Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 31, 2023

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

RE: CCN: 245435
Cycle Start Date: September 22, 2023

Dear Administrator:

On October 24, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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October 31, 2023

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

Re: Reinspection Results
Event ID: 07D112

Dear Administrator:

On October 24, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 22, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 3, 2023

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

RE: CCN: 245435
Cycle Start Date: September 22, 2023

Dear Administrator:

On September 22, 2023, a survey was completed at your facility by the Minnesota Department 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 22, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 22, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Electronically delivered
October 3, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 07D111

Dear Administrator:

The above facility was surveyed on September 21, 2023 through September 22, 2023 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 feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 09/22/2023

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 9/21/23 and 9/22/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H54355784C (MN00097024) As a result of the investigation, F583 was cited. 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 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a	F 583		10/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 10/10/2023

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

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F 583	Continued From page 1 private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain personal privacy for 4 of 4 residents (R1, R4, R5, R6) who had video monitoring devices in their bedrooms as an intervention to prevent falls and elopement. Findings include: R1's admission Minimum Data Set dated 9/13/23, identified intact cognition, diagnosis of a stroke with wandering tendencies that placed R1 at significant risk of getting to a potentially dangerous place (e.g. outside facility, stairs). R1 used a walker and a wheelchair for mobility,	F 583	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R1, R4, R6, R7, R8, R9, and R10 have had their video monitors removed from their rooms and nursing station. The video monitors have been discontinued for these residents. Upon review of the monitors with R5, the resident requested that the camera remained in his room and would sign the consent form for electronic surveillance. Education provided to	

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F 583 Continued From page 2

impairment of lower extremity on one side, and required supervision with transfers, locomotion on and off unit, dressing, personal hygiene, toileting, and always continent of bowel and bladder.

R1's care plan dated 9/18/23, identified R1 elopement risk and video monitor used along with wander guard applied. R1 resided in alarmed unit and staff were directed to check wander guard every shift.

R4's significant change MDS dated 8/24/23, identified severely impaired cognition and diagnosis of dementia. R4 required extensive assistance with bed mobility, transfers, personal cares, toileting, locomotion on unit, dressing, and was frequently incontinent of bladder and occasionally incontinent of bowel. R4 used a walker and wheelchair for mobility.

R4's care plan dated 7/20/23, identified R4 high risk for falls due to history of falls and instability. Staff were directed to place call light within reach, bed in lowest position with blue mat on floor next to bed, used concave mattress, ensure adequate lighting and clear pathways to room, video monitor in room, and wipe up fluid spills form floor. R4 was also identified as risk for elopement due to dementia. Staff were directed to provide frequent checks on resident and wander guard placement and workability.

R4's progress notes dated 9/15/23, identified an unwitnessed fall in bathroom. R4's new intervention implemented: video monitor placed in room. R4's family/wife notified of fall.

R5's quarterly MDS dated 8/24/23, identified intact cognition and daily verbal and physical

F 583

resident on right to privacy and dignity. R5's camera will be moved off the Pines nursing station and into the Pines nursing office, this will provide privacy for the camera usage and those that can view them.

How the facility will identify other residents having the potential to be affected by the same deficient practice.

Staff will be educated that video monitor usage needs to be proposed and driven by residents and their families and not staff. It should be used as a last resort for resident safety and not as a replacement for staff supervision. Staff will also be educated about the development of the consent form that needs to be reviewed and signed before a video monitor is put into place as well as the video monitor policy.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not occur.

The facility will not put video monitors into use as a replacement for staff supervision. Video surveillance usage will be driven by residents and their families. A video monitor consent form and policy will be developed to ensure residents and decision makers are aware of the use of the camera and when it is in place. Cameras that continue to be in use will be moved off the Pines nursing station and into the Pines nursing office, this will provide privacy for the camera usage and

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F 583 Continued From page 3

behavioral symptoms not directed toward others. R5's diagnoses included hemiplegia (weakness on one side), anxiety, depression, post-traumatic stress disorder (PTSD). R5 required extensive assistance with bed mobility, transfers, dressing eating, personal hygiene, toileting, and locomotion per wheelchair on and off the unit. R5 had impairment upper and lower extremities on one side, and frequently incontinent of bowel and bladder.

R5's care plan dated 10/26/22, identified R5 received psychotropic medications related to behavior management, depression, anxiety, OCD (obsessive compulsive behaviors, and pseudobulbar effect (nervous system disorder that can make you laugh, cry, or become angry without being able to control it). Video monitor was to be placed in R5's room for close monitoring of R5 due to history of suicidal statements. R5 was aware and wife aware of monitor in room.

R5's progress note dated 11/25/22, identified discontinued hourly checks as resident has made no more suicidal comments. R5 continued to have video monitor in his room for staff to keep close supervision while in his room.

R6's quarterly MDS dated 9/13/23, identified severely impaired cognition and no behaviors. R6's diagnoses included Alzheimer's disease, anxiety, and depression. R6 required extensive assistance with bed mobility, transfers, mobility on and off the unit, toilet use, and personal hygiene. R6 was frequently incontinent of bowel and bladder. R6 had daily use of wander/elopement alarm and used a walker and wheelchair for mobility.

F 583

those that can view them.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

Monthly video monitor audits will be developed. The audits will be used to review the video monitors that are in use for residents that have completed the new & updated process and that the video monitors are in a safe and private area. The audit Results of the audits will be taken to the QAPI committee for further recommendations.

The date that each deficiency will be corrected.
Completion date: October 24, 2023.

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F 583	Continued From page 4	F 583		

R6's care plan dated 6/13/23, identified R6 elopement risk. R6 resided in an alarmed unit, wander guard applied to right ankle, and video monitored R5's location when in room.

R6's progress notes dated 3/17/23 at 4:50 a.m. fall occurred on 3/16/23 follow up indicated R6 denied pain, monitored for bruising and new pain. New intervention: monitor in place.

During intermittent observation in Pines unit on 9/21/23 from 11:00 a.m. to 12:00 p.m., in the center of the unit was a nurse's station against a wall with a counter surrounding the entire square space with an opening to walk in located at the front. The nurse's station was accessible from front by staff and visitors. Located on the right-side counter were five colored monitor receivers turned on (designated for R1, R4, R5, and two other resident residents) and located on the left side counter were three (designated for R6 and two other residents) colored monitor receivers turned on and broadcasting the live activity of reach resident from cameras in their rooms. The monitor screens measured approximately five inches by three inches and could be seen by anyone walking past and stopping at the nurse's station. The nurse's station was in a common area where residents, visitors, and staff frequented throughout the day. Located on all eight monitors was a yellow sticky that identified which room number the resident was located. Nursing assistants (NAs) and registered nurses (RNs) walked by nurse's station and glanced at screens occasionally, at times the Pine nurse's station was left unattended, but live video feed from all eight resident rooms ran continuously and could be seen by anyone who

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F 583	Continued From page 5	F 583		

glanced into the nurse's station.
Observation during this time showed:
-R1 laid in bed on his back fully clothed, uncovered with eyes closed.

-R4 laid in bed on his left side covered up with a patchwork blanket, eyes closed.

-R5's bed made and unoccupied.

-R6's camera view showed top half of bed, unoccupied.

During observation on 9/22/23 at 2:00 p.m., video feed from R1, R4, R5, R6 rooms identified:
-R1 lying in bed, fully clothed with shoes, pants and shirt on uncovered. R1's wife was also observed on the monitor camera as she sat next to the bed side table in a chair occasionally looking at camera. R1 folded his arms over his abdomen and closed his eyes.

-R4 lying on his left side in bed, faced the camera, covered with a patchwork blanket.

-R5's bed was unoccupied and made. At 2:11 p.m. a visitor in a pink dress sat on the edge of R5's bed and went through a bag of items. R5 sat in wheelchair talking to visitor.

-R6's monitor camera screen showed blue with small print on it. Licensed practical nurse (LPN)-D worked on the monitor while she sat at the nurse's station.

During an interview on 9/21/23 at 8:53 a.m., R1 stated he was aware of the camera in his room and felt he was he was being monitored which made him feel confined and spied on. R1

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F 583	Continued From page 6	F 583		

indicated he did not feel he was given a choice as to whether he wanted the monitor camera in his room. R1 also indicated he had no privacy in his bedroom and had to go into the bathroom and close the door to not be on the camera or have people watching.

During an interview on 9/21/23 at 12:30 p.m., licensed practical nurse (LPN)-A stated monitor cameras helped staff supervise those residents that crawled out of the bed and helped prevent falls. LPN-A indicated the monitor cameras were left on all the time so that the resident was monitored while they laid in bed, sat in a chair, and ate however, staff were expected to turn the camera away when cares were completed. LPN-A also stated the facility had used those monitor cameras for at least one year or more now.

During an interview on 9/21/23 at 4:30 p.m., RN-A stated the monitor camera was used for residents that self-transferred, restless, and high risk for falls. RN-A stated when staff saw movement of a resident in their bed, they would head to that room quickly to assist the resident. RN-A verified no written consent was obtained and only verbal discussion/consent with resident and/or family occurred, and information was placed in care plan, RN-A stated R1 had been educated on the monitor camera, educated that it could be turned off while he had visitors, staff would have noticed it was off at the nurse's station and turned it back on for him later.

During an interview on 9/22/23 at 10:03 a.m., R1's family member (FM)-A stated she had not been approached by staff to talk about the placement of the monitor camera, one day it just

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	245435	A. BUILDING ______ B. WING ______	C 09/22/2023

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

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F 583	Continued From page 7	F 583		

suddenly appeared and was used to monitor R1 in his room due to wandering. FM-A indicated she had asked about the monitor camera when R1 wanted to change clothes and was concerned about R1's privacy. FM-A stated had thought it was weird others would be able to see him, assumed we could not move the camera or shut it off during my visit but was not quite sure.

During an interview on 9/22/23 at 10:10 a.m., FM-B stated yesterday (9/21/23) she had noticed at least six monitors with screens when at the nurse's station and thought it was odd. FM-B stated she could see on the monitor screens residents laying in bed, sitting in a chair and her father lying in bed. FM-B stated she had been concerned about privacy because other people and staff could see her dad in bed and other residents as well.

During an interview on 9/22/23 at 10:47 a.m., via telephone R6's FM-C stated she was not made aware a camera monitor was implemented for R6. FM-C state R6 was a very private person and if she could speak for herself, she would not have allowed the monitor camera in her room. FM-C stated R6 would not appreciate someone being able to watch her, especially while she laid down and slept. FM-C added she was unsure why a camera monitor would even be necessary for R6 because she no longer attempted to get out of bed and was not at that great of risk.

During an interview on 9/22/23 at 11:13 a.m. LPN-B stated facility started to use the monitor cameras over one year ago. LPN-B indicated monitors were used on those residents with a history of falls, fall risks, and elopement risk. LPN-B stated nursing staff were expected to

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 09/22/2023

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F 583	Continued From page 8	F 583		

check the resident monitors throughout the shift and when charting was completed at the nursing station. LPN-B identified written consent had been used and documented in the medical record, and usually family or resident were able to consent. LPN-B stated nursing staff were expected to turn the camera when cares were provided.

During an interview on 9/22/23 at 11:30 a.m., RN-B stated once all other options were exhausted then they used a monitor camera because there were so invasive and was the last resort. RN-B stated no written consent was needed and only verbal from resident if cognition was intact or from family. RN-B stated the monitor cameras were used primarily for fall prevention and staff were expected to turn camera when they provided cares.

During an interview on 9/22/23 at 11:36 a.m., R5 stated had been aware of the monitor camera and that it was continuously on when in his room. R5 stated he did not like it. R5 indicated he did not have much privacy but felt he did not have a choice in the matter if he continued to live at this facility.

During an interview on 9/22/23 at 11:45 a.m., LPN-C stated the monitor cameras were used as an intervention and helped prevent falls and elopements. LPN-C indicated the monitor cameras were used as a type of supervision, helped staff monitor movement of the resident, showed if the resident had attempted to exit bed and/or left the room. LPN-C stated staff were expected to turn camera away during cares but were discouraged to turn the camera off, which defeated the purpose.

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 09/22/2023

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F 583	Continued From page 9	F 583		

During an interview on 9/22/23 at 11:53 a.m., NA-A stated the facility had used the monitor cameras at least for one year now. NA-A stated the monitor cameras were used so staff could monitor residents who were at risk of getting out of bed by themselves to prevent falls. NA-A verified the monitor cameras helped supervise the residents but not used very well. NA-A indicted staff were not always able to stop and view the cameras frequently.

During an interview on 9/22/23 at 1:41 p.m., NA-B indicated they checked the monitor cameras usually about every 30 minutes. NA-B stated she had observed resident care being completed on the receivers of the cameras. NA-B stated there were staff who had forgot to turn the camera away, were in a hurry, and completed cares with camera on. NA-B indicated she had been instructed by other staff to never turn the cameras off, make sure it was just turned sideways during cares to provide privacy.

During an interview on 9/22/23 at 1:45 a.m., NA-C stated there were eight monitor cameras located at the Pines nursing station and visitors would be able to see the monitor screens when they stood at the nurse's stations and possibly what the resident was doing but unable to identify which resident was on each screen due to the screen size.

During an interview on 9/22/23 at 1:57 p.m. NA-D stated the monitor cameras located at the Pines nurse's station were on continuously and were checked mostly during the morning when she arrived at work. NA-D indicated she saw on the screens residents laid in bed, sat up in bed, and

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 09/22/2023

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

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F 583	Continued From page 10	F 583		

sleeping. NA-D stated the monitor cameras were used to help prevent falls. NA-D stated she turned the camera away during cares to help provide privacy.

During an interview on 9/22/23 at 2:25 p.m. director of nursing (DON) stated the monitor camera was initiated on a resident after all other interventions had been tried usually after a fall or elopement. DON stated a written consent was not needed and a verbal consent was required from either the resident and/or family. DON stated staff were not trained during orientation, they are infant monitors, and staffed were educated by email after a fall and updated as to what was done. DON stated staff were expected to turn camera away in the room during cares and then move camera back to the same position after cares. DON indicated a resident with intact cognition was instructed on how they could turn the camera away during a visit from family and friends. DON verified the monitor cameras located in transitional care unit (TCU) were located behind a wall at the nurse's station out of the public view and the monitor cameras on Pine were located at the nurse's station in a more central area and the monitor screens were small.

The facility failed to ensure resident privacy in bedrooms by using video camera monitoring as a replacement for staff supervision and monitoring.

Facility policy titled Quality of Life-Dignity dated 5/1/23, identified each resident should be cared for in a manner that promotes and enhances quality of like, dignity, respect, and individuality. Staff were directed to promote, maintain, and protect resident privacy, which included bodily privacy during assistance with person care and

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F 583	Continued From page 11 during treatment procedures. Demeaning practices and standards of care that compromise dignity was prohibited. Facility policy titled Wander Guard Policy/Video Monitor dated 9/22, identified video monitor was used after verbal consent from resident and/or family for resident's identified at risk for elopement.	F 583		

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 09/22/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/21/23, and 9/22/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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	00113	A. BUILDING: ______ B. WING ______	C 09/22/2023

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2 000	Continued From page 1	2 000		

identify the date when they will be completed.

The following complaint was reviewed H54355784C (MN00097024) with a licensing order issued at 1855.

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

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 09/22/2023

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KNUTE NELSON	**420 12TH AVENUE EAST ALEXANDRIA, MN 56308**

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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		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain personal privacy for 4 of 4 residents (R1, R4, R5, R6) who had video monitoring devices in their bedrooms as an intervention to prevent falls and elopement. Findings include: R1's admission Minimum Data Set dated 9/13/23, identified intact cognition, diagnosis of a stroke with wandering tendencies that placed R1 at significant risk of getting to a potentially dangerous place (e.g. outside facility, stairs). R1 used a walker and a wheelchair for mobility,	21855	Corrected	10/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00113	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 09/22/2023

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

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21855	Continued From page 3	21855		

impairment of lower extremity on one side, and required supervision with transfers, locomotion on and off unit, dressing, personal hygiene, toileting, and always continent of bowel and bladder.

R1's care plan dated 9/18/23, identified R1 elopement risk and video monitor used along with wander guard applied. R1 resided in alarmed unit and staff were directed to check wander guard every shift.

R4's significant change MDS dated 8/24/23, identified severely impaired cognition and diagnosis of dementia. R4 required extensive assistance with bed mobility, transfers, personal cares, toileting, locomotion on unit, dressing, and was frequently incontinent of bladder and occasionally incontinent of bowel. R4 used a walker and wheelchair for mobility.

R4's care plan dated 7/20/23, identified R4 high risk for falls due to history of falls and instability. Staff were directed to place call light within reach, bed in lowest position with blue mat on floor next to bed, used concave mattress, ensure adequate lighting and clear pathways to room, video monitor in room, and wipe up fluid spills form floor. R4 was also identified as risk for elopement due to dementia. Staff were directed to provide frequent checks on resident and wander guard placement and workability.

R4's progress notes dated 9/15/23, identified an unwitnessed fall in bathroom. R4's new intervention implemented: video monitor placed in room. R4's family/wife notified of fall.

R5's quarterly MDS dated 8/24/23, identified intact cognition and daily verbal and physical behavioral symptoms not directed toward others.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21855	Continued From page 4	21855		

R5's diagnoses included hemiplegia (weakness on one side), anxiety, depression, post-traumatic stress disorder (PTSD). R5 required extensive assistance with bed mobility, transfers, dressing eating, personal hygiene, toileting, and locomotion per wheelchair on and off the unit. R5 had impairment upper and lower extremities on one side, and frequently incontinent of bowel and bladder.

R5's care plan dated 10/26/22, identified R5 received psychotropic medications related to behavior management, depression, anxiety, OCD (obsessive compulsive behaviors, and pseudobulbar effect (nervous system disorder that can make you laugh, cry, or become angry without being able to control it). Video monitor was to be placed in R5's room for close monitoring of R5 due to history of suicidal statements. R5 was aware and wife aware of monitor in room.

R5's progress note dated 11/25/22, identified discontinued hourly checks as resident has made no more suicidal comments. R5 continued to have video monitor in his room for staff to keep close supervision while in his room.

R6's quarterly MDS dated 9/13/23, identified severely impaired cognition and no behaviors. R6's diagnoses included Alzheimer's disease, anxiety, and depression. R6 required extensive assistance with bed mobility, transfers, mobility on and off the unit, toilet use, and personal hygiene. R6 was frequently incontinent of bowel and bladder. R6 had daily use of wander/elopement alarm and used a walker and wheelchair for mobility.

R6's care plan dated 6/13/23, identified R6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21855	Continued From page 5	21855		

elopement risk. R6 resided in an alarmed unit, wander guard applied to right ankle, and video monitored R5's location when in room.

R6's progress notes dated 3/17/23 at 4:50 a.m. fall occurred on 3/16/23 follow up indicated R6 denied pain, monitored for bruising and new pain. New intervention: monitor in place.

During intermittent observation in Pines unit on 9/21/23 from 11:00 a.m. to 12:00 p.m., in the center of the unit was a nurse's station against a wall with a counter surrounding the entire square space with an opening to walk in located at the front. The nurse's station was accessible from front by staff and visitors. Located on the right-side counter were five colored monitor receivers turned on (designated for R1, R4, R5, and two other resident residents) and located on the left side counter were three (designated for R6 and two other residents) colored monitor receivers turned on and broadcasting the live activity of reach resident from cameras in their rooms. The monitor screens measured approximately five inches by three inches and could be seen by anyone walking past and stopping at the nurse's station. The nurse's station was in a common area where residents, visitors, and staff frequented throughout the day. Located on all eight monitors was a yellow sticky that identified which room number the resident was located. Nursing assistants (NAs) and registered nurses (RNs) walked by nurse's station and glanced at screens occasionally, at times the Pine nurse's station was left unattended, but live video feed from all eight resident rooms ran continuously and could be seen by anyone who glanced into the nurse's station.
Observation during this time showed:
-R1 laid in bed on his back fully clothed,

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 09/22/2023

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KNUTE NELSON	**420 12TH AVENUE EAST ALEXANDRIA, MN 56308**

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21855	Continued From page 6	21855		

uncovered with eyes closed.

-R4 laid in bed on his left side covered up with a patchwork blanket, eyes closed.

-R5's bed made and unoccupied.

-R6's camera view showed top half of bed, unoccupied.

During observation on 9/22/23 at 2:00 p.m., video feed from R1, R4, R5, R6 rooms identified:
-R1 lying in bed, fully clothed with shoes, pants and shirt on uncovered. R1's wife was also observed on the monitor camera as she sat next to the bed side table in a chair occasionally looking at camera. R1 folded his arms over his abdomen and closed his eyes.

-R4 lying on his left side in bed, faced the camera, covered with a patchwork blanket.

-R5's bed was unoccupied and made. At 2:11 p.m. a visitor in a pink dress sat on the edge of R5's bed and went through a bag of items. R5 sat in wheelchair talking to visitor.

-R6's monitor camera screen showed blue with small print on it. Licensed practical nurse (LPN)-D worked on the monitor while she sat at the nurse's station.

During an interview on 9/21/23 at 8:53 a.m., R1 stated he was aware of the camera in his room and felt he was he was being monitored which made him feel confined and spied on. R1 indicated he did not feel he was given a choice as to whether he wanted the monitor camera in his room. R1 also indicated he had no privacy in his bedroom and had to go into the bathroom and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21855	Continued From page 7	21855		

close the door to not be on the camera or have people watching.

During an interview on 9/21/23 at 12:30 p.m., licensed practical nurse (LPN)-A stated monitor cameras helped staff supervise those residents that crawled out of the bed and helped prevent falls. LPN-A indicated the monitor cameras were left on all the time so that the resident was monitored while they laid in bed, sat in a chair, and ate however, staff were expected to turn the camera away when cares were completed. LPN-A also stated the facility had used those monitor cameras for at least one year or more now.

During an interview on 9/21/23 at 4:30 p.m., RN-A stated the monitor camera was used for residents that self-transferred, restless, and high risk for falls. RN-A stated when staff saw movement of a resident in their bed, they would head to that room quickly to assist the resident. RN-A verified no written consent was obtained and only verbal discussion/consent with resident and/or family occurred, and information was placed in care plan, RN-A stated R1 had been educated on the monitor camera, educated that it could be turned off while he had visitors, staff would have noticed it was off at the nurse's station and turned it back on for him later.

During an interview on 9/22/23 at 10:03 a.m., R1's family member (FM)-A stated she had not been approached by staff to talk about the placement of the monitor camera, one day it just suddenly appeared and was used to monitor R1 in his room due to wandering. FM-A indicated she had asked about the monitor camera when R1 wanted to change clothes and was concerned about R1's privacy. FM-A stated had thought it

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 09/22/2023

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
21855	Continued From page 8	21855		

was weird others would be able to see him, assumed we could not move the camera or shut it off during my visit but was not quite sure.

During an interview on 9/22/23 at 10:10 a.m., FM-B stated yesterday (9/21/23) she had noticed at least six monitors with screens when at the nurse's station and thought it was odd. FM-B stated she could see on the monitor screens residents laying in bed, sitting in a chair and her father lying in bed. FM-B stated she had been concerned about privacy because other people and staff could see her dad in bed and other residents as well.

During an interview on 9/22/23 at 10:47 a.m., via telephone R6's FM-C stated she was not made aware a camera monitor was implemented for R6. FM-C state R6 was a very private person and if she could speak for herself, she would not have allowed the monitor camera in her room. FM-C stated R6 would not appreciate someone being able to watch her, especially while she laid down and slept. FM-C added she was unsure why a camera monitor would even be necessary for R6 because she no longer attempted to get out of bed and was not at that great of risk.

During an interview on 9/22/23 at 11:13 a.m. LPN-B stated facility started to use the monitor cameras over one year ago. LPN-B indicated monitors were used on those residents with a history of falls, fall risks, and elopement risk. LPN-B stated nursing staff were expected to check the resident monitors throughout the shift and when charting was completed at the nursing station. LPN-B identified written consent had been used and documented in the medical record, and usually family or resident were able to consent. LPN-B stated nursing staff were

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	00113	A. BUILDING: ______ B. WING ______	C 09/22/2023

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
21855	Continued From page 9	21855		

Continued From page 9

expected to turn the camera when cares were provided.

During an interview on 9/22/23 at 11:30 a.m., RN-B stated once all other options were exhausted then they used a monitor camera because there were so invasive and was the last resort. RN-B stated no written consent was needed and only verbal from resident if cognition was intact or from family. RN-B stated the monitor cameras were used primarily for fall prevention and staff were expected to turn camera when they provided cares.

During an interview on 9/22/23 at 11:36 a.m., R5 stated had been aware of the monitor camera and that it was continuously on when in his room. R5 stated he did not like it. R5 indicated he did not have much privacy but felt he did not have a choice in the matter if he continued to live at this facility.

During an interview on 9/22/23 at 11:45 a.m., LPN-C stated the monitor cameras were used as an intervention and helped prevent falls and elopements. LPN-C indicated the monitor cameras were used as a type of supervision, helped staff monitor movement of the resident, showed if the resident had attempted to exit bed and/or left the room. LPN-C stated staff were expected to turn camera away during cares but were discouraged to turn the camera off, which defeated the purpose.

During an interview on 9/22/23 at 11:53 a.m., NA-A stated the facility had used the monitor cameras at least for one year now. NA-A stated the monitor cameras were used so staff could monitor residents who were at risk of getting out of bed by themselves to prevent falls. NA-A

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21855	Continued From page 10	21855		

verified the monitor cameras helped supervise the residents but not used very well. NA-A indicted staff were not always able to stop and view the cameras frequently.

During an interview on 9/22/23 at 1:41 p.m., NA-B indicated they checked the monitor cameras usually about every 30 minutes. NA-B stated she had observed resident care being completed on the receivers of the cameras. NA-B stated there were staff who had forgot to turn the camera away, were in a hurry, and completed cares with camera on. NA-B indicated she had been instructed by other staff to never turn the cameras off, make sure it was just turned sideways during cares to provide privacy.

During an interview on 9/22/23 at 1:45 a.m., NA-C stated there were eight monitor cameras located at the Pines nursing station and visitors would be able to see the monitor screens when they stood at the nurse's stations and possibly what the resident was doing but unable to identify which resident was on each screen due to the screen size.

During an interview on 9/22/23 at 1:57 p.m. NA-D stated the monitor cameras located at the Pines nurse's station were on continuously and were checked mostly during the morning when she arrived at work. NA-D indicated she saw on the screens residents laid in bed, sat up in bed, and sleeping. NA-D stated the monitor cameras were used to help prevent falls. NA-D stated she turned the camera away during cares to help provide privacy.

During an interview on 9/22/23 at 2:25 p.m. director of nursing (DON) stated the monitor camera was initiated on a resident after all other

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21855	Continued From page 11	21855		

interventions had been tried usually after a fall or elopement. DON stated a written consent was not needed and a verbal consent was required from either the resident and/or family. DON stated staff were not trained during orientation, they are infant monitors, and staffed were educated by email after a fall and updated as to what was done. DON stated staff were expected to turn camera away in the room during cares and then move camera back to the same position after cares. DON indicated a resident with intact cognition was instructed on how they could turn the camera away during a visit from family and friends. DON verified the monitor cameras located in transitional care unit (TCU) were located behind a wall at the nurse's station out of the public view and the monitor cameras on Pine were located at the nurse's station in a more central area and the monitor screens were small.

The facility failed to ensure resident privacy in bedrooms by using video camera monitoring as a replacement for staff supervision and monitoring.

Facility policy titled Quality of Life-Dignity dated 5/1/23, identified each resident should be cared for in a manner that promotes and enhances quality of like, dignity, respect, and individuality. Staff were directed to promote, maintain, and protect resident privacy, which included bodily privacy during assistance with person care and during treatment procedures. Demeaning practices and standards of care that compromise dignity was prohibited.

Facility policy titled Wander Guard Policy/Video Monitor dated 9/22, identified video monitor was used after verbal consent from resident and/or family for resident's identified at risk for elopement.

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21855	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise policies relating to the privacy and confidentiality provided to all residents and provide inservice for all staff regarding privacy and confidentiality. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21855		