Companies sent an email report in December and Knute submitted the report to the Deputy State Fire Marshal. The document will be placed into the Life Safety Code book. Completion Date: Re-inspection was 11/16/17 with the follow up report in December 2017	

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K 345	Continued From page 5 current 2017. This deficient condition was confirmed by the Environmental Services Supervisor.	K 345	Responsible Person: Thomas Storer - Lead Maintenance	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 77 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 11/15/2017 record review and staff interview	K 712	K 712 NFPA 101 □ 2012 Edition Life Safety Code Standard Section 19.7.1.4 to 19.7.1.7 Fire Drills With each Fire Drill that is performed at Knute Nelson, all staff that are involved will sign a sign-in sheet. The sign-in sheet will be submitted to the Lead Maintenance person who will place the documentation into the Life Safety Code book. Completion Date: Starting in December 2017	12/1/17

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K 712	Continued From page 6 revealed the fire drill sheets were not filled out with all of the required information for the last 12 months. This deficient condition was confirmed by the Environmental Services Supervisor.	K 712	Responsible Person: John Hew Len □ Lead Maintenance	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all residents. Findings include: During documentation review between 8:00 AM and 12:00 PM on 11/15/2017, documentation review and staff interview revealed the required risk assessment NFPA 99 had not been started at the time of the survey.	K 901	K901 NFPA 99 - 2012 Edition Chapter 4 sections 1 - 4 Fundamentals □ Building System Categories The risk assessment in chapter 4 sections 1 □ 4 that apply to the Environmental Services staff not having been trained in Medical gas equipment. All Environmental Services personnel shall participate in the annual training of the proper technique of handling Medical Gas equipment if in the event of an urgent circumstance and they are asked to assist nursing staff. This will be an In-service performed by the Director of Nursing or designated agent on an	12/20/17

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K 901	Continued From page 7 This deficient condition was confirmed by the Environmental Services Supervisor.	K 901	annual basis. There will be a sign in sheet of participants and kept by the Director of Nursing. A copy will also be placed into the Life Safety Code book. Date Completed: December 20, 2017 Responsible Person: John Hew Len - Lead Maintenance	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		11/16/17

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K 918	Continued From page 8 readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems. This deficient practice could affect the safety of all 77 patients and an undetermined amount of staff and visitors if the generator failed to operate during a power outage. Findings include: On the facility tour between 8:00 am to 12:00 pm on 11/15/2017 record review and staff interview revealed the monthly generator log was not completed from July 2017- November 2017. This deficient condition was confirmed by the Environmental Services Supervisor.	K 918	K918 NFPA 101 - 2012 Edition Life Safety Code section 9.1.3.1 and NFPA 110 Electrical Systems □ Essential Electrical System Maintenance and Testing The Life Safety Code book did not have the Monthly Generator log inspection report from July 2017 through November 2017. The folder of field reports was misplaced at the time of inspection that contained the recorded information, the folder was found after the surveyor exited. The inspection report information was then transferred into the Life Safety Code book from July 2017 to the current date of December 2017. Date Completed: November 16, 2017 Responsible Person: John Hew Len - Lead Maintenance	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment	K 920		11/16/17

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K 920	Continued From page 9 (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a multiple outlet connection was in accordance with the 2012 edition of NFPA 99 section 10.2.3.6 item 2 for total ampacity. This deficient practice could cause an overload of a circuit which could cause a power outage to necessary equipment or cause a fire. This could affect an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am and 12:00pm on 11/15/2017, observations and staff interview revealed: 1) In room 604 a refrigerator was plugged into the wall with an extension cord.	K 920	K920 NFPA 101 □ 2012 Edition Life Safety Code of NFPA 99 section 10.2.3.6 item 2 Power and Extension Cords To avoid an overload of a circuit which could cause a power outage or fire the Maintenance personnel will correct all appliances that are plugged into powerstrips or extension cords. 1. In Room 604 a refrigerator was plugged into an extension cord. Maintenance plugged the refrigerator directly into an electrical outlet. 2. In room 506 a refrigerator was plugged into a powerstrip. Maintenance plugged the refrigerator directly into an electrical outlet. 3. In the Activity room a microwave was	

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K 920	Continued From page 10 2) In room 506 a refrigerator was plugged into a powerstrip. 3) In the activity room a microwave was plugged into a powerstrip. 4) In the Life Enhancement Office a refrigerator was plugged into a powerstrip. This deficient condition was confirmed by the Environmental Services Supervisor.	K 920	plugged into a powerstrip. Maintenance plugged the microwave directly into an electrical outlet. 4. In the Life Enhancement office a refrigerator was plugged into a powerstrip. Maintenance plugged the refrigerator directly into and electrical outlet. Date Completed: November 2017 Responsible Person: John Hew Len - Lead Maintenance	