CENTERS FOR MEDICARE & MEDICAID SERVICES

WEDICARE/WEDICAID CERTIFICATION AND TRANSMITT	AL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGE	NCY

ID: O9DB Facility ID: 00113

MEDICARE/MEDICAID PROVIDER (L1)		3. NAME AND AD (L3) KNUTE NEI (L4) 420 12TH AV (L5) ALEXANDR 7. PROVIDER/SUI 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	LSON VENUE EAST RIA, MN		(L6) 56308 02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	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 FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	93 (L18) 93 (L17)	Compliance1.	Requirements ce Based On:	1	And/Or Approved Waivers Of Th 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
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 93 (L37) (L38) 16. STATE SURVEY AGENCY REMARKATION	19 SNF (L39)	ICF (L42)	IID (L43)		* Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
17. SURVEYOR SIGNATURE Gail Anderson, Unit Supe	ervisor	Date :	01/11/2018		18. STATE SURVEY AGENCY A	0.4.4.0.4.0.4.0
-	71 11001		01/11/2010	(L19)	<u>Joanne Simon, Enforce</u>	ement Specialist 01/18/2018
		E COMPLETED		(L19) EGIONAI	,	(L20
	ART II - TO BE	20. COM		EGIONAI	L OFFICE OR SINGLE ST 21. 1. Statement of Finar	ATE AGENCY cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)
P 19. DETERMINATION OF ELIGIBILIT _X 1. Facility is Eligible to Pa	Y urticipate (L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATI	20. COM RIG	BY HCFA RI	EGIONAI CIVIL	21. 1. Statement of Finar 2. Ownership/Contro	(L20 ATE AGENCY ncial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) (L30) INVOLUNTARY 05-Fail to Meet Health/Safety one of the state of the
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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



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

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ARE/MEDICAL - TO BE COMPI							: O9DB cility ID: 0011	3
1. MEDICARE/MEDICAID PROVIDE (L1) 245435 2.STATE VENDOR OR MEDICAID NO (L2) 178540100 5. EFFECTIVE DATE CHANGE OF CO (L9)	ER NO.	3. NAME AND ADI (L3) KNUTE NEL (L4) 420 12TH AV (L5) ALEXANDR 7. PROVIDER/SUP 01 Hospital	DRESS OF FACIL SON ENUE EAST IA, MN	ITY		56308	1. Initi 3. Teri 5. Vali 7. On-5	E OF ACTION:	2 (L8) 2. Recertific 4. CHOW 6. Complain 9. Other	ation
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12.Total Facility Beds 13.Total Certified Beds	93 (L18) 93 (L17)	X B. Not in Com	•			ife Safety Code **B**	_	Beds/Room		
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 93 (L37) (L38)		ICF (L42)	IID (L43)		15. FACILITY	Y MEETS or 1861 (j) (1):		(L15)		
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICABL	E SHOW LTC CANCE	LLATION DATE)	:						
17. SURVEYOR SIGNATURE		Date :			18. STATE SU	URVEY AGENCY	APPROVAL		Date:	
Beth Nowling, HFE - NE	Ξ ΙΙ	1	2/20/2017	(L19)	Joanne S	imon, Enforc	ement Spe	cialist	01/09	/2018 _(L2)
	PART II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	OFFICE O	R SINGLE ST	TATE AGE	NCY		
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25. LTC EXTENSION DATE:	27. ALTERNATIV A. Suspension		(L23)			oluntary Termination	n	OTHER 07-Provider S 00-Active		
(L27)	B. Rescind Sus	pension Date:	(L45)							
28. TERMINATION DATE:	29	INTERMEDIARY/C	ARRIER NO.		30. REMARKS	3				

(L31)

(L33)

DETERMINATION APPROVAL

03001

32. DETERMINATION OF APPROVAL DATE

(L28)

(L32)

31. RO RECEIPT OF CMS-1539



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:

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

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

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

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

Knute Nelson December 6, 2017 Page 2

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

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

DEPARTMENT CONTACT

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

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

Knute Nelson December 6, 2017 Page 5

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 Knute Nelson December 6, 2017 Page 6

> 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

PRINTED: 12/20/2017 FORM APPROVED OMB NO. 0938-0391

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.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY IPLETED
STREET ADDRESS, CITY, STATE, ZIP CODE			245435	B. WING			
PREFIX TAG EACH DEPICIENCY WINST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG					420 12TH AVENUE EAST	1 11/	11/2017
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 225 INVESTIGATE/REPORT SS=D 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, misraprropriation 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	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
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body as a result of a finding of abuse, neglect, LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		(3) Not employ or o who- (i) Have been found exploitation, misappristreatment by a complete to the complete t	d guilty of abuse, neglect, propriation of property, or court of law; sing entered into the State concerning abuse, neglect, atment of residents or their property; or hary action in effect against his license by a state licensure a finding of abuse, neglect,				

Electronically Signed 12/14/2017

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.

-	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		COM	E SURVEY PLETED
		245435	B. WING				C 17/2017
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COF	ER'S PLAN OF CORRECTIC RRECTIVE ACTION SHOUL ERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	exploitation, mistrea misappropriation of (4) Report to the St licensing authorities actions by a court of which would indicat nurse aide or other (c) In response to a exploitation, or mist of the state of the exploitation of the state of the state of the administrator of the administrator of officials (including the adm	atment of residents or resident property. ate nurse aide registry or any knowledge it has of any knowledge it has of all investigations or service as a facility staff. Illegations of abuse, neglect, reatment, the facility must: Illeged violations involving alloitation or mistreatment, unknown source and resident property, are ally, but not later than 2 hours is made, if the events that an involve abuse or result in any or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other to the State Survey Agency and vices where state law provides and the law through established that all alleged violations are atted. Cotential abuse, neglect, areatment while the rogress. Its of all investigations to the		25			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245435	B. WING			C 17/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 225	representative and with State law, inclu Agency, within 5 wo if the alleged violatic corrective action m This REQUIREMEI by: Based on interview facility failed to immadministrator and for the State agency investigate, for 1 of of unknown source to report to SA with investigate for 1 of had knowledge of source (hip fracture to immediately report to the SA with abuse, and failed to investigating a second 1 resident (R163)w Further, the facility administrator and tiallegation of misapproperty for 1 of 3 mabuse prohibition. Findings include: R105 R105's significant of identified R105 had cognition, a diagnose extensive assistant toilet and personal	to other officials in accordance uding to the State Survey orking days of the incident, and on is verified appropriate	F2	F 000 Preparation and exemplan of correction in no way admission or agreement by of the truth of the facts alleg statement of deficiency and correction is submitted exclusion reserves the right to legal proceedings, all deficiency and statements, findings, facts a conclusions that form the bestated deficiency. This plan serves as the allegation of a This statement of deficiency taken to Knute Nelson as Committee. We are in full compliance a 20, 2017 and respectfully review in lieu of a post surveriew in lieu of a post surveriew in lieu of a post surveriew in an environment that alleged violations involving neglect, exploitation or mist including injuries of unknown misappropriation of resident what corrective action(s) waccomplished for those residents.	r constitutes and r Knute Nelson ged in this diplan of lusively to ral law. Knute of challenge in encies, and reasis of the of correction compliance. The compliance of the provement as of December equest a desk rey revisit. ORT ALS delson to in a manner is free from abuse, treatment, we source and at property. Fill be	

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 pain9/23/17, in the evening, had continued pain, anxiousness and difficulty speaking and no memory recall of the previous night9/28/17, 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,	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		SURVEY				
STREET ADDRESS, CITY, STATE, ZIP CODE			245435	B. WING			
ALEXANDRIA, MN 56308 SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION CONSTRUCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	NAME OF I	PROVIDER OR SUPPLIER	ı		STREET ADDRESS. CITY. STATE. ZIP CODE	11/1	7/2017
XALEXANDRIA, MN 56308 XIJIMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG PROVIDER'S PLAN OF CORRECTION SCOMLETING (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 225 Continued From page 3 not walk. P 225 Deen found affected by the deficient practice? PRESIDENT TAG P	_						
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 225 Continued From page 3 not walk. R 105'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. -9/28/17, 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,	KNUTE N	NELSON					
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,	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETION
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 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	F 225	not walk. R105's current car included various protential for injury in CVA (cerebrovascus hemiplegia, use of poor safety awaren potential for injury in being abused by of Review of R105's protential for injury in being abused by of Review of R105's protential for injury in being abused by of Review of R105's protential for injury in being abused by of Review of R105's protential for injury in being abused by of Review of R105's protential for injury in being abused by of Review of R105's protential for injury in the even anxiousness and domemory recall of the result of the review of R105 left measured 1.24 cm in color with patched the left anterior thing the medial thing with moderate/severe protein the result of the review of R105's under the knowledge reported to the SA.	re plan reviewed 10/20/17, roblems which included the related to dementia, related to ular accident) with right side psychotropic medications, less, visual field cut, the related to falls, and a risk for ther individuals. Progress notes from 9/22/17 to the following: Is hollering out, anxious, anable to speak clearly. When heally, R105 complained of left ening, had continued pain, ifficulty speaking and no he previous night. In anterior thigh bruise which (centimeter) by 10 cm, yellow es of purple/green located on the scant edema, ain noted. Left lateral thigh 5 cm by 19 cm, light yellow in the scant edema, ain noted. Left lateral thigh 5 cm by 19 cm, light yellow in the scenter, and 1 plus edema te/severe pain. The related to dementia, related the scant edema and the scant edema and the scant edema and the scant edema are severe pain. The related to dementia, related the scant edema and th	F 225	been found affected by the deficied practice? Residents 105, 163 and 153 suffer adverse effects as a result of this Resident 105 was interviewed by Director of Nursing and resident as she has never felt abused, nor was hip fracture caused by anyone. Resident stated he diffeel abused by any of the staff, he at the community. No corrective a could be made for Resident 153 seresident was discharged from the How will you identify other resident having the potential to be affected same deficient practice and what correction actions will be taken? All residents have the potential to affected by the alleged deficient practiced by the of Nursing and designees to assume other residents were affected. What measures will be put into ple what systematic changes will you ensure that the deficient practice recur? The community has a policy regard abuse prohibition and immediated reporting suspected/alleged abus neglect, and injuries of unknown of the designated state agency/comentry point. Re-Education has be conducted by the Administrator of Tuesday, December 19, 2017, on immediate reporting for all care costaff. Staff will be educated during	ered no practice. the stated as her esident tor of d not e felt safe actions since the facility. Its d by the be practice. Director are that No other ace or make to does not rding y e, origin to mone en enter e	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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		245435	B. WING			11/1	17/2017
NAME OF F	PROVIDER OR SUPPLIER			4:	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	left hip pain, last Satheir mother they no strange. She was a nursing home staff seizure. Since last sheen having trouble and with transferrin spasms and hip paright femoral neck farthroplasty (surgic also has a history of sided hemiparesis. displaced left femoral neck farthroplasty (surgic also has a history of sided hemiparesis. displaced left femoral neck farthroplasty (surgic also has a history of sided hemiparesis. displaced left femoral neck farthroplasty (surgic also has a history of sided hemiparesis. displaced left femoral neck farthroplasty (surgic also has a history of sided hemiparesis. On 11/15/2017, at (NA)A indicated R105 at R105 did not have shad not had a fall for indicated R105 was failure of the hip repyear. On 11/16/2017, at had recently broker her normal abilities entirely sure how R	the following: Chief complaint: aturday when daughters visited officed that she was acting ppearing to have spasms. The thought she was having a Saturday 9/23/17, she had with moving in a wheel chair g she appears to be having in. She does have a history of racture (hip) with hemi-hip al joint repair) last year. She f a stroke with complete right. The X-ray identified a ral neck fracture. 11:30 a.m. R105 verified she her hip. R105 could not recall he had fallen. 2:46 p.m. nursing assistant 105 had a hip fracture a month dicated they had no idea how ed, and stated one day she he had excruciating pain and	F 2	225	yearly with an abuse prohibition in- How will the corrective action(s) be monitored to ensure the deficient p will not recur? Audits will be conducted on all incic reports by the Administrator or desi to monitor timeliness of reporting a allegations are correct. Results will brought to the Quality Assurance Performance Improvement commit further recommendations. Completion date: December 20, 2017	ractice dent gnee nd the be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED	
		245435	B. WING _			C / 17/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	attempt to self-transhad been more conrecent hip fracture. not fall when she brithink it was ever de On 11/16/2017, at R105 did not have a osteoporosis. With charting, CM-C veri 9/23/17, was not award confirmed the recort he left hip noted 9/2 yellow and green. On 11/16/2017, at R105's electronic of presented with pain confused. The DON a seizure resulting is stated she had not the SA as she had not the SA as she had not the SA as she had not caused by abuse. On 11/16/2017, at 3.1 verified the facility of fracture and did not On 11/16/2017, at 3.3 verified a person of Osteoporosis would stated she person of the person of th	cated R105 would at times afer. LPN-H indicated R105 fused around the time of her LPN-H indicated R105 did toke her hip, but stated I don't termined how it happened. 2:40 p.m. CM-C indicated any falls, however; did have review of the computerized fied R105 had pain on ware why she had pain, and also indicated bruising to 28/17, which was colored CM-C indicated R105 had a strokes, had osteoporosis and r." CM-C questioned if R105 for hip during a seizure. 3:05 p.m. the DON reviewed that and verified R105 for the 23rd, and was a indicated R105 possibly had in the hip fracture. The DON reported R105's hip fracture to nothing identifying that it was as 5 p.m. the administrator staff discussed R105's hip feel it needed to be reported.	F 2	25		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED	
		245435	B. WING				C 17/2017
NAME OF F	PROVIDER OR SUPPLIER			420	REET ADDRESS, CITY, STATE, ZIP CODE D 12TH AVENUE EAST EXANDRIA, MN 56308	117	11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	R163's admission Massessment (MDS) R163 had intact cogwhich included qua R163 required total daily living (ADL's). On 11/13/2017, at 1 approximately two multiple times for not during cares and to to do with him. R16 this request and cobody causing him prinformed his family stated he believed to two nursing assistate because they had rR163 stated one of worked with him agdown when moving repeatedly stated should be self serving and stated he had not reanyone; however, promote the self serving and stated he had not reanyone; however, promote the self serving and stated he had not reanyone; however, promote the self serving and stated he had not reanyone; however, promote the self serving and stated he had not reanyone; however, promote the self serving and stated he had not reanyone; however, promote the self serving and stated he had not reanyone; however, promote the self serving and stated the family nursing assistant not however had not girls.			225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245435	B. WING				C 17/2017
NAME OF F	PROVIDER OR SUPPLIER		,	42	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	regarding personal request of one nur work with R163, he not used the word. On 11/14/2017, at DON had brought R163's room. R16 verify this was the mistreated him. On 11/15/2017, at interview, FM-G st Sunday, she had be had then spoken wR163's allegation of specifically stated would move him to they would disregated that if staff wer then it is abuse. On 11/15/2017, at NA-C was currently residents. The DO on the investigation R163, she would him there was no On 11/16/2017, at 11/13/17, the nurse to no longer go into of abuse. NA-C she with other resident of 11/16/17, when	CM)-A spoke with the family I cares, therapy and the sing assistant to no longer owever stated the family had abuse. 3:07 p.m. R163 indicated the nursing assistant (NA-C) into 3 indicated he was able to nursing assistant that 3:15 p.m. via telephone ated two weeks ago on a recome aware of concerns and with the social worker regarding of abuse. FM-G stated [R163] there were two night staff that so quickly causing him pain and and his wishes. FM-G stated she told to slow down and don't, 3:50 p.m. the DON verified y working independently with N indicated she was working a report, and did not believe the to be true. The DON indicated proved NA-C had abused ave to be terminated but at this	F 2	225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		TE SURVEY MPLETED	
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F 225	had spoken with Ricomplaint was regarding R163. T concerns were immadministrator. The the problem two we adult situation. The felt the DON had his complaint was not aware of a the night nursing as reports of abuse would submit a repinvestigation. CM-Aclinical managers would submit a reports. CM assisted with these responsible for the concerns with the reports all the concerns were immadministrator or the administrator. The the problem two we adult situation. The felt the DON had here	3:05 p.m. the DON verified she 163 on 11/13/17, and the arding staff moving him fast, when they moved him. The ked to staff and did not 10:05 a.m. CM-A indicated she my problems R163 had with esistants. CM-A indicated were reported to the DON who ort to the SA and begin an a indicated DON and the were able to submit the reports dministrator then followed up M-A indicated the social worker reports but was not	F 22	5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245435	B. WING				C 17/2017
NAME OF F	PROVIDER OR SUPPLIER			420	REET ADDRESS, CITY, STATE, ZIP CODE 12TH AVENUE EAST EXANDRIA, MN 56308	<u>, 11/</u>	11/2017
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F 225	abuse, and had edu Review of R163's c revealed an entry d a care conference v (FM)-G's request. T and social service s with the daughter re	omputerized progress notes ated 11/7/17, which indicated was held per family member the notes indicated nursing staff participated in the call egarding questions and rd did not identify what the	F 2	225			
	R153 had diagnose fracture and hyperter R153 was cognitive with understanding express, understan required extensives the exception of ear Review of R153's Sprint date of 6/19/17 p.m. R153 reported wallet was missing investigative report 6/22/17, indicated Fmissing on 6/17/17 complete room sea not have any visitor reported to staff her Friday, 6/16/17 when her checkbook ledgher purse. R153 with the R153 was a cognitive and hyperter	MDS dated 6/20/17, indicated as which included pelvic ension. The MDS identified by intact and had no difficulty communication and ability to dor hear information. R153 staff assistance for ADL's with ting. A draft incident form with a 7, indicated on 6/17/17, at 5:30 to the charge nurse that her from her purse. Review of the submitted to the SA on R153 reported her wallet was a staff assisted R153 with a rch several times. R153 did as since admission. R153 rewallet was in her purse on an she had written a receipt in the put her wallet back in as alert and orientated times she had \$120.00 in her wallet,					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG	` '	COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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F 225	social security card cancel her debit and called, admitting he was with them, it we 6/19/17 to report R. On 11/16/17, at 11: resident reported mexpected to report director of nursing, for reported missing resident reports mis would need to be rehours. On 11/16/17, at 3:0 expected to report to the SA immediat CM-B verified 2 day money would be to the SA immediat CM-B verified 2 day money would be to 11/17/17, at 10: reported her wallet 6/17/17. The DON allegation on 6/17/10 DON verified she we situation until Money she reported the all police on 6/19/17, at the wallet.	credit card along with her I. Staff assisted R153 to d credit card, family was espital called to see if wallet as not. Police were notified on 153's missing wallet. 36 a.m. LPN-A indicated if a missing money staff were that to the nurse manager and call family and start searching g money. LPN-A verified if a essing money, the allegation eported to the SA within 24 4 p.m. CM-B stated staff were allegations of missing money ely, as soon as staff find out. ys after the report of missing	F 22	25			
	verified she was no immediately, nor w the SA immediately believed that kind of had just been admi	at updated on R153's allegation as an incident report filed to the administrator stated she of stuff happens, the resdient tted to the facility and staff and misplaced the wallet.					

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F 225	The administrator sidetermined the wall 6/19/17, they report contacted police at stated administratic immediately when the misappropriation of that is when we decould not find the was Review of the facility Abuse/Neglect Previndicated all injuries from accident/incide immediately to the sinjury is discovered suspected violation incidents of abuse to the SA. In addition of suspected resides source to be reported immediately and the amember of manafalleged incident. Fur residents shall be provestigation and erparticipating in the ammediately reassignivolve resident correviewed by the administration of reviewed by the administration of the resident corrections of the same distribution of the same distribution and erparticipating in the ammediately reassignivolve resident corrections.	tated once administration let was lost, on Monday led the incident to the SA and that time. The administrator on reported the incident hey "deemed" it was resident property, because cided it was missing and we rallet and missing money. By's Vulnerable Adult vention policy, revised 9/1/16, of unknown cause or injuries ent must be reported state agency at the time the and all substantiated would be immediately reported on, the policy directed incidents ent abuse, or injury of unknowned to the administrator endministrator would appoint gement to investigate the arther, the policy directed wordered from harm during an employees accused of alleged abuse would be gned to duties that do not entact or would be suspended the investigation had been ministrator. If the employee non-resident care duties, the not be in any part of the	F 2				12/20/17
SS=D	POLICIES	1)-(3), 483.95(c)(1)-(3)	1 2				12/20/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED			
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F 226	(1) Prohibit and pre exploitation of resident property, (2) Establish policies investigate any successigate any succession and successigate any succession and successigate any succession and su	t develop and implement procedures that: event abuse, neglect, and lents and misappropriation of es and procedures to h allegations, and as required at paragraph and exploitation. In addition to buse, neglect, and exploitation es3.12, facilities must also heir staff that at a minimum is constitute abuse, neglect, isappropriation of resident	F 2	F 226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLING It is the practice of Knute Nelson promote care for residents in a and in an environment that is falleged violations involving abu	ICIES on to a manner ree from		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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				420 12TH AVENUE EAST		
KNUTE N	IELSON			ALEXANDRIA, MN 56308		
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F 226	Continued From pa	ige 13	F 226	3		
F 226	failed to implement protection of reside allegations of abus immediately report report to the SA, ar of resident property. Findings include: Review of the facility Abuse/Neglect Preindicated all injuries from accident/incid immediately to the injury is discovered suspected violation incidents of abuse to the SA. In addition incidents of abuse to the injury is discovered abuse to the injury is disco	abuse prohibition policies for ents during the investigation of e. Further, the facility failed to to the adminstrator, timely a allegation of misappropriation	F 226	neglect, exploitation or mistrea including injuries of unknown somisappropriation of resident properties accomplished for those reside been found affected by the definition practice? Residents 105, 163 and 153 stadverse effects as a result of the Resident 105 was interviewed Director of Nursing and resides she has never felt abused, nor hip fracture caused by anyone 163 was interviewed by the Director of Nursing and resident stated here is a substantial to the staff at the community. No corrective could be made for Resident 15 resident was discharged from How will you identify other resident was discharged from How will you identify other resident was discharged from How will you identify other resident affected by the alleged deficient interviews were conducted by of Nursing and designees to a no other residents were affected on the concerns were identified. What measures will be put into what systematic changes will yensure that the deficient practice recur? The community has a policy resident interviews and the process of the community has a policy resident practice.	ource and operty. The operty.	
	identified R105 had	change MDS dated 10/10/17, I moderately impaired sis of hemiplegia and required		abuse prohibition and immedia reporting suspected/alleged at neglect, and injuries of unknow the designated state agency/co entry point. The Administrator	ouse, vn origin to ommon	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245435	B. WING				C 1 7/2017
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308				,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	toilet and personal assistance with trannot walk. R105's current carrincluded various propotential for injury r CVA (cerebrovascuhemiplegia, use of poor safety awaren potential for injury r being abused by other potential of the potential for injury r being abused by other potential of the potential for injury r being abused by other potential of the potential for injury r being abused by other potential of the potential for injury r being abused by other potential of the potential for injury r being abused by other potential of the potential for injury r being abused by other potential for injury	e for bed mobility, dressing, care, and required total affers and locomotion, but did be plan reviewed 10/20/17, oblems which included the elated to dementia, related to lar accident) with right side osychotropic medications, ess, visual field cut, the elated to falls, and a risk for her individuals. rogress notes from 9/22/17 to be following: Inhollering out, anxious, anable to speak clearly. When ally, R105 complained of left on the previous night, anterior thigh bruise which (centimeter) by 10 cm, yellow in sof purple/green located on the scant edema, an noted. Left lateral thigh ocm by 19 cm, light yellow in rple center, and 1 plus edema	F 2	26	and updated the facilities policy. Re-Education has been conducted care center staff by the Administrat Tuesday, December 19, 2017, on trevised abuse prohibition policy. St be educated during orientation and also be educated yearly with an abprohibition in-service. How will the corrective action(s) be monitored to ensure the deficient pwill not recur? Audits will be conducted on all incide reports by the Administrator or desito monitor that staff are following the abuse prohibition policy. Results with brought to the Quality Assurance Performance Improvement commit further recommendations. Completion date: December 20, 2017	or on he aff will will use ractice dent ignee he ill be	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245435	B. WING _		11	C / 17/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		71172017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 226	9/30/17, identified the left hip pain, last Satheir mother they not strange. She was a nursing home staff seizure. Since last been having trouble and with transferring spasms and hip paright femoral neck that arthroplasty (surgicalso has a history sided hemiparesis, displaced left femoor on 11/15/2017, at had recently broker details but stated so two ago. NA-A in the fracture occurre was fine, the next she didn't know who on 11/15/2017, at R105 did not have had not had a fall foindicated R105 was failure of the hip religear.	ital record with admit date he following: Chief complaint: aturday when daughters visited oticed that she was acting appearing to have spasms. The thought she was having a Saturday 9/23/17, she had e with moving in a wheel chair g she appears to be having in. She does have a history of fracture (hip) with hemi-hip hal joint repair) last year. She of a stroke with complete right. The X-ray identified a ral neck fracture. 11:30 a.m. R105 verified she her hip. R105 could not recall he had fallen. 2:46 p.m. nursing assistant 105 had a hip fracture a month adicated they had no idea how ed, and stated one day she she had excruciating pain and		26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245435	B. WING		11	C / 17/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	entirely sure how R On 11/16/2017, at nurse (LPN)-H indicattempt to self-transhad been more correcent hip fracture. not fall when she bithink it was ever de On 11/16/2017, at R105 did not have osteoporosis. With charting, CM-C ver 9/23/17, was not avconfirmed the recorthe left hip noted 9/yellow and green. Ohistory of seizures, was "acting peculiar possibly fractured hor 11/16/2017, at R105's electronic corresented with pair confused. The DON a seizure resulting stated she had not the SA as she had caused by abuse. On 11/16/17, at 3:1 verified the facility of fracture and did not on 11/16/2017, at 3:1 verified the facility of seizure and did not on 11/16/2017, at 3:1 verified the facility of fracture and did not on 11/16/2017, at 3:1 verified a person of the seizure and did not on 11/16/2017, at 3:1 verified a person of the seizure and did not on 11/16/2017, at 3:1 verified a person of the seizure and did not on 11/16/2017, at 3:1 verified a person of the seizure and did not on 11/16/2017, at 3:1 verified a person of the seizure and did not on 11/16/2017, at 3:1 verified a person of the seizure and did not on 11/16/2017, at 3:1 verified a person of the seizure and did not on 11/16/2017, at 3:1 verified a person of the seizure and did not on 11/16/2017, at 3:1 verified a person of the seizure and did not on 11/16/2017, at 3:1 verified a person of the seizure and did not on 11/16/2017, at 3:1 verified a person of the seizure and did not on 11/16/2017, at 3:1 verified a person of the seizure and did not on 11/16/2017, at 3:1 verified a person of the seizure and did not on 11/16/2017, at 3:1 verified a person of the seizure and did not on 11/16/2017 and 11/16/20	105's broken hip occurred. 11:25 a.m. licensed practical cated R105 would at times sfer. LPN-H indicated R105 if used around the time of her LPN-H indicated R105 did roke her hip, but stated I don't termined how it happened. 2:40 p.m. CM-C indicated any falls, however; did have review of the computerized iffed R105 had pain on ware why she had pain, and rod also indicated bruising to 28/17, which was colored CM-C indicated R105 had a strokes, had osteoporosis and r." CM-C questioned if R105 her hip during a seizure. 3:05 p.m. the DON reviewed hart and verified R105 had in the hip fracture. The DON reported R105's hip fracture to nothing identifying that it was 5 p.m. the administrator staff discussed R105's hip if feel it needed to be reported.	F 22	6		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245435	B. WING			C 11/17/2017	
NAME OF F	PROVIDER OR SUPPLIER			4:	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST ALEXANDRIA, MN 56308	<u> 11/</u>	17/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	stated he did not fe appropriate. R163 R163's admission Massessment (MDS) R163 had intact cogwhich included quared total daily living (ADL's). On 11/13/2017, at 1 approximately two multiple times for not during cares and to to do with him. R16 this request and cobody causing him prinformed his family stated he believed to two nursing assistated because they had reference they had referen	el a VA report would be	F2	226	DEFICIENCY)		
	allegation of abuse DON indicated she or present concerns	by the nursing assistant. The was not aware of R163's past of potential abuse. The DON had requested a specific					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245435	B. WING _		11	C / 17/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	nursing assistant no however had not gi was honored. The clinical manager (C regarding personal request of one nurs work with R163, ho not used the word at On 11/14/2017, at C DON had brought rR163's room. R163 verify this was the mistreated him. On 11/15/2017, at C interview, FM-G sta Sunday, she had be had then spoken wR163's allegation of specifically stated the would move him to they would disregal felt that if staff were then it is abuse. On 11/15/2017, at NA-C was currently residents. The DON on the investigation R163, she would had time there was no properties on longer go into the longer go in the lon	o longer work with R163, ven a reason and the request DON indicated she and the EM)-A spoke with the family cares, therapy and the sing assistant to no longer wever stated the family had abuse. 3:07 p.m. R163 indicated the nursing assistant (NA-C) into 3 indicated he was able to nursing assistant that 3:15 p.m. via telephone ated two weeks ago on a ecome aware of concerns and ith the social worker regarding f abuse. FM-G stated [R163] here were two night staff that o quickly causing him pain and red his wishes. FM-G stated she at told to slow down and don't, 3:50 p.m. the DON verified of working independently with N indicated she was working a report, and did not believe the to be true. The DON indicated broved NA-C had abused ave to be terminated but at this				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245435	B. WING		11	C / 17/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		71172017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	with other residents of 11/16/17, when set that she could no loresidents. On 11/16/2017, at 3 had spoken with Ricomplaint was regarded and that it hurt him DON stated she tall consider it abuse. On 11/16/2017, at 3 was not aware of a the night nursing as reports of abuse would submit a repinvestigation. CM-A clinical managers who to the SA and the awith the reports. CN assisted with these responsible for there on 11/16/2017, at 3 worker (LSW) identificated abuse all responsibility and high gathering information needed. On 11/16/2017, at 3 indicated she was regarding R163. The concerns were immadministrator or the administrator. The	son the unit until the morning the been informed by the DON onger work alone with 8:05 p.m. the DON verified she 163 on 11/13/17, and the arding staff moving him fast, when they moved him. The ked to staff and did not 10:05 a.m. CM-A indicated she my problems R163 had with esistants. CM-A indicated ere reported to the DON who cort to the SA and begin an a indicated DON and the were able to submit the reports dministrator then followed up M-A indicated the social worker reports but was not	F 22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245435	B. WING				C 17/2017
NAME OF F	PROVIDER OR SUPPLIER			420	REET ADDRESS, CITY, STATE, ZIP CODE 0 12TH AVENUE EAST LEXANDRIA, MN 56308	117	11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	adult situation. The felt the DON had had appropriately, she habuse, and had edu. Review of R163's crevealed an entry da care conference (FM)-G's request. Tand social services with the daughter research.	administrator indicated she andled the situation and no reason to believe it was ucated staff at that time. omputerized progress notes ated 11/7/17, which indicated was held per family member he notes indicated nursing staff participated in the call egarding questions and rd did not identify what the	F2	226			
	R153 had diagnose fracture and hyperter R153 was cognitive with understanding express, understan required extensives the exception of ear Review of R153's Sprint date of 6/19/17 p.m. R153 reported wallet was missing investigative report 6/22/17, indicated Fmissing on 6/17/17 complete room sea not have any visitor reported to staff her Friday, 6/16/17 when	MDS dated 6/20/17, indicated as which included pelvic ension. The MDS identified by intact and had no difficulty communication and ability to d or hear information. R153 staff assistance for ADL's with ting. 6A draft incident form with a 7, indicated on 6/17/17, at 5:30 to the charge nurse that her from her purse. Review of the submitted to the SA on R153 reported her wallet was a staff assisted R153 with a rch several times. R153 did as since admission. R153 rewallet was in her purse on the she had written a receipt in the per, then put her wallet back in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245435	B. WING				C 1 7/2017	
NAME OF PROVIDER OR SUPPLIER KNUTE NELSON				420	REET ADDRESS, CITY, STATE, ZIP CODE 0 12TH AVENUE EAST LEXANDRIA, MN 56308	,,	11/2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ULD BE COMPLÉTION		
F 226	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 2	226				

AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245435	B. WING	i			C 17/2017	
NAME OF PROVIDER OR SUPPLIER KNUTE NELSON				42	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST LEXANDRIA, MN 56308	117	17/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 329 SS=D	had just been admit thought maybe R15 The administrator's determined the wall 6/19/17, they report contacted police at stated administratio immediately when t misappropriation of that is when we decould not find the w DRUG REGIMEN IS UNNECESSARY DCFR(s): 483.45(d)(d) 483.45(d) Unneces Each resident's dru unnecessary drugs drug when used- (1) In excessive dost therapy); or (2) For excessive dost therapy); or (3) Without adequal (4) Without adequal (5) In the presence which indicate the odiscontinued; or	tted to the facility and staff is a had misplaced the wallet. It atted once administration let was lost, on Monday ited the incident to the SA and that time. The administrator on reported the incident they "deemed" it was resident property, because cided it was missing and we reallet and missing money. S FREE FROM RUGS (e)(1)-(2) sary Drugs-General. g regimen must be free from an unnecessary drug is any see (including duplicate drug) uration; or the monitoring; or the indications for its use; or of adverse consequences dose should be reduced or the of the reasons stated in through (5) of this section.		329	DETICIENCY		12/20/17	
	() -]	. 5						

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245435	B. WING		11/1	C 1 7/2017
NAME OF PROVIDER OR SUPPLIER KNUTE NELSON			4	STREET ADDRESS, CITY, STATE, ZIP CODE 120 12TH AVENUE EAST ALEXANDRIA, MN 56308	1	172011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	resident, the facility (1) Residents who drugs are not given medication is necest condition as diagnor clinical record; (2) Residents who designed interventions, unless an effort to discontion This REQUIREMED by: Based on interview facility failed to ensure for range orders and of 5 residents (R11 medications. Findings include: R112's admission r11/3/17, revealed Fand diagnoses which weakness, gout, consteopenia and diagnoses which weakness, gout, consteopenia and diagnoses with activities of data admission note data denied pain, and R with sleep. R112's care plan data had arthritis and directions and diagnoses.	chensive assessment of a must ensure that nave not used psychotropic these drugs unless the ssary to treat a specific sed and documented in the use psychotropic drugs receive tions, and behavioral is clinically contraindicated, in	F 329	F 329 DRUG REGIMEN IS FRE FROM UNNECESSARY DRUGS It is the practice of Knute Nelson to ensure parameters are identified forders and use of dual analgesics. What corrective action(s) will be accomplished for those residents to been found affected by the deficient practice? Resident 112 suffered no adverse as a result of this practice. Reside 112 stylenol order was changed 2 tabs to 2 tabs for a pain rating of lbuprofen is 600mg for a pain rating 10/10. How will you identify other resident having the potential to be affected same deficient practice and what correction actions will be taken? All residents have the potential to affected by this practice. No other residents in the facility have range and use of dual analgesics.	of or range of to have nt effects nt from 1-1-5/10, ng of 6-ts by the oe current	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245435			C 11/17/2017	
NAME OF PROVIDER OR SUPPLIER KNUTE NELSON			5		11/11/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	Review of R112's p 11/3/17, revealed of (acetaminophen) 3t tablets by mouth expressed an order of the following stablets by mouth expressed an order of the following stablets and when to the following stablets and the following stablets are stablets are stablets and the following stablets are st	e effects of medications. hysician orders signed	F 329	What measures will be put into what systematic changes will yo ensure that the deficient practic recur? Licensed Nursing staff received on orders that are not clear or oparameters, the orders must be with the prescribing provider up receiving the order. If prescribin wishes to keep a range order the staff have been educated on the document what dose was given electronic medication administrasheet. This education will be coon 12/19/2017. How will the corrective action(s) monitored to ensure the deficient will not recur? Random audits will be done by Director of Nursing/designee of nursing hours to ensure that all who have more than one analge have parameters within the order if there are range orders the state documenting what dose was give electronic medication administrate record. Results of the audit will to the QAPI committee for furth recommendations. Completion date: December 20, 2017	e does not e does not e does not e ducation lo not have c clarified on g provider le nursing e need to on the ation mpleted be nt practice the the residents esic order er and that off are ven in the ation be taken	
	confirmed R112's p	hysician orders lacked				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245435	B. WING				C 1 7/2017	
NAME OF PROVIDER OR SUPPLIER KNUTE NELSON				ST 42	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST LEXANDRIA, MN 56308		17/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG			ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE		
F 329	PROVIDER OR SUPPLIER NELSON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F3	329				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245435	B. WING			C
	PROVIDER OR SUPPLIER	240400	2	STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST	1 11/	17/2017
KNUTE N	MELSON			ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	(CM)-B verified R11 acetaminophen and CM-B indicated star doctor for clarifications 1 or 2 tablets on use the ibuprofen.	7 p.m. clinical manager 12's physican orders for d ibuprofen lacked parameters. ff should have contacted the on and parameters on when to f acetaminophen and when to	F3	29		
	(DON) stated she w listed for R112's acc The DON reported	10 a.m. the director of nursing would expect parameters to be etaminophen and ibuprofen. R112 was new to the facility, sected the nurse to send out a ician for the order				
F 356 SS=C	revised 7/2016, indi unclear and ambigu source for medicati be encouraged to n and clear as possib pain rating of 5 or le pain rating of 6 or h show the amount g dose.	ation Range Order policy icated range orders may be uous and may also be a on errors. Prescriber's should nake range orders as specific ble (e.g., morphine 5 mg for a ess; morphine 10 mg for a higher). Documentation must iven for each range order STAFFING INFORMATION 1)-(4)	F 3	56		12/20/17
	(g) Nurse Staffing In (1) Data requirement	nformation ents. The facility must post aation on a daily basis:				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245435	B. WING				C 1 7/2017
NAME OF F	PROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST LEXANDRIA, MN 56308	11/	17/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	by the following cate unlicensed nursing resident care per shape (A) Registered nursing (B) Licensed practic vocational nurses (a) C) Certified nurse a (iv) Resident censury (2) Posting requirent (i) The facility must specified in paragradaily basis at the best (ii) Data must be post (A) Clear and reada (B) In a prominent presidents and visitor (3) Public access to The facility must, up make nurse staffing for review at a cost standard. (4) Facility data retefacility must maintain	er and the actual hours worked egories of licensed and staff directly responsible for nift: es. cal nurses or licensed as defined under State law) aides. s. nents. post the nurse staffing data uph (g)(1) of this section on a eginning of each shift. ested as follows: able format.	F3	856			
	Stanning Uata 101 d II	minum of 10 months, of as					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245435	B. WING			C I 7/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308	1 11/	11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 356	required by State la This REQUIREMENT by: Based on observator review, the facility for staffing information This had the potent 79 residents who residents include: During the initial too 6:51 a.m. the untitle 11/6/17, were observed to the entrance hanging in clear plathe facility name, do the number of licenstaff scheduled for information for the entrance of the number of licensed practical in posting dated 11/00 recent nurse staffing and surveyor review confirmed they were and included the fanursing staff scheduled included in	iw, whichever is greater. NT is not met as evidenced tion, interview and document ailed to ensure the nurse was posted on a daily basis. it is affect all visitors and all esided in the facility. The forms dated 10/31/17, to rived to be posted on the wall edoor. There were 7 forms astic files. The forms include ates, census of 75 to 79, and sed and unlicensed nursing each shift. The nurse staffing current date of 11/13/17, was posted anywhere in the 11/13/17, at 7:08 a.m. urse (LPN)-F confirmed the 3/17, had been the most g information posted. LPN-F wed the 7 forms posted and e dated 10/31/17 to 11/6/17 cility name, date, census and duled for each shift including	F 350	F 356 POSTED NURSE STAFFI INFROMATION It is the practice of Knute Nelson ensure that the nurse staffing info is posted on a daily basis. What corrective action(s) will be accomplished for those residents been found affected by the deficie practice? No residents suffered adverse eff because of this practice. How will you identify other resident having the potential to be affected same deficient practice and what correction actions will be taken? All visitors and residents in the far have the potential to be affected by practice. What measures will be put into pl what systematic changes will you ensure that the deficient practice recur? The staffing coordinator is resport post the nursing hours each day a beginning of the day. These hours changed as schedule changes of policy was updated to reflect that the staffing coordinator is not presperson who is responsible for stat would make the changes on the restaffing hours as needed. On weet the RN manager will make neces changes to the posted hours. Sta	to bring to have ent ects to have ent ects to have ent ects to by the cility by this ace or make to does not estate the sare ecur. The when sent the ffing nursing ekends sary	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			COM	ATE SURVEY DMPLETED	
		245435	B. WING				C 1 7/2017	
NAME OF F	PROVIDER OR SUPPLIER			4:	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST LEXANDRIA, MN 56308		17/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 356	partition of the partit	<u> </u>	F 3	56		ļ		
	scheduled for each staffing coordinator completion and pos information. DON i the forms would be	d and unlicensed nursing staff shift. She reported the (SC) was responsible for the sting of the nurse staffing ndicated her expectation was posted daily.			importance of having the nursing hoposted timely on 12/19/2017. How will the corrective action(s) be monitored to ensure the deficient pr will not recur? Random audits will be done by the Director of Nursing/designee of the nursing hours to ensure that they ar	actice		
	responsible for upd SC indicated she m needed. She indica Fridays and if chang would update them	ating the nursing staff posting. ade changes to the forms as ated she posted them on ges during the weekend she on Mondays. She verified if during the weekend, the forms			current and correct. Results of the a will be taken to the QAPI committee further recommendations. Completion date: December 20, 2017	audit		
	hours, undated, ind hours were posted of by the staffing coord beginning of the first direction for person staffing coordinator updates were made	LABEL/STORE DRUGS &	F 4	31			12/20/17	
	drugs and biologica them under an agre §483.70(g) of this p unlicensed personn	art. The facility may permit rel to administer drugs if State y under the general						
	(a) Procedures. A f pharmaceutical serv	acility must provide vices (including procedures						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245435	B. WING				C 1 7/2017
NAME OF PR	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	11/	17/2017
KNUTE NE	I SON			4	20 12TH AVENUE EAST		
KNUTENE	LSON			1	ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
th country () country	dispensing, and adroiologicals) to meet biologicals) to meet biologicals) to meet biologicals) to meet biologicals biologicals as yelisposition of all condetail to enable an adroiological abeled in account of a maintained and periodical propropriate accessons professional principal appropriate accessons and the facility must storocked compartment and access to the control and periodical and permit have access to the control access to th	urate acquiring, receiving, ministering of all drugs and the needs of each resident. ation. The facility must e services of a licensed stem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and drug records are in order and all controlled drugs is iodically reconciled. Is and Biologicals. Is used in the facility must be ce with currently accepted les, and include the bry and cautionary e expiration date when Is and Biologicals. Is and Biologicals. Is and Biologicals in the facility must be ce with currently accepted les, and include the bry and cautionary e expiration date when	F 4	1 31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245435	B. WING _			C 17/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308	-	11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 431	be readily detected This REQUIREMENT by: Based on observation review, the facility for were labeled with in insulin pens review facility. Findings include: On 11/13/17, at 8:0 medication cart was practical nurse (LPI R183's humalog (in	inimal and a missing dose can	F 43	,	on to ly labeled e nts to have icient ered no nis practice. lin pens did	
	R183's name, date number, room num She confirmed the with instructions. L had not labeled the facility label on the On 11/13/17, at 8:5 medication cart was medication aide (TI R30's Lantus insulimedication cart had name, room number birth and primary pl pharmacy label with administered. On 11/13/17, at 8:4 wing medication carregistered nurse (R	I facility labels which included of birth, medical record ber and primary physician. pen lacked a pharmacy label PN indicated the pharmacy actual pens, so they applied a pen. 4 a.m. the 500 wing sobserved with trained MA)- A present, who verified in pen, stored in the 500 wing da facility label with R30's er, medical number, date of hysicians name, but lacked a in instructions for dose to be 1 a.m. the transitional care rt was observed with N)-A present. R184's Novolog nal care wing medication cart		time this was found, pharmacy affected insulin pens with propartice and what insulin pens with propartice and what insulin pens will be taken having the potential to be affect same deficient practice and what correction actions will be taken All residents who have orders a pens have the potential to be a this. No other current residents facility with insulin orders were have any concerns with their pheing properly labeled. What measures will be put into what systematic changes will yensure that the deficient practice recur? Nursing staff will receive educations in pens must have their over each pen, if a pen is found not proper label on it, nursing staff	labeled all er labels. proper dents ted by the nat? for insulin ffected by in the found to ens and not place or ou make to be does not ation that all wn label on to have a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED			
		245435	B. WING			C 1 7/2017
NAME OF	PROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP COD 120 12TH AVENUE EAST ALEXANDRIA, MN 56308		,2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 431	label was partially over most of the later over most of the later and the resident into be administered. R183's signed physicated R183 was 100 unit/ml (insulin subcutaneously wit mellitus), with an orand Lantus 100 uniunits subcutaneous an ordered start date of 5/26/1 R184's signed physicated R30 was 100 unit/ml (insulin subcutaneously at start date of 5/26/1 R184's signed physicated R184 was 100 unit/ml (insulin subcutaneously be (blood sugar) <120 11/1/17. On 11/16/17, 9:22 a pharmacy consulta aware that insulin plabeled with pharm she would recomm pharmacy labels or boxes with pharmacy Cn 11/16/17, at 11: (DON) confirmed the control of	A verified the pen's pharmacy worn off and had black areas pel. This made it unable to ame and instructions for dose sician orders dated 11/10/17, a prescribed Humalog solution lispro) inject 10 units h meals for DM (diabetes redered start date of 11/9/17, t/ml (insulin glargine) inject 70 sly in the morning for DM, with the of 11/10/17. Cian orders dated 9/15/17, prescribed Lantus Solution glargine) inject 26 units bedtime for DM, with an order	F 431	back to pharmacy for proper la education will be completed or 12/19/2017. Director of Nursin spoken to the pharmacies involved the requirement is each pen or labeled individually, if the pharmable to comply with this the inswill be obtained from another that can meet this requirement How will the corrective action (monitored to ensure the deficitivill not recur? Random audits will be done by Nursing/designee of residents insulin pens to ensure that the proper labels on them. Results audits will be taken to the QAR committee for further recomm Completion date: 12/20/17	n g has plyed that nust be macy is not sulin pens pharmacy t. s) be ent practice by Director of who use by have sof the Pl	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245435	B. WING			C 17/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 456 SS=E	to assure the 5 right resident, time and condicated some phase on the insulin pensions. Expect the staff would label if it became upon the insulin pensions maintated to the condition of the certain pharmacies only the dispensing medication contained ESSENTIAL EQUIFICONDITION CFR(s): 483.90(d)(d)(2) Maintain all in patient care equipmedication. (e) Resident Rooms must for adequate nursing residents. This REQUIREMENT by: Based on observator review, the facility for ice machine was must resident was must review, the facility for ice machine was must resident was must review, the facility for ice machine was must resident was must review, the facility for ice machine was must resident was must review, the facility for ice machine was must resident was must review, the facility for ice machine was must review.	cation administration records ts (the right route, medication, dosage) were accurate. She armacies refused to put labels DON indicated she would ald call pharmacy for a new areadable. Ided Pharmacy-Drug Labeling, awed 11/16, indicated all ained in the facility shall be accordance with current state ons. The policy also indicated aust be legible at all times. It box that they come in would as were labeled with facility em (this was for specific pharmacy could label a per or package. PMENT, SAFE OPERATING 2)(e) The control of the records and ment in safe operating	F 4		•	12/20/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245435	B. WING		C 11/17/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
KNUTE N	IEI CON			420 12TH AVENUE EAST	
KNUIE	NELSON			ALEXANDRIA, MN 56308	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE COMPLÉTION
F 456	Continued From pa	ge 34	F 456	3	
	potential to affect a	Il 16 residents who received the machine on the short-term		electrical, and patient care equipm safe operating conditions. What corrective action(s) will be accomplished for those residents to been found affected by the deficient accomplished.	to have
	kitchen was comple	5 a.m. the initial tour of the eted with dietary cook (DC)-A. erns were identified:		practice? No residents suffered adverse effer a result of this practice. How will you identify other resident having the potential to be affected.	ts
	from the short- tern observed to have e build up under the i	e machine located adjacent n dining room area was ncrusted hard water lime scale ce and water dispenser area,		same deficient practice and what correction actions will be taken? All residents in the facility have the potential to be affected by this practice.	etice.
	down the front right	of the water tray, and running and left side of the machine ms of the metal, which ran all		The ice machine was thoroughly d cleaned and scrapped of all lime s build up. What measures will be put into pla what systematic changes will you	cale ace or
		8 a.m. during follow up tour of rith the dietary manger (DM) rns were noted:		ensure that the deficient practice of recur? The community has a policy regard equipment being maintained in a second community has a policy regard equipment being maintained in a second community has a policy regard equipment being maintained in a second community has a policy regard equipment being maintained in a second community has a policy regard equipment being maintained in a second community has a policy regard equipment being maintained in a second community has a policy regard equipment being maintained in a second community has a policy regard equipment being maintained in a second community has a policy regard equipment being maintained in a second community has a policy regard equipment being maintained in a second community has a policy regard equipment being maintained in a second community has a policy regard equipment being maintained in a second community has a second community has a policy regard equipment being maintained in a second community has a policy regard equipment being maintained in a second community has a se	ding
	from the short- tern observed to have e build up under the i behind the seams of	e machine located adjacent in dining room area was incrusted hard water lime scale ce and water dispenser area, of the water tray, and running		clean, functional, comfortable man Care Center staff have been re-ed on this policy on Tuesday, Decemb 2017. Ice machines are deep clea monthly and as needed via audits.	nner. All lucated per 19, aned
	in between the sea the way to the floor			How will the corrective action(s) be monitored to ensure the deficient p will not recur? Random audits will be done by Dir Dining Services or designee of the	ector of
	and was able to pic build up from under dispenser area. The ice machine could I lime scale getting b	M confirmed the above finding of chunks of lime scale reath the ice and water e DM indicated the water and be cleaned better due to the ead after a week. The DM and water machine appeared to		machine equipment to ensure it is clean, functional, and in a comfort manner. Results of the audits will I taken to the QAPI committee for furecommendations. Completion date:	safe, able be

	OF DEFICIENCIES OF CORRECTION	ES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245435	B. WING				C 1 7/2017
NAME OF I	PROVIDER OR SUPPLIER			42	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST LEXANDRIA, MN 56308	1 11/	11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 456	be leaking to cause seams of the mach up interview with the and water machine be replaced, the pla replaced and stated. The DM indicated is and needed to be fill. Review of the Mont the ice machines or room area was clean 10/25/17 and 11/1/1/1/1/1/2 cleaning and maintan machine was provided. Review of facility poundated, indicated would be cleaned or clean, sanitary confor the ice machine	the lime scale build up on the ine. At 11:27 a.m. in a follow e DM, she indicated the ice was old, the water line should astic ice dispenser should be discould take a while to clean. The machine was a problem sed. The machine logs revealed in the short term stay dining aned on 9/1/17, 10/1/17, 17. No other information for aining the water and ice	F 4	156	December 20, 2017		



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:

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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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.

Knute Nelson December 6, 2017 Page 2

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

Minnesota Department of Health

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					C	;
		00113	B. WING		11/1	7/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE N	NELSON		AVENUE EA			
			PRIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency form of corrected shall limits a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.com/	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/in ate licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 12/14/17

STATE FORM 6899 O9DB11 If continuation sheet 1 of 36

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE COMP	SURVEY PLETED		
		00113	B. WING		11/1	7/ 2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
KNUTE	NELSON		AVENUE EAS ORIA, MN 563			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department State Licensing federal software. Ta assigned to Minnesota Nursing Homes. The assigned tag in column entitled "ID statute/rule out of c "Summary Statement and replaces the "T correction order. The findings which are in after the statement, evidence by." Follow are the Suggested Time period for Corplease DISREGA FOURTH COLUMN "PROVIDER'S PLA	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 7/17, surveyors of this visited the above provider and ation orders are issued. Our electronic plan of have reviewed these orders, e when they will be completed. The Health is documenting Correction Orders using ag numbers have been not a state statutes/rules for the Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the nis	2 000			

6899

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY
		00113	B. WING			C 1 7/2017
NAME OF I	PROVIDER OR SUPPLIER	420 12TH	DRESS, CITY, S AVENUE EADRIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 995	MN Rule 4658.0610 Requirements -Gro	O Subp. 3 Dietary Staff oming.	2 995			12/20/17
	clean outer garmer restraints must be v contamination of fo	g. Dietary staff must wear nts. Hairnets or other hair worn to prevent the od, utensils, and equipment. acceptable hair restraint.				
	by: Based on observati review the facility fa hair net properly to while serving food i 1 of 1 observation o unit. This deficient affect 33 of 33 resid	ent is not met as evidenced on, interview and document tiled to ensure staff utilized a prevent contamination of food n the Pines kitchenette during of food service in the Pines practice had the potential to dents in the facility who were the Pines kitchenette.		Corrected		
	Findings include:					
	on 11/13/2017, at 7 stood in the Pines I steam table. A thin covered DA-A's hai hanging down the bher bangs uncovered table with her hair pechecked the tempe	of the morning meal service:37 a.m. dietary aid (DA)A Kitchenette in front of the net type hair covering partially r leaving pieces of hair back of DA-A's neck and all of ed. DA-A stood over the steam partially uncovered and rature of the cooked cereal, abled eggs. DA-A walked				

Minnesota Department of Health

STATE FORM 6899 O9DB11 If continuation sheet 3 of 36

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		С	
		00113	B. WING			; 7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE I	NELSON		AVENUE EA ORIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 995	partially covering he meal service, place table and toasted be scooped food items with utensils and ple gloved hand. At 8:3 service observation bangs and hair at the uncovered. When interviewed to DA-A indicated here serving food items morning meal. DA-here bangs uncovered hair net was a usual hair should be content nets were not large hair. On 11/13/2017, at manager (DSM)-A have all of their hair working with foods. On 11/13/2017, at indicated staff were working and should uncovered. The facilities policy Procedure revised employees shall: 1. all times.	henette with the hair net er hair as she prepared for the ed utensils near the steam read. At 7:48 a.m. DA-A into bowls and onto plates acced toast on plates with a 9 a.m. the morning meal was completed and DA-A's ne back of her neck remained on 11/13/2017, at 12:19 p.m. usual duties did include in the kitchenette for the A indicated although leaving ed and not contained by the all practice, she was aware all ained, however; stated the hair enough to cover all of her 12:21 p.m. the dining services werified dietary staff were to recompletely covered when 1:24 p.m. The DSM-B at to cover all of their hair when I not purposely leave hair titled Dietary Policy and May 21, 2008, identified: All Hair restraints are required at THOD OF CORRECTION:	2 995			
		could provide education to facility policy on food safety				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY LETED
71112 1 27111	or confidence	ISEITTII TOTTI TOTTI TOTTI TI	A. BUILDING:		C	
		00113	B. WING			, 7/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE N	KNUTE NELSON 420 12TH					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	PRIA, MN 56	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE
2 995	Continued From pa	ge 4	2 995			
	restraints. The diet perform audits to en and quality assuran	th focus on facial hair ary director/or designee could asure compliance and review are meeting. R CORRECTION: Twenty One				
21540	. , ,	5 Subp. 2 Unnecessary Drug	21540			12/20/17
	monitor each reside unnecessary drug to home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the resider adversely affected, matter to the medical director is not the medical director is not the order and if the change the order, the change the order, the attending physician does not the attending physician does not the order and if the change the order, the change the order, the attending physician does not the attending physician does not the attending physician directly to the QAA.	g. A nursing home must ent's drug regimen for usage, based on the nursing diprocedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist not's quality of life is being the pharmacist must refer the eal director for review if the not the attending physician. If or determines that the attending have adequate justification for attending physician does not the matter must be referred for y Assurance and Assessment equired by part 4658.0070. If the interior is the medical director, macist shall refer the matter				
		and document review, the ure parameters were identified		Corrected		

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Minnesc	<u>ita Department of He</u>	alth	_			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00113	B. WING		C 11/17/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
			AVENUE EA			
KNUTE I	NELSON	ALEXAND	PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 5	21540			
		d use of dual analgesics for 1 2) reviewed for unnecessary				
	Findings include:					
	11/3/17, revealed R and diagnoses whice weakness, gout, consteopenia and dial The admission assorequired extensive a with activities of dail admission note date	dursing assessment dated (112 had cognitive impairment ch included dementia, ngestive heart failure (CHF), betes mellitus(DM) type II. essment also indicated R112 assistance from facility staff ly living (ADL's). The ed 11/3/17, indicated R112 112's pain had not interfered				
	had arthritis and dir and symptoms of pa	ated 11/10/17, indicated R112 ected staff to monitor for signs ain, monitor fatigue and e effects of medications.				
	11/3/17, revealed of (acetaminophen) 32	hysician orders signed rders for Tylenol 25 milligrams (mg), give 1-2 very 4 hours for pain.				
	revealed an order for	hysician order dated 11/15/17, or ibuprofen 600 mg, give by as as needed for severe pain.				
	level of pain was inc	ders lacked guidance for what dicated to use the Tylenol 1-2 use the ibuprofen for pain.				
	records (MAR) from	nedication administration November 3, 2017, to revealed the following:				

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winneso	ta Department of He	eaitn				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					С	
		00113	B. WING	 		7/2017
NAME OF I	PROVIDER OR SUPPLIER	CTDEET AD	DDECC CITY (STATE, ZIP CODE		
INAIVIL OF I	THO VIDEN ON SOFF EIEN		AVENUE EA	•		
KNUTE N	NELSON		ORIA, MN 56			
	0111414151/074		1			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	(X5) COMPLETE DATE
				DEFICIENCY)		
21540	Continued From pa		21540			
		acetaminophen 13 times for				
		ged from a 2 to 7 on a numeric				
		no pain and 10 being the				
		ble.) The MAR did not indicate or 2 tablets when the				
		s given. The MAR further				
		received ibuprofen 600 mg 3				
		017 to 11/17/2017, for pain				
		a 4 to 8. The MAR revealed				
	all but 5 doses of acetaminophen administrations					
	were effective in relieving R112's pain, and all 3					
		were effective in relieving				
	R112's pain.					
	On 11/16/17, at 2:1	7 p.m. trained medication aide				
		R112 had physician orders for				
		n and ibuprofen. TMA-B				
		hysician orders lacked				
		n to use 1 or 2 tablets of				
		d when to use which				
		3 stated she had to ask the				
		or the unit if 1 or 2 tablets d when the ibuprofen was to				
	•	dicated R112 was pleasantly				
		not identify a number on the				
		ked, so staff used a tool for				
		entia to identify how much pain				
		stated she had only given '				
		en one time, when she asked				
		y tablets to give, the nurse				
	directed her to give	2 tablets.				
	On 11/16/17 at 2:2	3 p.m. registered nurse				
		R112 had physician orders for				
		n and ibuprofen. RN-B				
		practice was for the physician				
		s on how many tablets to give				
		nich medication. RN-B stated				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
					С	
		00113	B. WING			7/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KNUTE I	NELSON		AVENUE EA RIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROID DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 7	21540			
	consult with the channeded medication assess the resident	on aides were required to arge nurse prior to giving as s for pain so the nurse could s pain. RN-B stated both of orders should have been 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.					
	(CM)-B verified R11 acetaminophen and CM-B indicated sta doctor for clarification	7 p.m. clinical manager 2's physican orders for d ibuprofen lacked parameters. ff should have contacted the on and parameters on when to f acetaminophen and when to				
	(DON) stated she w listed for R112's acc The DON reported	10 a.m. the director of nursing would expect parameters to be etaminophen and ibuprofen. R112 was new to the facility, ected the nurse to send out a ician for the order				
	revised 7/2016, indi	ation Range Order policy icated range orders may be uous and may also be a				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		00110	B. WING		C 11/17/2017		
NAME OF F		00113			11/1	7/2017	
	PROVIDER OR SUPPLIER		AVENUE EA	STATE, ZIP CODE ST			
KNUTE N	IELSON		RIA, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21540	Continued From pa	ge 8	21540				
	be encouraged to n and clear as possib pain rating of 5 or le pain rating of 6 or h show the amount g dose.	on errors. Prescriber's should nake range orders as specific le (e.g., morphine 5 mg for a ess; morphine 10 mg for a igher). Documentation must iven for each range order					
	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 (21) days.	R CORRECTION: Twenty-one					
21620	MN Rule 4658.1345	5 Labeling of Drugs	21620			12/20/17	
	Drugs used in the n in accordance with	oursing home must be labeled part 6800.6300.					
	by: Based on observatireview, the facility fawere labeled with ir	on, interview and document ailed to ensure insulin pens astructions for use for 4 of 4 and on medication carts in the		Corrected			

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		00113	B. WING			7/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KNUTE	NELSON		AVENUE EA PRIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	On 11/13/17, at 8:0 medication cart was practical nurse (LPI R183's humalog (in glargine) insulin permedication cart had R183's name, date number, room num She confirmed the with instructions. Linad not labeled the facility label on the On 11/13/17, at 8:5 medication cart was medication aide (TN R30's Lantus insulin medication cart had name, room number birth and primary plant pharmacy label with administered. On 11/13/17, at 8:4 wing medication cart registered nurse (R pen on the transitio with surveyor. RN-A label was partially wover most of the latered the resident nato be administered. R183's signed physindicated R183 was 100 unit/ml (insulin subcutaneously with mellitus), with an or and Lantus 100 unit mand cart in the side of the latered that the resident nato be administered.	2 a.m. the 700 wing sobserved with licensed N)-D present. She verified sulin lispro) and toujeo (insulinens, stored in the 700 wing difacility labels which included of birth, medical record ber and primary physician. pen lacked a pharmacy label PN indicated the pharmacy actual pens, so they applied a	21620			

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00113	B. WING		11/1	C 1 7/2017
	NAME OF PROVIDER OR SUPPLIER KNUTE NELSON ALEXAN			- -		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21620	an ordered start date R30's signed physic indicated R30 was 100 unit/ml (insulin subcutaneously at the start date of 5/26/12 R184's signed physic indicated R184 was 100 unit/ml (insulin subcutaneously bef (blood sugar) <120 to 11/11/17. On 11/16/17, 9:22 a pharmacy consultar aware that insulin plabeled with pharmacy labeled with pharmacy labels on boxes with pharmacy labels on boxes with pharmacy orders on the medications were usureders on the medications were usureders on the medicated some pharmacy label if it became until the staff world label if it became until the facility policy tit dated 11/1/11, reviewedications maintal properly labeled in and federal regulations and federal regulations and federal regulations and federal regulations.	te of 11/10/17. cian orders dated 9/15/17, prescribed Lantus Solution glargine) inject 26 units bedtime for DM, with an order 7. cician orders dated 11/3/17, prescribed Novolog solution aspart) inject 3 unit ore meals for DM, hold for BS, with an order start date of a.m. during a phone interview, at (PC) indicated she was not ens in the facility were not acy instructions. PC indicated end insulin pens would have them when not stored in cy labels on the boxes. 28 a.m. director of nursing the pharmacy labels on sed to compare the written cation administration records ts (the right route, medication, dosage) were accurate. She trmacies refused to put labels DON indicated she would ald call pharmacy for a new	21620			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				B. WING)
		00113	B. WING		11/1	7/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KNUTE I	KNUTE NELSON 420 12TI ALEXAN					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 11	21620			
	have the label, pensiabel attached to the certain pharmacies only the dispensing medication contained SUGGESTED MET. The director of nursimplement policies labeling medication necessary such as assessment and as perform random automatical performance.	THOD FOR CORRECTION: sing (DON) could develop and and procedures related to s when opened when				
21685	Subp. 2. Physical pincluding walls, floor systems, and equip continuous state of with regard to the highwell-being of the restriction of the restr	of Subp. 2 Plant Peration, & Maintenance Plant. The physical plant, rs, ceilings, all furnishings, ment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program. The physical plant, rs, ceilings, all furnishings, ment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program. This practice wand document ailed to ensure the water and aintained in good repair for 1. This practice had the lil 16 residents who received the machine on the short-term.	21685	Corrected		12/20/17

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
					С	
		00113	B. WING		11/17/2017	
		00110			11/1	1/2011
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALUE A	JEL CON	420 12TH	AVENUE EA	ST		
KNUTE N	NELSON	ALEXAND	RIA, MN 56	308		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
21685	Continued From pa	ge 12	21685			
	•					
	Eindings include:					
	Findings include:					
	On 11/13/17 at 6:5	5 a.m. the initial tour of the				
		eted with dietary cook (DC)-A.				
		erns were identified:				
	The fellowing conec	orno woro idontinod.				
	- The water and ice	e machine located adjacent				
	from the short- term dining room area was					
	observed to have encrusted hard water lime scale					
	build up under the i	ce and water dispenser area,				
	behind the seams of	of the water tray, and running				
	down the front right	and left side of the machine				
		ms of the metal, which ran all				
	the way to the floor.					
		8 a.m. during follow up tour of				
		rith the dietary manger (DM)				
	the following conce	rns were noted:				
	The weter and ice	a machine leasted adjacent				
		e machine located adjacent n dining room area was				
		ncrusted hard water lime scale				
		ce and water dispenser area,				
		of the water tray, and running				
		and left side of the machine				
		ms of the metal, which ran all				
	the way to the floor.					
	·					
		M confirmed the above finding				
	and was able to pic	k off chunks of lime scale				
		neath the ice and water				
		e DM indicated the water and				
		be cleaned better due to the				
		ad after a week. The DM				
		d water machine appeared to				
		the lime scale build up on the				
		ine. At 11:27 a.m. in a follow				
	up interview with the	e DM, she indicated the ice				

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and water machine was old, the water line should

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00113	B. WING		11/1	, 7/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	-	
KNUTE N	KNUTE NELSON 420 12TI ALEXAN					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	be replaced, the pla replaced and stated. The DM indicated in and needed to be fit. Review of the Mont the ice machines or room area was clea 10/25/17 and 11/1/ cleaning and maint machine was provide. Review of facility poundated, indicated would be cleaned of clean, sanitary condered for the ice machine recorded and replaneded. SUGGESTED MET The director of nursed develop and implementation and educate appropresidents's equipmed clean, functional, comonitoring and recover equipment is kept in system to audit the	astic ice dispenser should be di could take a while to clean. Se machine was a problem xed. The machine logs revealed in the short term stay dining aned on 9/1/17, 10/1/17, 17. No other information for aining the water and ice ded. Dicy titled, Knute Nelson, the ice machine equipment on a regular basis to maintain a dition. Cleaning and sanitation would be done monthly, ice parts of the ice machine as THOD OF CORRECTION: Sing or her designee could ment policies and procedures priate staff to ensure that the ent was maintained in a safe, comfortable manner. Ongoing ord keeping to ensure that the in good repair. Develop a equipment on an ongoing inpliance and monitor staff for	21685			
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
21990	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4 Reporting - Inerable Adults	21990			12/20/17

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
					C	<u> </u>
		00113	B. WING			7/2017
						.,2011
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE N	JELSON	420 12TH	AVENUE EA	ST		
KNOILI	ALLOON .	ALEXAND	RIA, MN 56	308		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
TAG	TIEGOE/TIOTTI OTTE	oo ibertii tiita iiti otiiviitiioitij	TAG	DEFICIENCY)	111/112	
21990	Continued From pa	ge 14	21990			
	Subd. 4. Reportin	g. A mandated reporter shall				
		an oral report to the common				
		a telecommunications device				
		r similar device shall be				
	considered an oral	report. The common entry				
		re written reports. To the				
		report must be of sufficient				
	,	he vulnerable adult, the				
		re and extent of the suspected				
		evidence of previous				
		name and address of the				
		date, and location of the ther information that the				
		ight be helpful in investigating				
		reatment. A mandated				
		se not public data, as defined				
		nd medical records under				
	T	the extent necessary to				
	comply with this sul					
	, ,					
	This MN Requireme	ent is not met as evidenced				
	by:					
		and document review, the		Corrected		
		nediately report to the				
		ailed to report within 24 hours				
		(SA) and thoroughly				
		1 resident (R105) with injuries				
		(extensive bruising) and failed				
	•	in 2 hours and thoroughly 1 resident (R105) when they				
		R105's injury of unknown				
		e). In addition, the facility failed				
		ort to the administrator, and				
		hin 2 hours an allegation of				
		protect residents while				
		and allegation of abuse for 1 of				
		ith allegations of abuse.				
		failed to immediately notify the				
		mely report to the SA an				
		propriation of resident's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		A. BUILDING:				
		00113	B. WING		11/1	, 7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE I	NELSON	_	AVENUE EA ORIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21990	Continued From pa	ge 15	21990			
	property for 1 of 3 rabuse prohibition.	esidents (R153) reviewed for				
	Findings include:					
	R105					
	identified R105 had cognition, a diagnos extensive assistant toilet and personal assistance with trannot walk. R105's current cardincluded various propotential for injury responses	change MDS dated 10/10/17, moderately impaired sis of hemiplegia and required se for bed mobility, dressing, care, and required total asfers and locomotion, but did e plan reviewed 10/20/17, oblems which included the elated to dementia, related to lar accident) with right side				
	hemiplegia, use of poor safety awaren	psychotropic medications, ess, visual field cut, the elated to falls, and a risk for				
	10/2/17 identified the -9/23/17, R105 was disorientated and unable to speak norm side body pain9/23/17, in the everanxiousness and dimemory recall of the -9/28/17, R105 left measured 1.24 cm in color with patche the left anterior thig the medial thigh wit	shollering out, anxious, nable to speak clearly. When ally, R105 complained of left ning, had continued pain, fficulty speaking and no e previous night. anterior thigh bruise which (centimeter) by 10 cm, yellow s of purple/green located on h, which wrapped around to				

Minnesota Department of Health

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING.	A. BOILDING.		,	
		00113	B. WING		11/1	7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE I	NELSON		AVENUE EA ORIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21990	Continued From pa	ge 16	21990			
	color with 13 cm pu noted and moderate -9/30/17, sent to en subcapital left femo to hospital	nergency room for displaced oral neck fracture and admitted				
	evidence R105's ur	facility VA reports lacked nexplained significant bruising of the fractured hip had been				
	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.					
		11:30 a.m. R105 verified she n her hip. R105 could not recall he had fallen.				
	(NA)A indicated R1 or two ago. NA-A in the fracture occurre was fine, the next s she didn't know what	2:46 p.m. nursing assistant 105 had a hip fracture a month dicated they had no idea howed, and stated one day she he had excruciating pain and at happened. 2:56 p.m. the CM-C indicated				

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Minnesota Department of Health

AND DIAN OF CODDECTION IN INDED.		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00113	B. WING		11/1	7/ 2017
					1 11/1	1/2011
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KNUTE I	NELSON		AVENUE EA RIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21990	Continued From pa	ge 17	21990	<u> </u>		
	had not had a fall for indicated R105 was	any incident reports on file and or nine months. CM-C last hospitalized due to pair completed the previous				
	had recently broken her normal abilities.	9:33 a.m. NA-B verified R105 her hip and was now back to NA-B stated staff were not 105's broken hip occurred.				
	nurse (LPN)-H indic attempt to self-trans had been more con recent hip fracture. not fall when she br	11:25 a.m. licensed practical cated R105 would at times afer. LPN-H indicated R105 fused around the time of her LPN-H indicated R105 did toke her hip, but stated I don't termined how it happened.				
	R105 did not have a osteoporosis. With charting, CM-C veri 9/23/17, was not aw confirmed the recor the left hip noted 9/2 yellow and green. Chistory of seizures, was "acting peculia"	2:40 p.m. CM-C indicated any falls, however; did have review of the computerized fied R105 had pain on vare why she had pain, and d also indicated bruising to 28/17, which was colored the colored R105 had a strokes, had osteoporosis and r." CM-C questioned if R105 er hip during a seizure.				
	R105's electronic of presented with pain confused. The DON a seizure resulting i stated she had not	3:05 p.m. the DON reviewed nart and verified R105 on the 23rd, and was I indicated R105 possibly had in the hip fracture. The DON reported R105's hip fracture to nothing identifying that it was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7.1. 20.25		C	;
		00113	B. WING		11/1	7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE I	NEI SON		AVENUE EA			
KNOTE	1LL30N	ALEXANI	DRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21990	Continued From pa	ge 18	21990			
	On 11/16/17, at 3:1 verified the facility s fracture and did not On 11/16/2017, at 3 was interviewed by identified a person Osteoporosis would	5 p.m. the administrator staff discussed R105's hip feel it needed to be reported. 3:34 p.m. the medical director phone. The medical director				
	арргорпате.					
	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).					
	approximately two was multiple times for not during cares and to to do with him. R16 this request and co body causing him prinformed his family stated he believed to two nursing assistated because they had reference they had reference they had reference to morked with him agreement about he cause pain. He stated be self serving and stated he had not reference and to do the cause pain.	1:36 a.m. R163 stated weeks ago he had requested ursing assistants to go slow tell him what they were going 3 stated staff did not honor ntinued to quickly move his ain. R163 indicated he had of the incident. R163 further the facility had removed these not worked with him for a while the nursing assistants had ain today and she did not slow him, causing pain and he was sorry when he her treatment but continued to ed he believed the apology to the treatment was abuse. He eported today's occurrence to blanned to if it continued.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		E SURVEY PLETED	
		00113	B. WING			C 17/2017
NAME OF	PROVIDER OR SUPPLIER	420 12TH	DDRESS, CITY, S' I AVENUE EAS DRIA, MN 563	ST	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21990	On 11/13/2017, at a nursing (DON) was allegation of abuse DON indicated she or present concerns indicated the family nursing assistant not however had not gives honored. The I clinical manager (C regarding personal request of one nurs work with R163, ho not used the word at On 11/14/2017, at 3 DON had brought in R163's room. R163 verify this was their mistreated him. On 11/15/2017, at 3 Sunday, she had be had then spoken with R163's allegation of specifically stated the would move him too they would disregar felt that if staff were then it is abuse. On 11/15/2017, at NA-C was currently residents. The DON on the investigative allegation of abuse if the investigation is supported to the control of the	I 2:00 p.m. the director of notified of R163's current by the nursing assistant. The was not aware of R163's past of potential abuse. The DON had requested a specific blonger work with R163, wen a reason and the request DON indicated she and the M)-A spoke with the family cares, therapy and the sing assistant to no longer wever stated the family had				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		С	
		00113	B. WING	·····		7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE I	NELSON		AVENUE EA ORIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21990	11/13/17, the nurse to no longer go into of abuse. NA-C she with other residents of 11/16/17, when so that she could no loresidents. On 11/16/2017, at 3 had spoken with R1 complaint was regard and that it hurt him DON stated she tall consider it abuse. On 11/16/2017, at 1 was not aware of an the night nursing as reports of abuse would submit a repoinvestigation. CM-A clinical managers with the SA and the a	oroof. 7:09 a.m. NA-C indicated on manager had instructed her R163's room due to a report had worked independently on the unit until the morning the been informed by the DON onger work alone with 8:05 p.m. the DON verified she l63 on 11/13/17, and the ording staff moving him fast, when they moved him. The ked to staff and did not 10:05 a.m. CM-A indicated she had yere reported to the DON who cont to the SA and begin an a indicated DON and the overe able to submit the reports dministrator then followed up	21990			
		M-A indicated the social worker reports but was not n.				
	worker (LSW) ident past abuse allegation indicated abuse all responsibility and h	2:29 p.m. the licensed social ified she was not aware of a on for R163. The LSW egations were the DON's er role was to assist with on and documenting as				
		2:00 p.m. the administrator not aware of the allegation				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00113	B. WING			C 1 7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
KNUTE	NELSON		AVENUE EA ORIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21990	regarding R163 . The concerns were immadministrator or the administrator. The the problem two we adult situation. The felt the DON had ha appropriately, she habuse, and had edu. Review of R163's crevealed an entry dacare conference with the daughter reconcerns. The reconcerns. The reconcerns. The reconcerns. The reconcerns and hyperters and hyperters with understanding express, understanding express and follows and f	ne administrator indicated rediately reported to the DON who then informed the administrator stated she felt reks ago was not a vulnerable administrator indicated she andled the situation rad no reason to believe it was read at 11/7/17, which indicated was held per family member the notes indicated nursing staff participated in the call regarding questions and red did not identify what the or concerns were. MDS dated 6/20/17, indicated resident included pelvic rension. The MDS identified religions and ability to dor hear information. R153 staff assistance for ADL's with				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					C	;
		00113	B. WING		11/1	7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
KNUTE I	NELSON		AVENUE EA RIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21990	Friday, 6/16/17 wheher checkbook ledgher purse. R153 withree, and reported a debit card and a coordinate of a debit card and a coord	en she had written a receipt in per, then put her wallet back in as alert and orientated times she had \$120.00 in her wallet, credit card along with her. Staff assisted R153 to did credit card, family was spital called to see if wallet as not. Police were notified on 153's missing wallet. 36 a.m. LPN-A indicated if a missing money staff were that to the nurse manager and call family and start searching money. LPN-A verified if a sing money, the allegation exported to the SA within 24. 4 p.m. CM-B stated staff were allegations of missing money ely, as soon as staff find out. As after the report of missing to late. 48 a.m. DON confirmed R153 and money missing on stated R153 reported the 7 during the weekend. The mas not made aware of the as not made aware of the asy, 6/19/19, and at that time egation to the SA and the and staff continued to look for 49 a.m. the administrator	21990			
	verified she was no	t updated on R153's allegation as an incident report filed to				

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the SA immediately. The administrator stated she

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED
		00113	B. WING		11/1	, 7/2017
		00113			11/1	1/2011
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
	UEL CON	420 12TH	AVENUE EA	ST		
KNUTE I	NELSON	ALEXAND	RIA, MN 56	308		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				BEI IOIEIVOT)		
21990	Continued From pa	ge 23	21990			
		of stuff happens, the resdient				
		tted to the facility and staff				
		53 had misplaced the wallet.				
		tated once administration				
		let was lost, on Monday				
		ted the incident to the SA and				
		that time. The administrator				
		on reported the incident hey "deemed" it was				
		resident property, because				
		cided it was missing and we				
		rallet and missing money.				
	Could flot filld tile w	allet and missing money.				
	Review of the facilit	ry's Vulnerable Adult				
		vention policy, revised 9/1/16,				
		s of unknown cause or injuries				
		ent must be reported				
		state agency at the time the				
		. The policy directed all				
		s and all substantiated				
		would be immediately reported				
	to the SA. In addition	on, the policy directed incidents				
	of suspected reside	ent abuse, or injury of unknown				
	source to be reporte	ed to the administrator				
	immediately and the	e administrator would appoint				
		gement to investigate the				
		irther, the policy directed				
		rotected from harm during an				
		mployees accused of				
		alleged abuse would be				
		gned to duties that do not				
		ntact or would be suspended				
		the investigation had been				
		ministrator. If the employee				
		non-resident care duties, the				
		not be in any part of the				
	building which the r	esident frequented.				
	0110050555					
	SUGGESTED MET	HOD OF CORRECTION:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			71. BOILDING.		С	
		00113	B. WING			7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE I	NELSON	_	AVENUE EA PRIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21990	Continued From pa	ge 24	21990			
	need to immediately abuse, neglect, and the designated state The director of nurs reports for impleme	ould in-service all staff on the y report suspected/alleged I injuries of unknown origin to e agency/common entry point. sing could monitor incident entation of this requirement.				
22000	Reporting - Maltrea Subd. 14. Abuse facility, except hom personal care atten establish and enfor prevention plan. The assessment of the environment, and it factors which may early and a statement of to minimize the risk comply with any rule promulgated by the (b) Each facility, agency and person providers, shall dever prevention plan for residing there or reconstruction of the plan shall contains the same assessment of: (1)	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan licensing agency. Including a home health care al care attendant services elop an individual abuse each vulnerable adult ceiving services from them. In an individualized the person's susceptibility to	22000			12/20/17
	vulnerable adults; (i other vulnerable ad specific measures t risk of abuse to that	viduals, including other 2) the person's risk of abusing ults; and (3) statements of the o be taken to minimize the t person and other vulnerable coses of this paragraph, the es self-abuse.				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
				D. WILLO)
	00113		B. WING		11/1	7/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE N	NEI CON	420 12TH	AVENUE EA	ST		
KNUIE	IELSON	ALEXAND	RIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 25	22000			
	and personal care a knows that the vuln violent crime or an toward others, the i plan must detail the minimize the risk th reasonably be expe facility and persons unsupervised. Und of a vulnerable adu misconduct or phys such information fro authority or through another facility, and	except home health agencies attendant services providers, terable adult has committed a act of physical aggression individual abuse prevention at the vulnerable adult might exted to pose to visitors to the coutside the facility, if the ler this section, a facility knows lt's history of criminal sical aggression if it receives om a law enforcement in a medical record prepared by other health care provider, or grassessments of the				
	by: Based on interview facility failed to imple polices to immediat report within 2 hour thoroughly investigated allegations of a failed to implement protection of reside allegations of abuse immediately report report to the SA, and of resident property	ent is not met as evidenced and document review, the lement the abuse prohibition tely report to administrator and is to State agency (SA), and ate injuries of unknown source abuse. In addition, the facility abuse prohibition policies for ints during the investigation of the Eurther, the facility failed to to the adminstrator, timely allegation of misappropriation in.		Corrected		
	Findinas include:					ļ ,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00113	B. WING			C 17/2017
NAME OF	PROVIDER OR SUPPLIER	420 12TH	DRESS, CITY, S AVENUE EA DRIA, MN 56	- -		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
22000	Review of the facilit Abuse/Neglect Previndicated all injuries from accident/incide immediately to the sinjury is discovered suspected violation incidents of abuse to the SA. In addition of suspected resides source to be report immediately and the amember of manaralleged incident. Furesidents shall be provestigation and emparticipating in the simmediately reassignivolve resident coruntil the findings of reviewed by the adwas reassigned to resident coruntil to the same alleged to the same alleged by the adwas reassigned to reviewed by the same accident same alleged by the adwas reassigned to reviewed by the same accident same alleged incident.	cy's Vulnerable Adult vention policy, revised 9/1/16, is of unknown cause or injuries ent must be reported state agency at the time the . The policy directed all is and all substantiated would be immediately reported on, the policy directed incidents ent abuse, or injury of unknowned to the administrator e administrator would appoint gement to investigate the arther, the policy directed protected from harm during an imployees accused of alleged abuse would be gined to duties that do not intact or would be suspended the investigation had been ministrator. If the employee non-resident care duties, the not be in any part of the				
	identified R105 had cognition, a diagnos extensive assistand toilet and personal	change MDS dated 10/10/17, I moderately impaired sis of hemiplegia and required be for bed mobility, dressing, care, and required total asfers and locomotion, but did				
	included various pro potential for injury r CVA (cerebrovascu	e plan reviewed 10/20/17, oblems which included the elated to dementia, related to lar accident) with right side psychotropic medications.				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
					C	;
		00113	B. WING		11/1	7/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KNUTE I	NELSON		AVENUE EA RIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRIES OF THE APPROPRIES OF	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 27	22000			
	poor safety awareness, visual field cut, the potential for injury related to falls, and a risk for being abused by other individuals.					
	10/2/17 identified the -9/23/17, R105 was disorientated and unable to speak norm side body pain9/23/17, in the everanxiousness and dimemory recall of the -9/28/17, R105 left measured 1.24 cm in color with patche the left anterior thing the medial thingh with moderate/severe paragraphs of the purpose of	shollering out, anxious, nable to speak clearly. When ally, R105 complained of left ning, had continued pain, fficulty speaking and no e previous night. anterior thigh bruise which (centimeter) by 10 cm, yellow s of purple/green located on h, which wrapped around to h scant edema, ain noted. Left lateral thigh c cm by 19 cm, light yellow in urple center, and 1 plus edema				
	evidence R105's ur	facility VA reports lacked nexplained significant bruising of the fractured hip had been				
	9/30/17, identified the left hip pain, last Satheir mother they no strange. She was a nursing home staff seizure. Since last sheen having troubles	ital record with admit date he following: Chief complaint: aturday when daughters visited officed that she was acting ppearing to have spasms. The thought she was having a Saturday 9/23/17, she had with moving in a wheel chair g she appears to be having				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00113	B. WING			C I 7/2017
	NAME OF PROVIDER OR SUPPLIER KNUTE NELSON 420 12T ALEXAN					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
22000	spasms and hip pairight femoral neck farthroplasty (surgicalso has a history of sided hemiparesis. displaced left femoral neck farthroplasty (surgicalso has a history of sided hemiparesis. displaced left femoral neck farthroplasty broker details but stated should be	n. She does have a history of racture (hip) with hemi-hip al joint repair) last year. She f a stroke with complete right. The X-ray identified a ral neck fracture. 1:30 a.m. R105 verified she her hip. R105 could not recall he had fallen. 2:46 p.m. nursing assistant 05 had a hip fracture a month dicated they had no idea howed, and stated one day she he had excruciating pain and at happened. 2:56 p.m. the CM-C indicated any incident reports on file and or nine months. CM-C is last hospitalized due to be pair completed the previous of her hip and was now back to NA-B stated staff were not 105's broken hip occurred. 11:25 a.m. licensed practical cated R105 would at times after. LPN-H indicated R105 did toke her hip, but stated I don't termined how it happened.	22000			
		2:40 p.m. CM-C indicated any falls, however; did have				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00113	B. WING			C 1 7/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE	NELSON		AVENUE EA DRIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
22000	osteoporosis. With charting, CM-C veri 9/23/17, was not aw confirmed the record the left hip noted 9/2 yellow and green. On thistory of seizures, was "acting peculia possibly fractured horizonal confused. The DON a seizure resulting is stated she had not the SA as she had reaused by abuse. On 11/16/2017, at 3:13 verified the facility seizure and did not caused by abuse. On 11/16/2017, at 3:13 verified the facility seizure and did not caused by abuse. On 11/16/2017, at 3:14 verified the facility seizure and did not caused by abuse. On 11/16/2017, at 3:15 verified the facility seizure and did not caused by abuse. R163 the did not fe appropriate. R163 R163's admission Massessment (MDS) R163 had intact cogwhich included quarent for the complex of the complex	review of the computerized fied R105 had pain on vare why she had pain, and rd also indicated bruising to 28/17, which was colored CM-C indicated R105 had a strokes, had osteoporosis and r." CM-C questioned if R105 fer hip during a seizure. 3:05 p.m. the DON reviewed hart and verified R105 fon the 23rd, and was indicated R105 possibly had in the hip fracture. The DON reported R105's hip fracture to nothing identifying that it was 5 p.m. the administrator staff discussed R105's hip feel it needed to be reported. 3:34 p.m. the medical director phone. The medical director with a diagnosis of the at risk for hip fracture and el a VA report would be				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.12 . 27.11	. 6. 6626		A. BUILDING:			
		00113	B. WING		11/1	; <mark>7/2017</mark>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE	NELSON		AVENUE EA ORIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	approximately two multiple times for n during cares and to to do with him. R16 this request and cobody causing him pinformed his family stated he believed two nursing assistated because they had rR163 stated one of worked with him agdown when moving repeatedly stated scomplained about had cause pain. He stated he had not reanyone; however, ponce of the self serving and stated he had not reanyone; however, ponce of the self serving and stated he had not reanyone; however, ponce of the self serving and stated he had not reanyone; however, ponce of the self serving and stated he family nursing (DON) was allegation of abuse DON indicated she or present concernsindicated the family nursing assistant in however had not give was honored. The lactical manager (Oregarding personal request of one nurs work with R163, ho not used the word at the self-serving personal request of one nurs work with R163, ho not used the word at the self-serving personal request of one nurs work with R163, ho not used the word at the self-serving personal request of one nurs work with R163, ho not used the word at the self-serving personal request of one nurs work with R163, ho not used the word at the self-serving personal request of one nurs work with R163, ho not used the word at the self-serving personal request of one nurs work with R163, ho not used the word at the self-serving personal request of one nurs work with R163, ho not used the word at the self-serving personal request of one nurs work with R163, ho not used the word at the self-serving personal request of one nurs work with R163, ho not used the word at the self-serving personal request of one nurs work with R163, ho not used the word at the self-serving personal request of one nurs work with R163, ho not used the word at the self-serving personal request of one nurs work with R163, ho not used the word at the self-serving personal request of one nurs work with R163, ho not used the word at the self-serving personal request of one nurs work with R163, ho not used the word at	weeks ago he had requested ursing assistants to go slow tell him what they were going 3 stated staff did not honor ntinued to quickly move his pain. R163 indicated he had of the incident. R163 further the facility had removed these nts from the schedule not worked with him for a while. The nursing assistants had ain today and she did not slow him, causing pain and he was sorry when he ner treatment but continued to the believed the apology to the treatment was abuse. He aported today's occurrence to planned to if it continued. 12:00 p.m. the director of notified of R163's current by the nursing assistant. The was not aware of R163's past is of potential abuse. The DON in had requested a specific to longer work with R163, wen a reason and the request DON indicated she and the M)-A spoke with the family cares, therapy and the sing assistant to no longer wever stated the family had	22000			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
						;	
	00113		B. WING			7/2017	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
KNUTE I	NELSON		AVENUE EA RIA, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
22000	Continued From pa	ge 31	22000				
	interview, FM-G sta Sunday, she had be had then spoken wi R163's allegation of specifically stated the would move him too they would disregar felt that if staff were then it is abuse. On 11/15/2017, at NA-C was currently residents. The DON on the investigative allegation of abuse if the investigation p	B:15 p.m. via telephone ated two weeks ago on a ecome aware of concerns and the the social worker regarding f abuse. FM-G stated [R163] here were two night staff that o quickly causing him pain and the drief his wishes. FM-G stated she told to slow down and don't, 3:50 p.m. the DON verified working independently with a indicated she was working report, and did not believe the to be true. The DON indicated broved NA-C had abused ave to be terminated but at this proof.					
	11/13/17, the nurse to no longer go into of abuse. NA-C she with other residents of 11/16/17, when s that she could no loresidents. On 11/16/2017, at 3 had spoken with R1 complaint was regard and that it hurt him DON stated she tall consider it abuse.	7:09 a.m. NA-C indicated on manager had instructed her R163's room due to a report had worked independently on the unit until the morning the been informed by the DON onger work alone with 8:05 p.m. the DON verified she l63 on 11/13/17, and the ording staff moving him fast, when they moved him. The ked to staff and did not					
	was not aware of a	ny problems R163 had with sistants. CM-A indicated					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CONTILOTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00113	B. WING		11/1	7/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE I	NELSON		AVENUE EA RIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	reports of abuse w would submit a reprint investigation. CM-A clinical managers w to the SA and the a with the reports. CM assisted with these responsible for ther. On 11/16/2017, at 1 worker (LSW) ident past abuse allegatic indicated abuse all responsibility and h gathering information information in the problem two we adult situation. The the problem two we adult situation. The felt the DON had had appropriately, she habuse, and had edu. Review of R163's converse of R163's conver	ere reported to the DON who out to the SA and begin an a indicated DON and the vere able to submit the reports dministrator then followed up M-A indicated the social worker reports but was not m. 12:29 p.m. the licensed social diffied she was not aware of a confor R163. The LSW egations were the DON's er role was to assist with on and documenting as 2:00 p.m. the administrator administrator indicated deciately reported to the endiately reported to the administrator stated she felt eeks ago was not a vulnerable administrator indicated she andled the situation and no reason to believe it was ucated staff at that time. In omputerized progress notes ated 11/7/17, which indicated was held per family member the notes indicated nursing staff participated in the call egarding questions and red did not identify what the	22000			
	R153					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00113	B. WING		11/1	7/ 2017
	PROVIDER OR SUPPLIER	420 12TH	DRESS, CITY, S AVENUE EA DRIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	R153's admission NR153 had diagnose fracture and hyperte R153 was cognitive with understanding express, understanding expression of 6/19/17 p.m. R153's Sprint date of 6/19/17, indicated Fmissing on 6/17/17, complete room sea not have any visitor reported to staff her Friday, 6/16/17 when her checkbook ledgher purse. R153 withree, and reported a debit card and a contract of expression expected to report expected to report the expected to report the expected to report the expected to report the expected to be reported missing resident reports mis would need to be rehours.	MDS dated 6/20/17, indicated as which included pelvic ension. The MDS identified aly intact and had no difficulty communication and ability to d or hear information. R153 staff assistance for ADL's with	22000			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		С	
		00113	B. WING			7/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KNUTE N	KNUTE NELSON 420 12TH ALEXANI					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
	to the SA immediate CM-B verified 2 day money would be too On 11/17/17, at 10: reported her wallet 6/17/17. The DON allegation on 6/17/1 DON verified she w situation until Mond she reported the all police on 6/19/17, at the wallet. On 11/17/17, at 10: verified she was no immediately, nor wathe SA immediately believed that kind ohad just been admit thought maybe R15 The administrator s determined the wall 6/19/17, they report contacted police at stated administratio immediately when the misappropriation of that is when we decould not find the wall SUGGESTED MET The administrator of facility's current abuit mediately reportion of the summediately reportion of	allegations of missing money ely, as soon as staff find out.	22000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		00113	B. WING			C I 7/2017
NAME OF I	PROVIDER OR SUPPLIER		1	STATE, ZIP CODE		17/2017
KNUTE I	NELSON		I AVENUE EA DRIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 35	22000			
	policy. The administ perform audits usin	revised abuse prohibition strator or designee could g incident reports to ensure he abuse prohibition policy.				
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen				

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PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 245435 B. WING 11/15/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **420 12TH AVENUE EAST** KNUTE NELSON ALEXANDRIA, MN 56308 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

12/15/2017

Electronically Signed

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		COMPLETED	
		245435	B. WING	<u> </u>	11	/15/2017
NAME OF	PROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP COD 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	AND AND AND AND AND AND AND	HOULD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of vertice to correct the deficition of vertice to correct the deficition of the constructed at 5 difficulting with a partice constructed at 5 difficulting was constructed at 5 difficulting was constructed to be of 1961, an addition with determined to be of 1961, an addition with the conformal definition of the construction purple of the construction of the construction type of the facility was survival.	RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date.	*			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245435	B. WING _		11/	15/2017
NAME OF PROVIDER OR SUPPLIER KNUTE NELSON				STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX T A G	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	alarm system with secorridors and space monitored for autor notification. The factorial system is a second system of the second system of the second system is a second system of the second system of	ge 2 ne facility has a complete fire smoke detection in the es open to the corridor that is natic fire department cility has a licensed capacity of census of 77 at the time of the	K 00	00		
K 321 SS=E	The requirement at NOT MET as evide Hazardous Areas - CFR(s): NFPA 101	•	K 32	21		12/31/17
	having 1-hour fire refire rated doors) or system in accordant approved automatic option is used, the automatic office that do not exceed the door. Describe the floor automatic door. Describe the floor automatic door. Describe the floor automatic door. Area	re protected by a fire barrier esistance rating (with 3/4-hour an automatic fire extinguishing ce with 8.7.1. When the offire extinguishing system areas shall be separated from toke resisting partitions and e with 8.4. Doors shall be matic-closing and permitted to eld-applied protective plates 48 inches from the bottom of and zone locations of at are deficient in REMARKS.				
	Separation N/A a. Boiler and Fuel-F b. Laundries (larger c. Repair, Maintena	A fired Heater Rooms than 100 square feet) nce, and Paint Shops ms (exceeding 64 gallons)				

		IDENTIFICATION NUMBER		PLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245435	B. WING _		11/15/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
K 321	(exceeding 64 gallof. Combustible Stor (over 50 square fee g. Laboratories (if of Hazard - see K322) This REQUIREMED by: Based on observatifacility failed to mair room and one compactordance with the (NFPA 101) section condition could allogoridor making it up and efficient exiting undetermined amount of the facility tour long 11/15/2017, observe aled: 1) A combustible st without the proper in made of dividers. 2) A storage room of for the walls on the	age Rooms/Spaces et) classified as Severe NT is not met as evidenced ction and staff interview the ntain one hazardous storage bustible storage room in e 2012 Life Safety Code i 19.3.2.1.3. This deficient w smoke or fire to enter the ntenable and affect the quick for the 77 residents and an unt of staff and visitors. Detween 8:00 am to 12:00 pm ervations and staff interview orage room in the dining room requirements for the room constructed with plywood used otherside of the kitchen.	K 32	K 321 NFPA 101 - 2012 Edition Lif Safety Code Standard Section 19.3 Hazardous Areas - Enclosures We will have a licensed contractor the particle board wall and install sheetrock, tape, mud and paint to particle the 1 hour fire rating as required. Valso have a new door installed that 3/4 hour rated fire barrier. This is the Housekeeping supply room that ha inside room of more supplies. The and door that separates them is the of where the work will be performed has the proper sprinkler system the installed originally. In doing this wo should minimize fire or smoke enterinto the corridor for passage of resvisitors and staff to exit in the even emergency. Completion Date: To be completed December of 2017 Responsible Person: Thomas Sto Lead Maintenance	remove provide Ve will is a ne is an wall e area d. It at was rk, it ering idents, t of an	
	Fire Alarm System CFR(s): NFPA 101	- Testing and Maintenance	K 34	15	11/16/17	
		- Testing and Maintenance is tested and maintained in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245435	B. WING	=	11/1	5/2017
NAME OF F	PROVIDER OR SUPPLIER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	BE	(X5) COMPLETION DATE
K 345	accordance with a with the requireme Electric Code, and and Signaling Cod acceptance, maint available. 9.7.5, 9.7.7, 9.7.8,	n approved program complying ints of NFPA 70, National NFPA 72, National Fire Alarm e. Records of system enance and testing are readily and NFPA 25	K 345			
	by: Based on docume the Facility failed to Alarm System in a National Electric C Fire Alarm and Sig practice could affe Fire Alarm System A fire alarm system accordance with a with the requireme Electric Code, and and Signaling Cod acceptance, maint available. 9.7.5, 9.7.7, 9.7.8, Findings include: On facility tour bet on 11/15/2017, doc there were discrep Manual Fire Alarm detectors, Heat De	entation review and interview, to test and maintain the Fire ecordance with NFPA 70, ode, and NFPA 72, National maling Code. The deficient et 77 out of 77 residents. - Testing and Maintenance in stested and maintained in approved program complying ents of NFPA 70, National NFPA 72, National Fire Alarm e. Records of system enance and testing are readily and NFPA 25. ween 8:00 AM and 12:00 PM cumentation reviewed revealed eancies in the amount of Boxes, Photo detectors, Duct etectors and Supervisory Fire alarm report 2016 to the		K 345 NFPA 70, NFPA 72 section 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 NI and NFPA 72. Summit Companies who does our Fire Paninspection was notified about a discrepancy in 2 reports from 2016 2017 of the total number of devices devices were Manual Fire Alarm be Photo detectors, Heat detectors and Supervisory switches. On 11/16/17 Summit Companies sent out Greg to verify on the total number of devices were Manual Fire Alarm be Photo detectors, Heat detectors and Supervisory switches. On 11/16/17 Summit Companies sent an email in December and Knute submitted report to the Deputy State Fire Main The document will be placed into the Safety Code book. Completion Date: Re-inspection will becember 2017	FPA 70 sel s and s. The boxes, ad Sorell vices. report the rshal. he Life	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245435	B, WING			11/	15/2017	
NAME OF PROVIDER OR SUPPLIER KNUTE NELSON				42	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST LEXANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETIO DATE	
K 712	Continued From pacurrent 2017. This deficient cond Environmental Service Drills CFR(s): NFPA 101	ition was confirmed by the		345 712	Responsible Person: Thomas Sto Lead Maintenance	orer -	12/1/17	
	signal and simulatic conditions. Fire dril times under varying on each shift. The sand is aware that droutine. Responsib conducting drills is persons who are quality where drills are conducted of audible at 18.7.1.4 through 18.7.1.7 This REQUIREMED by: Based on record refacility failed to provat least quarterly on Life Safety Code (Nection 19.7.1.4 to practice could reduce conduct a safe and emergency, which and an undetermine Findings include:	ne transmission of a fire alarm on of emergency fire Is are held at unexpected g conditions, at least quarterly staff is familiar with procedures rills are part of established ility for planning and assigned only to competent ualified to exercise leadership. Inducted between 9:00 PM and announcement may be used alarms. 3.7.1.7, 19.7.1.4 through NT is not met as evidenced eview and staff interview the vide documentation of fire drills in each shift as required by the NFPA 101) 2012 edition, 19.7.1.7. This deficient ince the ability of staff to I timely response to a fire would affect all 77 residents ed amount of staff and visitors.			K 712 NFPA 101 □ 2012 Edition Safety Code Standard Section 19 19.7.1.7 Fire Drills With each Fire Drill that is perform Knute Nelson, all staff that are inwill sign a sign-in sheet. The sign will be submitted to the Lead Main person who will place the docume into the Life Safety Code book. Completion Date: Starting in Dece 2017	ned at volved in sheet ntenance entation		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245435	B. WING		11/15	/2017
NAME OF F	PROVIDER OR SUPPLIER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 20 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 901	with all of the requiremenths. This deficient conding Environmental Service Fundamentals - Buch CFR(s): NFPA 101 Fundamentals - Buch Building systems and through 4 requirementals - Buch Buch Buch Buch Buch Buch Buch Buch	Il sheets were not filled out red information for the last 12 stion was confirmed by the vices Supervisor. ilding System Categories re designed to meet Category ments as detailed in NFPA 99. ermined by a formal and assessment procedure fied personnel.	K 712	Responsible Person: John Hew Le Lead Maintenance		2/20/17
	by: Based on docume interview, the facilit systems are design through 4 requirem Categories are dete documented risk as performed by qualif practice could affect Findings include: During documentat and 12:00 PM on 1 review and staff interview.	ion review between 8:00 AM 1/15/2017, documentation erview revealed the required FPA 99 had not been started at		K901 NFPA 99 - 2012 Edition Charsections 1 - 4 Fundamentals □ Building System Categories The risk assessment in chapter 4 standard 1 □ 4 that apply to the Environment Services staff not having been train Medical gas equipment. All Enviror Services personnel shall participate annual training of the proper techn handling Medical Gas equipment if event of an urgent circumstance at are asked to assist nursing staff. The an In-service performed by the of Nursing or designated agent on	sections ital ined in inmental ine in the ique of in the ind they ihis will Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						E SURVEY PLETED	
		245435	B. WING			11/1	15/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
KNUTE NELSON					20 12TH AVENUE EAST LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 901	Continued From pa This deficient condi Environmental Serv	tion was confirmed by the	К9	01	annual basis. There will be a sign i of participants and kept by the Dire Nursing. A copy will also be placed the Life Safety Code book. Date Completed: December 20, 20 Responsible Person: John Hew Le Lead Maintenance	ector of into	
	CFR(s): NFPA 101 Electrical Systems - Maintenance and To The generator or ot and associated equivariate service within 10 secriterion is not metroprocess shall be processed shall be processed in the pr	- Essential Electric System esting her alternate power source ipment is capable of supplying econds. If the 10-second during the monthly test, a ovided to annually confirm this e safety and critical branches. esting of the generator and re performed in accordance inspected weekly, exercised tes 12 times a year in 20-40 xercised once every 36 uous hours. Scheduled test and automatic or manual oads, and are conducted by el. Maintenance and testing of er sources (Type 3 EES) are in	K 9	18	Ecad Maintenance		11/16/17
	program for periodic components is esta manufacturer requir	inspected annually, and a cally exercising the blished according to rements. Written records of esting are maintained and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION 6 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245435	B. WING		11/1	5/2017
NAME OF PROVIDER OR SUPPLIER KNUTE NELSON				STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 920	circuits are marked Minimizing the possemergency power sconsideration for no 6.4.4, 6.5.4, 6.6.4 (I 111, 700.10 (NFPA This REQUIREMENT by: Based on record refacility failed to provaccordance with the Safety Code (NFPA 2010 edition of NFF Emergency and Stadeficient practice copatients and an uncand visitors if the goduring a power outset in the facility tour on 11/15/2017 recorevealed the month completed from Jul This deficient condition and the facility tour on 11/15/2017 recorevealed the month completed from Jul This deficient condition Environmental Sent Electrical Equipment CFR(s): NFPA 101 Electrical Equipment Extension Cords Power strips in a paused for component	ES electrical panels and and readily identifiable. Sibility of damage of the source is a design ew installations. NFPA 99), NFPA 110, NFPA 70) NT is not met as evidenced eview and staff interview the vide test documentation in e 2012 edition of the Life a 101) section 9.1.3.1 and the PA 110 the Standard for andby Power Systems. This build affect the safety of all 77 determined amount of staff enerator failed to operate age. Detween 8:00 am to 12:00 pm and review and staff interview ly generator log was not by 2017- November 2017. Ition was confirmed by the vices Supervisor. Int - Power Cords and Extens are not each care vicinity are only eatient care vicinity are only	K 918	K918 NFPA 101 - 2012 Edition Lift Code section 9.1.3.1 and NFPA 11 Electrical Systems ☐ Essential Eles System Maintenance and Testing The Life Safety Code book did not the Monthly Generator log inspection report from July 2017 through Nov 2017. The folder of field reports was misplaced at the time of inspection contained the recorded information folder was found after the surveyo The inspection report information then transferred into the Life Safet book from July 2017 to the current December 2017. Date Completed: November 16, 20 Responsible Person: John Hew Lead Maintenance	have on ember as a that a, the r exited. was by Code t date of	11/16/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
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K 920	by qualified person 10.2.3.6. Power st may not be used for electronics), except rooms that do not upon that	es that have been assembled nel and meet the conditions of rips in the patient care vicinity or non-PCREE (e.g., personal tin long-term care resident use PCREE. Power strips for 363A or UL 60601-1. Power EE in the patient care rooms meet UL 1363. In non-patient strips meet other UL er strips are used with general usion cords are not used as a wiring of a structure. The determination of the purpose for ed and meets the conditions of ed and meets the conditions of the number of the purpose for each of the purpose for each of the purpose for ed and meets the conditions of the purpose for each of the purpose for ed and staff interview the ure a multiple outlet accordance with the 2012 to section 10.2.3.6 item 2 for a deficient practice could cause a cessary equipment or cause a cessary equipment or cause a cecsary equipm	K 920	K920 NFPA 101 □ 2012 Edition Safety Code of NFPA 99 section item 2 Power and Extensi To avoid an overload of a circuit vacual cause a power outage or find Maintenance personnel will correappliances that are plugged into powerstrips or extension cords. 1. In Room 604 a refrigerator was into an extension cord. Maintenant plugged the refrigerator directly in electrical outlet. 2. In room 506 a refrigerator was into a powerstrip. Maintenance plugged the refrigerator directly into an electrical outlet. 3. In the Activity room a microway	10.2.3.6 ion Cords which re the ct all s plugged nce nto an plugged lugged ectrical	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 12TH AVENUE EAST ALEXANDRIA, MN 56308		
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K 920	powerstrip. 3) In the activity rocinto a powerstrip. 4) In the Life Enhar was plugged into a	efrigerator was plugged into a om a microwave was plugged incommon a microwave was plugged into a microwave was plug	K 9.	plugged into a powerstrip. Maintena plugged the microwave directly into electrical outlet. 4. In the Life Enhancement office a refrigerator was plugged into a pow Maintenance plugged the refrigerat directly into and electrical outlet. Date Completed: November 2017 Responsible Person: John Hew Le Lead Maintenance	e an Verstrip, tor	