Electronically delivered
September 29, 2021

Administrator
Knute Nelson
420 12th Avenue East
Alexandria, MN 56308

RE: CCN: 245435
Cycle Start Date: September 8, 2021

Dear Administrator:

On September 8, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 14, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 14, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 14, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 14, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Knute Nelson will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 14, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 March 8, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	C 09/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/8/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5435031C (MN76223), with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide safe transport for	F 689	F 689 Free of Accidents Hazards/Supervision	10/1/21

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

Electronically Signed | 10/01/2021

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F 689	Continued From page 1 residents who require the use of a wheelchair on the facility bus. This resulted in 1 of 3 residents (R1) who were not strapped in securely and slid out of wheelchair during transport, causing multiple fractures. Findings include: R1's quarterly Minimal Data Set (MDS) dated 8/18/21, indicated R1's diagnoses included dementia, hemiplegia and showed moderate cognitive impairments. R1 required extensive assist by two staff members for bed mobility, dressing, toileting and extensive assist of one staff member for locomotion on and off the unit. R1's care plan printed 9/8/21, indicated R1 was at risk for falls related to impaired balance, neuropathy, hemiplegia, arthritis and anxiety with interventions that included call don't fall signs in room, assist with positioning in wheelchair to assure balance, low bed, floor mat while in bed, and one way glide in wheelchair. Further review of R1's care plan, indicated "when on outing- be sure resident is sitting properly in wheelchair, activity staff were educated to call nursing facility on outing if any need for repositioning." Review of facility incident report indicated on 8/27/21, at 11:16 a.m. R1 was attending an outing in the facility van, which was driven by facility staff. R1 was in wheelchair (w/c) and when driver applied brakes at stop light, R1 slid out of w/c to the floor of the van. The driver immediately pulled over and Emergency Medical Services (EMS) were called as resident complained of lower extremity pain. R1's emergency room provider note dated	F 689	Devices How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident R1 received multiple fractures because of the deficient practice of facility not providing safe transport for residents who require the use of a wheelchair on the facility bus. For R1 facility has completed training to ensure that employees who operate the facility bus and transport residents who use wheelchairs are using the safety devices including seatbelt to secure residents to prevent chance of injuries and keep environment free of accident hazards as possible. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who use the facility bus have this potential; all facility staff who operate the facility bus have received appropriate training on the use of safety devices including seatbelt with residents who require the use of wheelchairs when they are on the bus. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not occur. All facility staff who operate the facility bus have been educated on the importance of securing residents who require the use of wheelchairs with the safety devices including seatbelt while riding in the facility bus. These staff were educated on 9/ 8-10/21 by facility Administrator. An activity bus safety log has been developed	

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F 689	Continued From page 2 8/27/21, indicated R1 "was in her wheelchair on a bus when the bus driver slammed on her brakes. The wheelchair was locked in place and patient catapulted out of her wheelchair. She landed with her left leg underneath her. She complains of pain about her left ankle and left lower leg. EMS [emergency medical services] noted deformity and when they lifted her it seemed to be rotated. Patient does have a previous history of stroke and left-sided deficits. She does not bear weight but typically uses a wheelchair." Further review of provider notes indicated, "Patient has IV [intravenous] access with fentanyl titrated for pain x-ray of the left tib-fib, left ankle and left foot are personally reviewed shows evidence of an acute bimalleolar facture of the left ankle ...fracture of the rest of the tib-fib. There is a proximal phalanx fracture of the left great toe. With those fracture I personally placed patient into a posterior splint with stirrup component. Regarding the great toe fracture buddy tape was placed by nurse." R1's progress note dated 8/27/21, indicated "resident has a broken Left great toe and Left ankle." R1's fall risk assessment dated 8/30/21, indicated "resident had a fall out of wheelchair while on an activity outing. Seeked [SIK] care at the ER [emergency room] where she was found to have multiple fractures. New intervention: when on an outing, be sure resident is sitting properly in wheelchair. Activity staff educated to call nursing facility on outing if any need for repositioning. Administrator to be providing further education to life enhancement staff on bus safety. Will monitor for any changes." The fall assessment lacked evidence the failure	F 689	to be used each time a resident is on the facility bus, it is to be completed to ensure that all areas of this check list have been checked off and all safety devices including seatbelts are being used. Facility staff that use the facility bus were trained on this on 9/ 8-10/21, this included activity staff and maintenance staff. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur. QAPI (Quality Assurance Performance and Implementation) audits will be conducted on all residents who require the use of a wheelchair that ride on the facility bus to ensure that all safety devices including seatbelts are being used. Audits of the activity bus safety log will be audited to ensure that facility staff are correctly using these audits with each resident transport in facility bus. These audits will be done weekly for 4 weeks, then randomly by Administrator or designee. The results of these audits will be taken to the QAPI committee for further recommendations. The date that each deficiency will be corrected Completion date: October 1, 2021.	

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F 689	Continued From page 3	F 689		

to have R1 wearing a seatbelt while the bus was in transport was addressed as part of the facility's correction.

On 9/8/21, at 10:31 a.m. activities assistant (AA)-A indicated R1 was noted to be unpredictable while in her wheelchair. AA-A indicated she was driving the bus and AA-B was also assisting on the trip and was in the back of the bus with the residents at the time of the incident. AA-A indicated, "[AA-B] kept saying [R1] sit back and [R1] kept trying to sit up and get out. We were driving and stopped when [R1] slipped out of her chair." Further, AA-A indicated staff had locked R1's wheelchair to the bottom of the bus and locked the wheelchair brakes, however R1 did not have a seat belt on. AA-A confirmed that each spot on the facility bus has a seatbelt but stated, "I usually don't use the seatbelts." In addition, AA-A indicated that there are currently no more planned bus trips (all out of building activities were on hold), but there had also not been any additional training provided regarding safe transportation or seat belt use on the facility bus.

On 9/8/21, at 10:41 a.m. AA-B indicated R1 was paralyzed on her left side and utilizes a wheelchair for transportation. AA-B stated while on the outing to the apple orchard, R1 "started to jiggle and I directed her to sit still. On the way back, the bus driver put the brake on and R1 came out of her chair. We [staff] pulled over to the right and called 911 and then called [facility]." Further, AA-B indicated R1 was scooted down "quite a bit" in her wheelchair and she was unable to reposition her due to R1 requiring a mechanical hoyer lift for transfers. In addition, AA-B stated, "[R1] was in the back of the bus, her

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F 689	Continued From page 4	F 689		

wheelchair was strapped to the floor and locked but there was no strap across her and we were not trained to use the seatbelts. No one is buckled in the bus we [staff] just strap in the chair. The residents in the seats are strapped but the residents in wheelchairs are not wearing a seatbelt. I was never shown to use the strap but just trained to strap down the chair and put the brakes on." AA-B indicated since the incident, there have been no additional training provided to staff related to safe transportation and seat belt use. Lastly AA-B stated, "Since the incident nothing has changed," no one has talked to be about the seatbelts or trained me how to use them appropriately. AA-B added that she inquired about more training but has not received any further education. AA-B did confirm all off campus activities requiring vehicle transport were canceled until further notice.

On 9/8/21, at 1:10 p.m. administrator was interviewed regarding the incident and stated "ultimately it's a lack of foresight. They [AA-A and AA-B] weren't checking and securing; they were both at fault for not ensuring the seat belt was on [R1]. The seatbelt was there, the equipment was there, and they have been trained properly." Further, administrator indicated, "we have halted all outings for activities for the time period. I am just seeing how this goes over as of right now I talked to them [AA-A and AA-B] about what was wrong." Administrator indicated staff were expected to use the seat belt for all residents during transport on the bus.

On 9/8/21, at 1:33 p.m. R3 indicated she was on the outing and the bus driver applied the brakes, "not real hard", and "everyone to my knowledge was locked in except the lady in the wheelchair.

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F 689	Continued From page 5	F 689		

She should have had on her seatbelt but that is just my opinion."

On 9/8/21, at 1:38 p.m. R2 stated staff had strapped her wheelchair to the floor on the outing, however, R2 then stated, "I don't think they ever put a seat belt on me." R2 indicated she was in front of R1 at the time of the incident on the bus when the brakes were applied and R1 "got thrown forward and hit the back of my chair and I put my arms out to brace myself in front of the next one. [R1] broke her ankle and toe."

On 9/8/21, at 2:19 p.m. activities director (AD) indicated R1 had slid out of her seat while on the way back to the facility from the outing. AD indicated she went to meet the bus in a parking lot to help and R1 was on the floor of the bus and 911 was called. AD indicated she expected staff to ensure resident safety while on an outing and assist with applying the seatbelts for both residents in the seats and in personal wheelchairs. AD indicated AA-A and AA-B are the only two staff members for activity outings at this time. Further, AD stated "[AA-A] and [AA-B] have not been re-trained since the incident. I canceled all bus trips for a month. I felt they both needed a break from it and take a breather. We will retrain before we go out again." When asked about education provided to activities staff prior to going on an outing, AD stated "I don't have proof of education on the policies. We only have healthcare academy. I should put that in their records that they got that information and were trained."

Review of facility policy titled Off Premise Outings dated 11/14/18, indicated the procedure included "arrange for appropriate care staff to assist

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F 689	Continued From page 6 activity staff with lifting and transferring needs when loading resident on/off bus. Once seated, all passengers will wear their seat belts or be securely fastened in wheelchair." Further review of policy, indicated "all passengers will wear seatbelts and remain seated while vehicle is in motion." Review of facility policy titled Loading, Riding and Unloading Bus dated 3/6/19, indicated the procedure included when everyone is seated, staff will verify that all passengers are securely belted." Further review of policy, indicated "passengers will remain seating and belted while the bus is in motion."	F 689		

Electronically delivered
September 29, 2021

Administrator
Knute Nelson
420 12th Avenue East
Alexandria, MN 56308

Re: State Nursing Home Licensing Orders
Event ID: JU4411

Dear Administrator:

The above facility was surveyed on September 8, 2021 through September 8, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00113	A. BUILDING: _____ B. WING _____	C 09/08/2021

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	2 000		

*****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:
On 9/8/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5435031C (MN76223) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
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 interview and document review, the facility failed to provide safe transport for residents who require the use of a wheelchair on the facility bus. This resulted in 1 of 3 residents (R1) who were not strapped in securely and slid out of wheelchair during transport, causing multiple fractures. Findings include: R1's quarterly Minimal Data Set (MDS) dated 8/18/21, indicated R1's diagnoses included	2 830	Completion date 10/1/2021	10/1/21

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2 830	Continued From page 3	2 830		

dementia, hemiplegia and showed moderate cognitive impairments. R1 required extensive assist by two staff members for bed mobility, dressing, toileting and extensive assist of one staff member for locomotion on and off the unit.

R1's care plan printed 9/8/21, indicated R1 was at risk for falls related to impaired balance, neuropathy, hemiplegia, arthritis and anxiety with interventions that included call don't fall signs in room, assist with positioning in wheelchair to assure balance, low bed, floor mat while in bed, and one way glide in wheelchair. Further review of R1's care plan, indicated "when on outing- be sure resident is sitting properly in wheelchair, activity staff were educated to call nursing facility on outing if any need for repositioning."

Review of facility incident report indicated on 8/27/21, at 11:16 a.m. R1 was attending an outing in the facility van, which was driven by facility staff. R1 was in wheelchair (w/c) and when driver applied brakes at stop light, R1 slid out of w/c to the floor of the van. The driver immediately pulled over and Emergency Medical Services (EMS) were called as resident complained of lower extremity pain.

R1's emergency room provider note dated 8/27/21, indicated R1 "was in her wheelchair on a bus when the bus driver slammed on her brakes. The wheelchair was locked in place and patient catapulted out of her wheelchair. She landed with her left leg underneath her. She complains of pain about her left ankle and left lower leg. EMS [emergency medical services] noted deformity and when they lifted her it seemed to be rotated. Patient does have a previous history of stroke and left-sided deficits. She does not bear weight but typically uses a wheelchair." Further review of

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2 830	Continued From page 4	2 830		

provider notes indicated, "Patient has IV [intravenous] access with fentanyl titrated for pain x-ray of the left tib-fib, left ankle and left foot are personally reviewed shows evidence of an acute bimalleolar facture of the left ankle ...fracture of the rest of the tib-fib. There is a proximal phalanx fracture of the left great toe. With those fracture I personally placed patient into a posterior splint with stirrup component. Regarding the great toe fracture buddy tape was placed by nurse."

R1's progress note dated 8/27/21, indicated "resident has a broken Left great toe and Left ankle."

R1's fall risk assessment dated 8/30/21, indicated "resident had a fall out of wheelchair while on an activity outing. Seeked [SIK] care at the ER [emergency room] where she was found to have multiple fractures. New intervention: when on an outing, be sure resident is sitting properly in wheelchair. Activity staff educated to call nursing facility on outing if any need for repositioning. Administrator to be providing further education to life enhancement staff on bus safety. Will monitor for any changes."

The fall assessment lacked evidence the failure to have R1 wearing a seatbelt while the bus was in transport was addressed as part of the facility's correction.

On 9/8/21, at 10:31 a.m. activities assistant (AA)-A indicated R1 was noted to be unpredictable while in her wheelchair. AA-A indicated she was driving the bus and AA-B was also assisting on the trip and was in the back of the bus with the residents at the time of the incident. AA-A indicated, "[AA-B] kept saying [R1] sit back and [R1] kept trying to sit up and get out.

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2 830	Continued From page 5 We were driving and stopped when [R1] slipped out of her chair." Further, AA-A indicated staff had locked R1's wheelchair to the bottom of the bus and locked the wheelchair brakes, however R1 did not have a seat belt on. AA-A confirmed that each spot on the facility bus has a seatbelt but stated, "I usually don't use the seatbelts." In addition, AA-A indicated that there are currently no more planned bus trips (all out of building activities were on hold), but there had also not been any additional training provided regarding safe transportation or seat belt use on the facility bus. On 9/8/21, at 10:41 a.m. AA-B indicated R1 was paralyzed on her left side and utilizes a wheelchair for transportation. AA-B stated while on the outing to the apple orchard, R1 "started to jiggle and I directed her to sit still. On the way back, the bus driver put the brake on and R1 came out of her chair. We [staff] pulled over to the right and called 911 and then called [facility]." Further, AA-B indicated R1 was scooted down "quite a bit" in her wheelchair and she was unable to reposition her due to R1 requiring a mechanical hoyer lift for transfers. In addition, AA-B stated, "[R1] was in the back of the bus, her wheelchair was strapped to the floor and locked but there was no strap across her and we were not trained to use the seatbelts. No one is buckled in the bus we [staff] just strap in the chair. The residents in the seats are strapped but the residents in wheelchairs are not wearing a seatbelt. I was never shown to use the strap but just trained to strap down the chair and put the brakes on." AA-B indicated since the incident, there have been no additional training provided to staff related to safe transportation and seat belt use. Lastly AA-B stated, "Since the incident nothing has changed," no one has talked to be	2 830		

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2 830	Continued From page 6	2 830		

about the seatbelts or trained me how to use them appropriately. AA-B added that she inquired about more training but has not received any further education. AA-B did confirm all off campus activities requiring vehicle transport were canceled until further notice.

On 9/8/21, at 1:10 p.m. administrator was interviewed regarding the incident and stated "ultimately it's a lack of foresight. They [AA-A and AA-B] weren't checking and securing; they were both at fault for not ensuring the seat belt was on [R1]. The seatbelt was there, the equipment was there, and they have been trained properly." Further, administrator indicated, "we have halted all outings for activities for the time period. I am just seeing how this goes over as of right now I talked to them [AA-A and AA-B] about what was wrong." Administrator indicated staff were expected to use the seat belt for all residents during transport on the bus.

On 9/8/21, at 1:33 p.m. R3 indicated she was on the outing and the bus driver applied the brakes, "not real hard", and "everyone to my knowledge was locked in except the lady in the wheelchair. She should have had on her seatbelt but that is just my opinion."

On 9/8/21, at 1:38 p.m. R2 stated staff had strapped her wheelchair to the floor on the outing, however, R2 then stated, "I don't think they ever put a seat belt on me." R2 indicated she was in front of R1 at the time of the incident on the bus when the brakes were applied and R1 "got thrown forward and hit the back of my chair and I put my arms out to brace myself in front of the next one. [R1] broke her ankle and toe."

On 9/8/21, at 2:19 p.m. activities director (AD)

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2 830	Continued From page 7 indicated R1 had slid out of her seat while on the way back to the facility from the outing. AD indicated she went to meet the bus in a parking lot to help and R1 was on the floor of the bus and 911 was called. AD indicated she expected staff to ensure resident safety while on an outing and assist with applying the seatbelts for both residents in the seats and in personal wheelchairs. AD indicated AA-A and AA-B are the only two staff members for activity outings at this time. Further, AD stated "[AA-A] and [AA-B] have not been re-trained since the incident. I canceled all bus trips for a month. I felt they both needed a break from it and take a breather. We will retrain before we go out again." When asked about education provided to activities staff prior to going on an outing, AD stated "I don't have proof of education on the policies. We only have healthcare academy. I should put that in their records that they got that information and were trained." Review of facility policy titled Off Premise Outings dated 11/14/18, indicated the procedure included "arrange for appropriate care staff to assist activity staff with lifting and transferring needs when loading resident on/off bus. Once seated, all passengers will wear their seat belts or be securely fastened in wheelchair." Further review of policy, indicated "all passengers will wear seatbelts and remain seated while vehicle is in motion." Review of facility policy titled Loading, Riding and Unloading Bus dated 3/6/19, indicated the procedure included when everyone is seated, staff will verify that all passengers are securely belted." Further review of policy, indicated "passengers will remain seating and belted while the bus is in motion."	2 830		

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2 830	Continued From page 8 Suggested Method of Correction: The Directior of Nursing or designee could review policies and procedures, train staff, and implement measures to assure resident safety during transport. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		