MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Knute Nelson	H5435014	April 22, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
420 12th Avenue East	10:45 a.m.- 4:00 p.m.	March 10, 2017
Facility City:	**Investigator's Name and Title:**	
Alexandria	Jill Hagen, R.N., Special Investigator	

State:	ZIP:	County:
Minnesota	56308	Douglas

☒ **Nursing Home**

Allegation(s):
It is alleged that a resident was neglected when s/he fell and was burned by the baseboard heater in the resident's room.

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence, neglect occurred when the facility failed to assess the risk for burns from a baseboard heater in the resident's room. The resident rolled out of bed, came in contact with the heater, and sustained first, second, and third degree burns to the left hip and right foot including the heel and great toe.

The resident's diagnoses included peripheral neuropathy or decreased feeling to the lower extremities. The resident was capable of making his/her needs known to staff but required the assistance from others for decision making. Due to declining health, the resident was provided hospice care. At the time of the fall, the resident required extensive assistance from two staff and a walker for ambulation, two staff for repositioning, transfers, toilet use, and a wheelchair for mobility for longer distances. The resident had a history of falls at the facility and care plan interventions included keeping the call light and commonly used items within the resident's reach, reminding the resident of safety precautions, providing proper footwear, and staying with the resident in the bathroom with toileting. At the time of the fall, the facility had implemented an alarm that alerted staff of the resident's attempt at self-transfers.

Early one morning, staff entered the resident's room responding to the silent alarm notification. The resident was lying between the bed and the baseboard heater with his/her left hip and right foot in contact with the heater. The left hip burn was not measured but determined to be first degree. The burn to the right foot measured 17 centimeters (cm) by 5 cm with weeping blisters present on the right heel and great toe. The burn was second degree. There was a third degree burn to a small area of the right great toe that

measured .25 cm by 3 cm. The area was white with hard skin. The resident had an order for morphine sulfate for moderate to severe pain and staff provided the medication.

An interview with a staff member established when s/he found the resident on the floor touching the baseboard heater, s/he placed her/his leg between the heater and the resident to protect him/her from the heat. The staff said the baseboard heater was hot and it was difficult to keep her/his leg on the heater until help arrived.

At the time of the fall, the resident's bed was positioned parallel to the electric baseboard heater with a nightstand between the bed and heater. There was approximately 19.5 inches between the resident's bed and the heater. During an onsite visit, the surface of the baseboard heater taken with a laser infrared device was 130 degrees Fahrenheit. There was no prior assessment of the burn risk to the resident from the baseboard heater located in the resident's room.

At the time of the incident, the facility had no policy or system in place to monitor the surface temperature of the baseboard heater. Of the five resident rooms with the same type of baseboard heater, none of the beds were positioned close to the heater.

The resident passed away two days after the incident.

The death certificate indicated the primary cause of death was pneumonia.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

Even though the facility was aware of the resident's fall risk, they failed to have a system in place with policy and procedure to ensure the environmental assessment included the surface temperature of the baseboard heater.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Met
The facility was found to be in compliance with State Statutes for Chapters 144 & 144A. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

A follow-up visit was made by the Minnesota Department of Health in June, 2016 to determine compliance. Fall risk assessments were revised to include the surface temperature of the baseboard heater. Facility staff completed the revised assessment on all residents at risk for falls. Environmental services developed a policy for a consistent procedure for measuring baseboard heater surface temperatures. A log book of the recorded temperatures was kept at the nurse station and communicated to staff. Facility staff were trained on the new and revised policies. Audits were completed to ensure compliance. The facility was found to be back in compliance with the federal regulations and state licensing order.

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports
- [x] Therapy and/or Ancillary Services Records
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

☒ Death Certificate

Additional facility records:

☒ Resident/Family Council Minutes

☒ Staff Time Sheets, Schedules, etc.

☒ Facility Internal Investigation Reports

☒ Facility In-service Records

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Seven

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify:

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: The resident had passed away.

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ○ Yes ○ No ◉ N/A

Specify:

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify:

Did you interview the resident(s) identified in allegation:

○ Yes ○ No ◉ N/A Specify: The resident had passed away.

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Five

Interview with staff: ◉ Yes ○ No ○ N/A Specify:

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Six

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:
_____	_____	_____	_____	_____	_____

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Nursing Services
☒ Call Light
☒ Use of Equipment
☒ Safety Issues
☒ Facility Tour
☒ Injury
☒ Other: Surface temps of base board heater

Was any involved equipment inspected: ◉ Yes ○ No ○ N/A

Was equipment being operated in safe manner: ○ Yes ◉ No ○ N/A

Were photographs taken: ◉ Yes ○ No Specify: Resident's room and baseboard heater

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Alexandria Police Department

Douglas County Attorney

Alexandria City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5435014. As a result, the following deficiency is issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to comprehensively assess and provide adequate supervision to reduce the risk of injury from falls for 1 of 15 (R1) residents reviewed for falls. Actual harm occurred when R1 fell from bed and came into direct contact with the electric baseboard heater that caused first, second, and third degree burns to R1's right foot and left hip. Findings include: Observation of the room used by R1 with the director of nursing (DON) on 4/22/2016, at 12:00	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 1	F 323		

p.m. established R1's bed had been located parallel to the outside window and an electric baseboard heater. The electric baseboard heater was located directly under the outside window and measured 6.25 inches in height by 74 inches in length with an approximate 1 inch open area running along the top of the heater. According to the DON a nightstand measuring 19.5 inches long and 18.75 inches wide was located between the bed and the heater. Additionally, R1 had a wooden bedside table in front of the bedside table that was no longer in the room.

R1's medical record was reviewed and established R1 was admitted to the facility on 11/17/2015, from the hospital with diagnoses that included sepsis with pneumonia, respiratory failure, and peripheral neuropathy or damage to the nerves of the feet. Due to declining health status, on 12/19/2016, R1 was admitted to hospice care. Review of the significant change minimum data set (MDS) dated 12/28/2015, revealed R1's scored a 10 on the brief interview of mental status (BIMS) assessment indicating R1 was moderately cognitively impaired. The MDS established R1 required extensive assistance from one staff for repositioning in bed, transferring from the bed to the chair, and the use of the toilet. R1 required extensive assistance from two staff and a walker to ambulate in the room and used a wheelchair with staff assistance for longer distances. R1's was unsteady changing positions from sitting to standing and with walking. On 2/1/2016, R1 died at the facility under hospice care.

R1's care plan dated 11/18/2016, indicated fall interventions for R1 included keeping the call light within reach, reminding R1 of safety precautions,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2	F 323		

encourage R1 to use the call light, provide for proper footwear, staff to keep commonly used items within R1's reach, and to remain with R1 when in the bathroom.

A progress note dated 12/5/2015, indicated at 7:00 p.m. R1 was found sitting in the doorway between R1's bathroom and bedroom with the wheelchair behind R1. R1 fell during a self transfer attempt from the toilet to the wheelchair. No injuries were observed. The intervention was to have staff remain with R1 when in the bathroom.

A progress note dated 12/26/2015, revealed at 8:15 a.m. staff heard R1 call out for assistance. The door to R1's room was shut. R1 was sitting on the floor against a wall with the wheelchair between R1 and the bed. The call light was on and R1 was barefoot. R1 attempted to self transfer to the bathroom without waiting for staff assistance. R1 had bruising on the right upper leg, right elbow, and fingers. The immediate interventions following the fall was for staff to leave R1's room door partially open at night.

R1's fall assessment dated 12/28/2015, established R1 had a history of falls prior to admission and a fall at the facility when self-transferring in the bathroom. R1 stated she self transfers and falls all the time. The assessment stated R1's family refused a bed/chair alarm indicating the noise would upset R1. The intervention was to place a silent alarm clipped to R1's clothing that alarmed through the facility call system. Although the fall assessment addressed environmental risk factors, the assessment failed to address the risk of burns related to the electric baseboard heater.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3	F 323		

A progress note on 1/4/2016, at 1:48 p.m. established staff met with R1 and R1's family. R1 stated she was upset with the chair and bed alarms. Both R1 and family agreed to discontinue the silent clip alarms if R1 agreed to wait for staff assistance with transferring. Staff explained the risks verses benefits of discontinuing the alarms to R1 and the family however, staff failed to assess and initiate an alternative intervention to prevent falls.

A progress note dated 1/5/2016, revealed at 6:30 p.m. staff found R1 laying on her back on the floor in a lounge area of her room with the top of R1' head under the window and feet facing the door. R1 complained of a painful left shoulder with a 5 centimeter (cm) by 2 cm abrasion on the left wrist that required steri-strips. In addition, staff observed a bruise to R1's left eye suggesting R1 hit her head. The note stated family would discuss risks of ongoing falls with R1. The immediate intervention included informing staff to ensure R1's needs were met prior to leaving R1 in her room.

The care plan dated 1/6/2016, established R1 required the assistance from two staff for transfers from bed and chair, assistance to use the bathroom and bedside commode, ambulation, and bed mobility. R1 was continent of both bowel and bladder and assisted with toileting according to R1's request. The care plan directed staff to reposition R1 every three hours in bed and every 2-1/2 hours in the chair or as requested. Additional fall precautions included leaving R1 room door partially open and a silent clip alarm that alerted staff through the facility's pager system and was clipped to R1's clothing as R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4	F 323		

tolerated.

A progress note dated 1/18/2016, at 1:09 p.m. stated R1 was asleep in bed with the silent clip alarm on R1. No other documentation indicated when staff had started using the silent clip alarm.

A progress note on 1/20/2016, at 11:31 a.m. stated family indicated that R1 no longer had a memory of her falls and hoped R1 would not try to self transfer. Staff confirmed to family the silent clip alarm was on however family stated when R1 was aware the alarm was there, she would remove it. No further assessment occurred to develop alternative interventions to prevent further falls. Despite R1's history of falls and removing the clip silent tab alarm, staff continued the same intervention to alert staff of R1's attempts at self transferring.

A progress note on 1/29/2016, at 5:45 p.m. revealed R1 complained of feeling anxious with tightness in the chest. Staff gave R1 Lorazepam an antianxiety medication and nebulizer treatment. At 8:13 p.m. R1 was sleeping. At 11:13 p.m. R1 was hollering out, hyperventilating, attempting to crawl out of bed. Despite non-pharmacological interventions attempted, staff were not able to calm R1. Lorazepam was given to R1. On 1/30/2016, at 1:41 a.m. staff documented R1 was resting comfortably.

A progress note on 1/30/2016, revealed at 7:50 a.m. staff found R1 on on her back on the floor between the bed and window. R1's right leg was above and over her left leg with the right foot and toe in a one inch opening at the top of the electric baseboard heater. R1's left hip was against the lower portion of the heater. At 10:48 a.m. a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5	F 323		

progress note revealed R1 had a mild left hip burn presenting as redness, most likely a first degree burn without blistering and/or hardness. The red area measured 17 cm by 4 to 5 cm with irregular edges. The right foot assessment described a reddened area that measured 9 cm from the tip of the great toe to the ball of the foot and was 9 cm's wide. The proximal right great toe joint and bottom of the ball of the right foot had blistered, with a scant amount of yellow drainage probably second degree burns. Also, just left of the right great toenail there was an area that measured .25 cm by 3 cm, white in color and hard to the touch probably a third degree burn. Immediate interventions included moving R1's bed away from the electric baseboard heater, replacing the clip alarm with a sensor pad silent alarm in the bed and chair, placing a blue mat on the floor next to the bed, and initiated hourly safety and pain assessments.

Review of the incident report dated 1/30/2016, at 11:09 a.m. revealed following the fall with burns, R1 was lethargic and rated her pain at a 5 on a 1 to 10 scale with 10 being the worst pain. R1 was oriented to person, place, time, and situation and no predisposing environmental factors were assessed including the electric baseboard heater. The incident report stated R1 had a history of removing her silent clip alarm.

An interview with LPN-A on 5/5/2016, at 10:53 a.m. revealed R1 had a history of self transferring attempts and of removing the clip silent alarm. Staff frequently checked on R1 at least every hour. On 1/30/2016, LPN-A responded to R1's room immediately when notified by nursing assistant (NA)-B that R1 was on the floor. R1 right toe was located in the opening at the top of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6	F 323		

the electric baseboard heater and R1's hip was against the lower side of the heater. R1 had removed the silent clip alarm which was on the floor next to R1 and not sounding. R1's bed was in the low position. R1 had no complaints of pain. LPN-A and two additional staff transferred the resident with a sling mechanical lift to R1's recliner. LPN-A assessed the burns, moved R1's bed away from the heater, and developed additional interventions.

An interview with NA-B on 5/5/2016, at 12:15 p.m. indicated she was aware that R1 had a history of self transferring and removing the silent clip alarm. NA-B was alerted to R1's room when the silent clip alarm activated on her pager. R1 was lying on the floor between the bed and the window with R1's right toes inside the open space of the electric baseboard heater with her left hip touching the lower portion of the heater. R1's silent clip alarm had been removed and NA-B believed was activated by R1's movements on the floor. NA-B immediately removed R1's toes from the heater and placed her leg between R1's hip and the heater. NA-B said the heater was hot and difficult to keep her leg against the heater. NA-B said R1 often removed the silent clip alarm from her clothing even though staff attempted to place the alarm in various locations.

An interview with LPN-C on 5/5/2016, at 4:02 p.m. revealed she worked the night shift prior to R1's fall on 1/30/2016. LPN-C said R1 would have been checked on by staff during last rounds between 4:00 and 5:00 a.m. LPN-C could not remember whether R1 was awake at 7:00 a.m. for the incentive spirometer and deep breathing treatment to be completed every two hours when R1 was awake.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 An interview with the employee-D maintenance established an audit of the surface temperatures of the electric baseboard heater was started on 2/1/2016. The temperatures were taken with a laser infrared device at the base or bottom of the heater. The temperatures varied from 60 degrees Fahrenheit to 119 degrees Fahrenheit. On 2/2/2016, surface temperature were obtained from the top of the electric baseboard heater. The surface temperature for the electric baseboard heater in R1's room was 130 degrees Fahrenheit. After 2/2/2016, staff only monitored the surface temperatures of the lower cooler portion of the heater. Each resident's room had a thermostat that was individually adjusted to a desired temperature. An interview with the Director of Environmental Services (ESD) on 5/5/2016, at 10:36 a.m. established a standard had not been developed for measuring surface temperatures of the electric baseboard heaters. The measurements should always be taken from the same distance. The ESD had not trained staff to have a standard in measuring the temperatures. The ESD said the department continued to complete random audits of the surface temperatures from the base of the heater and not the surface temperature from the top of the heater. The audit information had not been communicated to the nursing staff however, the resident beds had been moved away from the heaters. Review of the facility's policy and procedure titled Risk Management revised 6/24/2011, stated a fall assessment would be completed as needed with a fall incident. If the fall assessment determined a	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 resident to be a high risk for falls the RN will review, select, and care plan appropriate fall precautions. Following a fall, an investigative protocol was to be completed that included identification of hazards and risks, an evaluation and analysis of the incident, implementation of interventions, and monitoring and modifying the plan as needed.	F 323		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00113	A. BUILDING: _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5435014. As a result the following correction order is issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Office of	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00113	A. BUILDING: _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Health Facility Complaints; 85 East Seventh Place, Suite 220, St. Paul, Minnesota, 55164-0970.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the facility failed to comprehensively assess and provide adequate supervision to reduce the risk of injury from falls for 1 of 15 (R1) residents reviewed for falls. Actual harm occurred when R1 fell from bed and came into direct contact with the electric baseboard heater that caused first, second, and third degree burns to R1's right foot and left hip. Findings include: Observation of the room used by R1 with the director of nursing (DON) on 4/22/2016, at 12:00 p.m. established R1's bed had been located	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00113	A. BUILDING: _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 2 parallel to the outside window and an electric baseboard heater. The electric baseboard heater was located directly under the outside window and measured 6.25 inches in height by 74 inches in length with an approximate 1 inch open area running along the top of the heater. According to the DON a nightstand measuring 19.5 inches long and 18.75 inches wide was located between the bed and the heater. Additionally, R1 had a wooden bedside table in front of the bedside table that was no longer in the room. R1's medical record was reviewed and established R1 was admitted to the facility on 11/17/2015, from the hospital with diagnoses that included sepsis with pneumonia, respiratory failure, and peripheral neuropathy or damage to the nerves of the feet. Due to declining health status, on 12/19/2016, R1 was admitted to hospice care. Review of the significant change minimum data set (MDS) dated 12/28/2015, revealed R1's scored a 10 on the brief interview of mental status (BIMS) assessment indicating R1 was moderately cognitively impaired. The MDS established R1 required extensive assistance from one staff for repositioning in bed, transferring from the bed to the chair, and the use of the toilet. R1 required extensive assistance from two staff and a walker to ambulate in the room and used a wheelchair with staff assistance for longer distances. R1's was unsteady changing positions from sitting to standing and with walking. On 2/1/2016, R1 died at the facility under hospice care. R1's care plan dated 11/18/2016, indicated fall interventions for R1 included keeping the call light within reach, reminding R1 of safety precautions, encourage R1 to use the call light, provide for proper footwear, staff to keep commonly used	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00113	A. BUILDING: _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 items within R1's reach, and to remain with R1 when in the bathroom. A progress note dated 12/5/2015, indicated at 7:00 p.m. R1 was found sitting in the doorway between R1's bathroom and bedroom with the wheelchair behind R1. R1 fell during a self transfer attempt from the toilet to the wheelchair. No injuries were observed. The intervention was to have staff remain with R1 when in the bathroom. A progress note dated 12/26/2015, revealed at 8:15 a.m. staff heard R1 call out for assistance. The door to R1's room was shut. R1 was sitting on the floor against a wall with the wheelchair between R1 and the bed. The call light was on and R1 was barefoot. R1 attempted to self transfer to the bathroom without waiting for staff assistance. R1 had bruising on the right upper leg, right elbow, and fingers. The immediate interventions following the fall was for staff to leave R1's room door partially open at night. R1's fall assessment dated 12/28/2015, established R1 had a history of falls prior to admission and a fall at the facility when self-transferring in the bathroom. R1 stated she self transfers and falls all the time. The assessment stated R1's family refused a bed/chair alarm indicating the noise would upset R1. The intervention was to place a silent alarm clipped to R1's clothing that alarmed through the facility call system. Although the fall assessment addressed environmental risk factors, the assessment failed to address the risk of burns related to the electric baseboard heater. A progress note on 1/4/2016, at 1:48 p.m. established staff met with R1 and R1's family. R1	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00113	A. BUILDING: _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4 stated she was upset with the chair and bed alarms. Both R1 and family agreed to discontinue the silent clip alarms if R1 agreed to wait for staff assistance with transferring. Staff explained the risks verses benefits of discontinuing the alarms to R1 and the family however, staff failed to assess and initiate an alternative intervention to prevent falls. A progress note dated 1/5/2016, revealed at 6:30 p.m. staff found R1 laying on her back on the floor in a lounge area of her room with the top of R1' head under the window and feet facing the door. R1 complained of a painful left shoulder with a 5 centimeter (cm) by 2 cm abrasion on the left wrist that required steri-strips. In addition, staff observed a bruise to R1's left eye suggesting R1 hit her head. The note stated family would discuss risks of ongoing falls with R1. The immediate intervention included informing staff to ensure R1's needs were met prior to leaving R1 in her room. The care plan dated 1/6/2016, established R1 required the assistance from two staff for transfers from bed and chair, assistance to use the bathroom and bedside commode, ambulation, and bed mobility. R1 was continent of both bowel and bladder and assisted with toileting according to R1's request. The care plan directed staff to reposition R1 every three hours in bed and every 2-1/2 hours in the chair or as requested. Additional fall precautions included leaving R1 room door partially open and a silent clip alarm that alerted staff through the facility's pager system and was clipped to R1's clothing as R1 tolerated. A progress note dated 1/18/2016, at 1:09 p.m. stated R1 was asleep in bed with the silent clip	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00113	A. BUILDING: _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 alarm on R1. No other documentation indicated when staff had started using the silent clip alarm. A progress note on 1/20/2016, at 11:31 a.m. stated family indicated that R1 no longer had a memory of her falls and hoped R1 would not try to self transfer. Staff confirmed to family the silent clip alarm was on however family stated when R1 was aware the alarm was there, she would remove it. No further assessment occurred to develop alternative interventions to prevent further falls. Despite R1's history of falls and removing the clip silent tab alarm, staff continued the same intervention to alert staff of R1's attempts at self transferring. A progress note on 1/29/2016, at 5:45 p.m. revealed R1 complained of feeling anxious with tightness in the chest. Staff gave R1 Lorazepam an antianxiety medication and nebulizer treatment. At 8:13 p.m. R1 was sleeping. At 11:13 p.m. R1 was hollering out, hyperventilating, attempting to crawl out of bed. Despite non-pharmacological interventions attempted, staff were not able to calm R1. Lorazepam was given to R1. On 1/30/2016, at 1:41 a.m. staff documented R1 was resting comfortably. A progress note on 1/30/2016, revealed at 7:50 a.m. staff found R1 on on her back on the floor between the bed and window. R1's right leg was above and over her left leg with the right foot and toe in a one inch opening at the top of the electric baseboard heater. R1's left hip was against the lower portion of the heater. At 10:48 a.m. a progress note revealed R1 had a mild left hip burn presenting as redness, most likely a first degree burn without blistering and/or hardness. The red area measured 17 cm by 4 to 5 cm with irregular edges. The right foot assessment	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00113	A. BUILDING: _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 described a reddened area that measured 9 cm from the tip of the great toe to the ball of the foot and was 9 cm's wide. The proximal right great toe joint and bottom of the ball of the right foot had blistered, with a scant amount of yellow drainage probably second degree burns. Also, just left of the right great toenail there was an area that measured .25 cm by 3 cm, white in color and hard to the touch probably a third degree burn. Immediate interventions included moving R1's bed away from the electric baseboard heater, replacing the clip alarm with a sensor pad silent alarm in the bed and chair, placing a blue mat on the floor next to the bed, and initiated hourly safety and pain assessments. Review of the incident report dated 1/30/2016, at 11:09 a.m. revealed following the fall with burns, R1 was lethargic and rated her pain at a 5 on a 1 to 10 scale with 10 being the worst pain. R1 was oriented to person, place, time, and situation and no predisposing environmental factors were assessed including the electric baseboard heater. The incident report stated R1 had a history of removing her silent clip alarm. An interview with LPN-A on 5/5/2016, at 10:53 a.m. revealed R1 had a history of self transferring attempts and of removing the clip silent alarm. Staff frequently checked on R1 at least every hour. On 1/30/2016, LPN-A responded to R1's room immediately when notified by nursing assistant (NA)-B that R1 was on the floor. R1 right toe was located in the opening at the top of the electric baseboard heater and R1's hip was against the lower side of the heater. R1 had removed the silent clip alarm which was on the floor next to R1 and not sounding. R1's bed was in the low position. R1 had no complaints of pain. LPN-A and two additional staff transferred the	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00113	A. BUILDING: _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 resident with a sling mechanical lift to R1's recliner. LPN-A assessed the burns, moved R1's bed away from the heater, and developed additional interventions. An interview with NA-B on 5/5/2016, at 12:15 p.m. indicated she was aware that R1 had a history of self transferring and removing the silent clip alarm. NA-B was alerted to R1's room when the silent clip alarm activated on her pager. R1 was lying on the floor between the bed and the window with R1's right toes inside the open space of the electric baseboard heater with her left hip touching the lower portion of the heater. R1's silent clip alarm had been removed and NA-B believed was activated by R1's movements on the floor. NA-B immediately removed R1's toes from the heater and placed her leg between R1's hip and the heater. NA-B said the heater was hot and difficult to keep her leg against the heater. NA-B said R1 often removed the silent clip alarm from her clothing even though staff attempted to place the alarm in various locations. An interview with LPN-C on 5/5/2016, at 4:02 p.m. revealed she worked the night shift prior to R1's fall on 1/30/2016. LPN-C said R1 would have been checked on by staff during last rounds between 4:00 and 5:00 a.m. LPN-C could not remember whether R1 was awake at 7:00 a.m. for the incentive spirometer and deep breathing treatment to be completed every two hours when R1 was awake. An interview with the employee-D maintenance established an audit of the surface temperatures of the electric baseboard heater was started on 2/1/2016. The temperatures were taken with a laser infrared device at the base or bottom of the heater. The temperatures varied from 60 degrees	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00113	A. BUILDING: _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 Fahrenheit to 119 degrees Fahrenheit. On 2/2/2016, surface temperature were obtained from the top of the electric baseboard heater. The surface temperature for the electric baseboard heater in R1's room was 130 degrees Fahrenheit. After 2/2/2016, staff only monitored the surface temperatures of the lower cooler portion of the heater. Each resident's room had a thermostat that was individually adjusted to a desired temperature. An interview with the Director of Environmental Services (ESD) on 5/5/2016, at 10:36 a.m. established a standard had not been developed for measuring surface temperatures of the electric baseboard heaters. The measurements should always be taken from the same distance. The ESD had not trained staff to have a standard in measuring the temperatures. The ESD said the department continued to complete random audits of the surface temperatures from the base of the heater and not the surface temperature from the top of the heater. The audit information had not been communicated to the nursing staff however, the resident beds had been moved away from the heaters. Review of the facility's policy and procedure titled Risk Management revised 6/24/2011, stated a fall assessment would be completed as needed with a fall incident. If the fall assessment determined a resident to be a high risk for falls the RN will review, select, and care plan appropriate fall precautions. Following a fall, an investigative protocol was to be completed that included identification of hazards and risks, an evaluation and analysis of the incident, implementation of interventions, and monitoring and modifying the plan as needed.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00113	A. BUILDING: _____ B. WING _____	C 05/06/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could educate staff on the importance of including an assessment of all environmental hazards to reduce a residents risk of injury. The maintenance director and director of nursing could ensure surface temperature audits of the electric baseboard heaters and other environmental hazards are communicated to the nursing staff. The information could be shared with the quality assurance/risk management committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 15, 2016

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

Re: Enclosed Reinspection Results - Complaint Number H5435014

Dear Ms. Solwold:

On June 13, 2016 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on May 6, 2016. At this time these correction orders were found corrected.

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

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

Sincerely,

Mark Meath

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

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 15, 2016

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

RE: Project Number H5435014

Dear Ms. Solwold:

On May 18, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 23, 2016. (42 CFR 488.422)

In addition, on May 18, 2016, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on May 6, 2016. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On June 13, 2016, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on May 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 7, 2016. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on May 6, 2016, as of June 7, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 7, 2016.

In addition, this Department recommended to the CMS Region V Office the following action related to the imposed remedy in our letter of May 18, 2016:

- Civil money penalty for the deficiency cited at F323, remain in effect. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, and appeal rights.

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

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

Sincerely,

Mark Meath

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

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