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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: SBHP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00113

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245435**
2.STATE VENDOR OR MEDICAID NO.
(L2) **178540100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **012/12/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Gail Anderson, Unit Supervisor — 12/18/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kami Fiske-Downing, Enforcement Specialist — 12/24/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2018

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

RE: Project Number S5435030

Dear Administrator:

On November 14, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on October 26, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 12, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 17, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 26, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 14, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 26, 2018, effective December 14, 2018 and therefore remedies outlined in our letter to you dated November 14, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245435

December 18, 2018

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

Dear Administrator:

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

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

Effective December 14, 2018 the above facility is certified for:

93 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: SBHP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00113

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(L1) **245435**
2.STATE VENDOR OR MEDICAID NO.
(L2) **178540100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/26/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Susan Bachleitner, HFE- NE II 11/28/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/17/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 14, 2018

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

RE: Project Number S5435030

Dear Administrator:

On October 26, 2018, a standard survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the October 26, 2018 standard survey, the Minnesota Department of Health completed an investigation of complaint number H5435011 that was found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is December 5, 2018.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (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 a 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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 January 26, 2019 (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 April 26, 2019 (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:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@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 _____	10/26/2018

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 10/23/18, to 10/26/18 , during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 10/23/18, to 10/26/18, and a complaint investigation was also completed at the time of the standard survey. At the time of the survey, an investigation of H5435011 was completed and was found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		12/3/18

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

Electronically Signed | 11/21/2018

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 _____	10/26/2018

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 578	Continued From page 1 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident current wishes for	F 578	F 000 Preparation and execution of this plan of correction in no way constitutes an	

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 _____	10/26/2018

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 578	Continued From page 2 resuscitation status were accurately documented in the clinical record for 1 of 2 residents (R27) reviewed for advanced directives. Findings include: R27's quarterly Minimum Data Set (MDS) dated 9/13/18, identified R27 had intact cognition, and diagnoses which included heart failure, paraplegia (an impairment in motor or sensory function of the lower extremities), and legal blindness. R27's care plan, last revised 10/4/18, identified R27's code status was "Full Code" and HCD was reviewed and accepted. It instructed staff to comply with code status/HCD wishes. Review of R27's Health Care Directive (HCD) dated 7/31/13, indicated no certain code status for R27. However, R27's HCD had Terminal Condition Instructions, that were to be used only if R27 had a terminal condition and was unable to express her wishes. In the event of a terminal condition, R27 wished to be allowed to die naturally and not be kept alive by artificial means or heroic measures. Review of R27's Resuscitation Guideline form dated 8/18/17, indicated R27 wished to receive cardiopulmonary resuscitation (CPR). The form directed staff to "Call 911, Full treatment as appropriate." The form had been signed by R27, and facility representative, however, lacked a physician signature to be ensure the form was valid and it's intent carried out. Review of R27's Advance Directive 1.5 form,	F 578	admission or agreement by Knute Nelson of the truth of the facts alleged in this statement of deficiency and plan of correction is submitted exclusively to comply with state and federal law. Knute Nelson reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. This statement of deficiencies will be taken to Knute Nelson□s Quality Assurance Performance Improvement Committee. We are in full compliance as of December 03, 2018 and respectfully request a desk review in lieu of a post survey revisit. F 578 Request/Refuse/Discontinue Treatment; Formulate Advance Directive How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility will ensure that resident resuscitation wishes are accurately documented in their clinical record. For R 27, she suffered no adverse effects because of this practice. R 27’s code status has been updated on the electronic health record, her resuscitation guidelines are signed and in her chart. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be	

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 _____	10/26/2018

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 578	Continued From page 3 dated 8/21/17, indicated R27 had an advance directive (AD) completed. The form indicated R27's wishes for AD would be included on her care plan, medical records would be notified to include in the physician orders, and a copy of the AD would be placed in the medical record. No further Advance Directive 1.5 forms for R27 were provided. Review of R27's physician signed Medication Review Report dated 9/21/18, did not contain R27's wishes for resuscitation status. Review of R27's progress notes from 10/23/18 to 10/25/18 revealed: -10/23/18, nurse manager (NM)-A spoke with R27 regarding R27's visit with physician and no transport. NM-A and R27 discussed R27's full code status, discussed risk versus benefit, and that some family members wanted R27 to live. NM-A stated it should be R27's decision. NM-A asked if the one family member who was against DNR understood full code? R27 stated probably not. R27 indicated she would like to change to DNR/DNI [Do Not Intubate], but would like NM-A to call family member first. R27 was alert and oriented. -10/24/18, NM-A attempted to contact family member [regarding R27's advance directive wishes]. "Unable to get through. Will try again." -10/25/18, physician saw R27 in regards to emergency room (ER) visit, syncope (temporary loss of consciousness usually related to insufficient blood flow to the brain) episodes, low	F 578	affected by this deficiency. Audit was completed to ensure that all residents resuscitation guidelines wishes are correct and documented in their electronic health record. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not occur. All residents upon admission will have a discussion with facility staff on their resuscitation wishes, the appropriate Resuscitation Guideline form will be filled out, signed by the resident, staff and physician. These are kept in the hard chart under the tab Advance Directives. The resuscitation wishes will be entered into the electronic medical record and scanned into the electronic medical record. At each care conference these resuscitation wishes are reviewed and are documented in the electronic medical record. At any time, the resident has the choice to change these wishes and the same process will be followed as we do on admission. On instances that the resident is not able or chooses to have family members involved, this will be done immediately when the resident voices to make changes in their resuscitation wishes. The Advance Directive policy has been updated to reflect these changes. Licensed nursing staff and Social Services staff did receive education on the policy updates on 11/20/1018. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not	

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F 578	Continued From page 4 blood pressure, episodes of being unresponsive. R27's clinical record lacked documentation of update for R27's wishes for DNR status and lacked further documentation of communication with R27's family. On 10/24/18, at 9:20 a.m. RN-C stated to look up a resident's current code status, she would look on the EHR header for Code Status, or EMAR header for Code Status. On 10/24/18, at 9:35 a.m. RN-A stated to look up a resident's current code status, she would look on the EMAR header under Code Status. On 10/26/18, at 8:52 a.m. RN-B stated to look up a resident's current code status, she would go into the resident's EHR and under their profile header it indicated Code Status for Full Code or Do Not Resuscitate (DNR). RN-B stated if the EHR code status was blank, she would go to the resident's paper chart and go to the face sheet in the front of the chart to get the information. On 10/26/18, at 8:57 a.m. NM-A stated resident's AD were in the paper chart, and when a resident was newly admitted, staff have them fill out a CPR form and send it to the physician to sign. NM-A stated the resident's current code status was also in the EHR in the resident's profile under Code Status and the EMAR. NM-A reviewed R27's EHR and EMAR and confirmed R27's code status was blank in both locations. NM-A stated she would have expected to see R27's current code status in the EHR and EMAR, but added the current CPR form would be in R27's paper chart. NM-A indicated if a resident	F 578	occur. QAPI audits will be done to ensure that facility staff are following the Advance Directive policy. Upon admission, staff will have a discussion with the resident and/or their responsible person regarding their resuscitation guideline wishes; making sure the form is signed by resident, staff member and physician. DON/designee will audit admission documentation to make sure that these wishes are documented in the electronic medical record. Audits will be completed on care conference progress notes and hospital returns to ensure that the resuscitation guidelines are reviewed and if resident and/or responsible person request changes that a new resuscitation guideline form is completed and that these wishes are entered into the electronic medical record. These audits will be done weekly for 4 weeks, then randomly on all new admissions, re-admissions and care conference progress notes, as well as random audits to resident medical records to ensure that the facility staff are following the policy. These audits will be done by the Director of Nursing/designee. Results of the audits will be taken to the QAPI committee for further recommendations. The date that each deficiency will be corrected. Completion date: 12/3/2018	

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F 578	Continued From page 5	F 578		

wanted to change their code status, then staff would have the resident fill out a new CPR form and have the physician sign it. NM-A reviewed R27's progress notes dated 10/23/18, and stated R27 felt like she wanted to change her wishes on code status, but wanted NM-A to call the family member to do education on what code statuses meant. NM-A stated she tried calling the family member on 10/24/18, but NM-A had one number off on the family members phone number. NM-A stated she was going to attempt to reach the family member again today.

On 10/26/18, at 9:02 during an interview with R27, she stated she wanted to discuss her code status with her family due to her recent medical concerns. R27 stated she had several syncope episodes in the past and currently she would wake up and be alert and know everything that was going on, but did not know if that would continue to happen. R27 stated she had been a nurse for 40 years, worked in an ER and with her recent medical concerns she had been thinking about her current AD wishes a lot lately. R27 stated her current wishes would depend on the situation, because she would not want a feeding tube, or to be intubated (medical procedure in which a tube is placed into the windpipe (trachea) through the mouth or nose) very long and her family would have to decide what to do. R27 stated she was just waiting for NM-A to educate the family member and return to R27 to discuss.

On 10/26/18, at 9:30 a.m. the director of nursing (DON) stated staff were educated to go to the resident's paper chart, to review the resident's current advance directive. The DON indicated if a resident changed their wishes for an AD, then the

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F 578	Continued From page 6 NM or social worker would update the resident's wishes as soon as the decision had been made. DON reviewed R27's progress note from 10/23/18, and indicated her expectation would be to confirm R27's current AD wishes within that same day. Review of facility policy titled Advance directive policy, last revised 6/18, indicated it was the policy of Knute Nelson to have a resident participate in the planning of their care and treatment, whenever possible. The policy identified staff were educated that they should be going to the resident's chart for their AD. The policy further indicated "16. When a Resident and/or responsible party completes the Resuscitation Guideline, Social Services will fax the document to the physician for their signature. All Guidelines will be signed, including CPR, DNR, DNI and DNT." ... "21. Social Services will update the physician orders and the care plan."..."25. The Resident may revoke, cancel or modify an Advance Directive or Resuscitation Guideline at any time and request a change in treatment."	F 578		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		12/3/18

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F 609	Continued From page 7 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the State Agency (SA) was immediately notified of allegations of potential mistreatment and failed to conduct a thorough investigation for 1 of 2 residents (R4) reviewed for potential mistreatment when R4 reported rough treatment with cares. Findings include: R4's annual Minimum Data Set (MDS) dated 8/9/18, identified R4 was cognitively intact and had diagnoses which included coronary artery disease, Diabetes Mellitus, and macular degeneration. The MDS identified R4 had a functional limitation in both upper extremities and required extensive assistance for activities of daily living (ADLs) including bed mobility,	F 609	F 609 Reporting of Alleged Violations How corrective action will be accomplished for those residents found to have been affected by the deficient practice. For R 4 suffered no adverse effects because of this practice. R 4 was interviewed by the Director of Nursing and resident stated that she never felt abused and felt safe within the facility. The facility will immediately report to state agency any complaints from residents of alleged abuse, neglect or mistreatment. Administrator and Director of Nursing will be notified of complaint of alleged abuse, neglect or mistreatment. A thorough investigation will be completed on all	

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F 609	Continued From page 8 toileting, and transfers. R4's Care Area Assessments (CAA) dated 8/16/18, identified R4 was cognitively intact, required extensive staff assistance with ADLs, and was legally blind. The CAA indicated R4 had diagnoses which included weakness, neuropathy (a result of damage to your peripheral nerves, often causes weakness, numbness and pain), fibromyalgia (neurologic health problem that causes widespread pain and tenderness), and osteoporosis. R4's care plan last revised 10/23/18, identified R4 required staff participation to reposition and turn slowly in bed and staff assistance to transfer on and off a toilet. The care plan indicated one of R4's strengths was her cognitive status, appropriate statements and no memory loss. The care plan further identified R4 had no pre-existing psychosocial issues, but made critical, negative comments that made it difficult for staff to be around her. On 10/23/18, at 6:06 p.m. R4 stated she felt staff treated her roughly at night with bed mobility and when they assisted her to use the bed pan. R4 stated she had poor vision and did not know which staff treated her roughly, but stated she reported it to the nurse manager (NM). On 10/25/18, at 9:35 a.m. nursing assistant (NA)-D stated R4 required staff assistance with bed mobility and toilet use. NA-D stated R4 was cognitively intact and she would take a concern from R4 seriously. NA-D stated R4 had complained of rough care in February of this year.	F 609	concerns. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. Interviews were conducted by the Director of Nursing/designee to assure that no other residents were affected. No other concerns were identified. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not occur. All facility staff have completed in-service training on 11/20/2018, re-education was conducted by Administrator on immediate reporting alleged abuse, neglect or mistreatment. Staff will be educated during orientation and will also be educated yearly with an abuse prohibition in-service. Facility has a policy regarding abuse prohibition and immediately reporting suspected/alleged abuse, neglect, and injuries of unknown origin to the designated state agency. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur. QAPI audits will be conducted on all allegations of alleged abuse to ensure that facility staff are following Abuse Prevention policy. These audits will monitor timeliness of reporting and allegations are correct. These audits will be done weekly for 4 weeks, then done randomly by Director of Nursing or designee. Results of these audits will be	

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F 609	Continued From page 9 On 10/26/18, at 9:53 a.m. NA-E stated R4 required extensive assistance with ADLs. NA-E stated R4 was alert and oriented and she would take a concern from R4 seriously. On 10/26/18, at 10:14 a.m. registered nurse (RN)-A stated R4 required assistance with bed mobility and transfers. RN-A stated R4 was alert and oriented and would be reliable if she had a concern or complaint. RN-A indicated R4 reported a concern a few weeks ago. On 10/26/18, at 10:32 a.m. RN-B stated R4 required assistance with ADLs and used a bedpan for a toilet while in bed. RN-B indicated R4 required two staff assistance to boost her in bed, and staff had to reposition her slowly in bed. RN-B stated she was aware that R4 had reported rough care in the past and stated R4 had reported rough cares directly to her. She stated R4 reported rough treatment while placed on a bedpan, and during boosting in bed. RN-B indicated when R4 reported the rough care; she talked with staff and reported the complaint to the NM. RN-B stated she had not thought of rough treatment as reportable as possible abuse, but recalled education from the director of nursing (DON) which indicated to report rough treatment as possible abuse. On 10/26/18, at 10:49 a.m. NM-A stated R4 was cognitively intact, but had some periods of confusion. However, NM-A stated she would take a complaint or concern seriously from R4. NM-A stated R4 had reported rough cares on 10/17/18, and NM-A had updated the DON. She indicated she had an "unofficial" interview with staff and	F 609	taken to the QAPI committee for further recommendations. The date that each deficiency will be corrected. Completion date: 12/3/2018	

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F 609	Continued From page 10	F 609		

R4, but the staff reported nothing had happened. NM-A stated the facility would report rough treatment if there was obvious distress from a resident or bruising, but if there was no distress or bruising, then it would be up to the DON to report or not. NM-A was unaware if the concern was reported to the SA.

On 10/26/18, at 11:01 a.m. DON stated NM-A reported to her R4's concerns and stated the facility investigated any concern brought to them. The DON stated she would investigate a complaint of rough care first, and if justified would report it to the SA. The DON indicated she spoke with R4 and staff and thought the concern was more R4 not liking the staff. She stated R4 had no injuries and was very particular on how and who cared for her. She indicated R4 had verbalized many concerns and added R4 wasn't always the happiest person and when her concerns were investigated they usually did not amount to anything. The DON indicated no incident report was completed for R4's concern and it was not reported to the SA.

Review of a facility provided email dated 10/17/18 indicated NM-A emailed DON after a discussion with R4. The email indicated R4 "mentioned that last night when staff came into her room they didn't turn the light on or talk to her during cares. She also mentioned that when they were using the bedpan they pushed up on her. Will you follow up with her?" The DON replied to NM-A: "Here [NM-A], this is my investigation: I spoke with her she stated during the night the night staff put her on the bedpan-she felt that the aide pushed her to get on the bedpan. I feel that due to her size and being bottom heavy and not

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F 609	Continued From page 11 assist staff much with turning staff use a draw sheet to assist to turn her and feel resident could feel like staff was pushing her." The DON indicated she spoke with staff and it was difficult to get her on the bedpan due to her size. The DON told R4 to make sure if she felt like staff were not caring for her to make sure she let the nurse know immediately. R4 stated she understood. The DON indicated she would fill out a grievance form and give to the administrator to put in her file. The DON indicated "I do not feel this is a reportable, just a complaint". On 10/26/18, at 11:07 a.m. the administrator indicated she was updated on R4's concern. She stated she had a "quick" conversation and the facility felt it was nothing and it was not reported to the SA. Review of the facility policy titled Vulnerable Adult Abuse/Neglect Prevention/Resident Protection Program, last revised 6/2018, indicated each individual at the facility had the right to be free from mistreatment. The policy indicated further that any employee shall not mistreat a resident and report mistreatment immediately to the administrator/designee. The policy indicated an incident or suspected incident of mistreatment must be immediately reported to the administrator. The policy indicated the administrator/designee will report mistreatment to the state agency no later than 2 hours after the allegation was made.	F 609		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		12/3/18

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F 880	Continued From page 12 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 13 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the common use blood glucometer machine was disinfected according to current manufacture's recommendation after resident use for 1 of 5 residents (R12) observed for glucometer use, which had the potential to affect all 5 residents (R12, R20, R42, R6 and R4) who resided on the Maple neighborhood and received blood glucose testing in the facility. In addition, the facility failed to ensure appropriate hand hygiene while	F 880	F880 Infection Prevention & Control How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility will have an infection prevention and control program which it investigates, controls and monitors that proper procedures are used to prevent infections within the facility. For R 12	

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F 880	Continued From page 14 providing assistance with personal cares to prevent the spread of infection for 1 of 3 resident (R4) observed during personal cares. Further, the facility failed to transport contaminated linens in a manner to prevent the potential spread of infection during 1 of 1 observation of soiled linen handling. Findings include: R12's Medication Review Report signed 10/20/18, identified R12 had diagnoses which included diabetes mellitus. R12's orders included blood sugar QHS (every hour of sleep) at bedtime for DM (diabetes mellitus). R12's orders also included Novolog insulin per sliding scale subcutaneously (under the skin) before meals for DM. On 10/25/18, at 12:08 p.m. registered nurse (RN)-A removed an Assure Platinum glucometer from the top drawer of the medication cart, and proceeded to enter a office across from the Maple dining room and placed the glucometer on the desk. At that time, RN-A indicated all residents had their own glucometers in their room, but she stated she would use the common use one in the cart, since R12 was in the dining room. RN-A approached R12 in the dining room, transported R12 to the office and then proceeded to complete the blood sugar check with the Assure common use glucometer. At 12:17 p.m., RN-A assisted R12 to the dining room, returned to the office, picked up the common use glucometer and supplies and immediately walked to the medication cart and placed the glucometer in the top drawer of the cart. RN-A then exited the area, and entered the nurses office. RN-A	F 880	proper disinfecting of the glucometer per manufacture's and facility policy will occur and be enforced, for R 4 proper hand washing and glove use will be done during personal cares per facility policy and be enforced. For all resident's staff will handle, store, and transport linens per facility policy and be enforced to prevent the spread of infections. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this, due to the risk of infections in a health care facility and continual contact with staff. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not occur. All licensed nursing staff were instructed on the proper way to disinfect the glucometers, all nursing staff were instructed on proper hand washing, glove use when providing direct resident care. All nursing staff were instructed on proper linen handling per facility policy. Hand washing, glove use and linen handling policy were reviewed during scheduled in-service on 11/20/2018. All licensed nursing staff were instructed on proper disinfecting of glucometer on 11/13/18 and 11/15/18. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur. QAPI audits will be done to ensure that the manufacture's and facility	

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	245435	A. BUILDING _____ B. WING _____	10/26/2018

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 880	Continued From page 15 was not observed to sanitize the common use glucometer. - At 12:42 p.m. RN-A confirmed R12 had her own glucometer and all the residents had their own glucometer machine in their room. RN-A stated her usual practice was to wipe the glucometer down with a sanitizing wipe for a minute, and indicated she felt she had wiped down the common use glucometer, for "a little less than a minute." -At 12:48 p.m. RN-A clarified she had not sanitized the common use glucometer after performing the glucometer check for R12, prior to putting it back into the medication cart. RN-A indicated her usual practice was to complete glucometer checks in the residents rooms using their own glucometers. Review of the Assure Platinum glucose monitor by Arkray instruction manual suggested cleaning and disinfection the meter between patient use. The manual indicated cleaning and disinfecting to be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe. The manual further indicated to follow product label instructions to disinfect the meter. The manual indicated if blood was visibly present on the meter two wipes must be used, one wipe to clean and a second wipe to disinfect. The Super Sani-Cloth germicidal disposable wipes label indicated it is a bactericidal, tuberculocidal and virucidal in 2 minutes. Special instructions for cleaning and decontamination against HIV-1, Hepatitis B virus (HBV) and Hepatitis C virus (HCV) of surfaces/objects soiled	F 880	policy/procedures on disinfecting glucometer are followed, will observe licensed nurses cleaning the glucometers after use; by wiping the glucometer down with Super Sani-cloth germicidal disposable wipes, use first wipe to remove heavy soil and second wipe to keep glucometer wet and disinfect glucometer, allow to remain wet for two minutes and air dry. Audits on proper hand washing, glove use and linen handling will be completed by interviewing staff and observing staff during cares. Audits will be completed to ensure proper procedure of washing hands between changing gloves is occurring, by using hand sanitizer, unless visibly soiled then hands must be washed with soap and water for 20 seconds. Audits will be completed to ensure that when removing gloves that hand washing is done when handling commode or other items that contain bodily fluids. Audit will be completed to ensure that gloves are not worn outside of the resident rooms. Audits will be completed to ensure that all dirty linens are placed in plastic bags/container prior to leaving a room. If staff uniforms become soiled they are to cover the soiled area or change uniforms and have them laundered. These audits will be done weekly for 4 weeks, then randomly by Director of Nursing and/or designee. Results of the audits will be taken to the QAPI committee for further recommendations. The date that each deficiency will be corrected.	

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F 880	Continued From page 16 with blood/body fluids. Cleaning instructions: all blood and other body fluids must be thoroughly cleaned from surfaces and objects before disinfection by the germicidal wipe. Open, unfold and use first germicidal wipe to remove heavy soil Contact time: use second germicidal wipe to thoroughly wet surfaces. Allow to remain wet two minutes, let air dry. On 10/26/18, at 10:24 a.m. CM-A confirmed residents who required glucometer checks had their own glucometers in their rooms. CM-A indicated she would expect the common use glucometer to be sanitized after use. CM-A indicated the usual facility process to sanitize the common use glucometers included using the purple capped sanitizer wipes (Super Sani-Cloth germicide wipes). The glucometers were wiped down for 2 minutes then allowed to air dry. CM-A indicated she would expect the common use glucometer to be sanitized using the facility process she described after use. CM-A indicated the nurses received education during orientation by another nurse how to sanitize the glucometers. CM-A confirmed she had not performed audits to assure the common use glucometer was being sanitized between use. CM-A indicated if the common use glucometer was not sanitized after use, there could be blood on it, which could make someone sick and pass it on to other residents. CM-A indicated there were 5 residents on the unit who required blood glucose monitoring. and provided a list of those residents. R20's Medication Review Report signed 9/25/18, identified R20 had diagnoses which included type 2 diabetes mellitus. R20's orders included	F 880	Completion date: 12/3/2018	

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F 880	Continued From page 17 Novolog insulin 6 units in the morning and 6 units two times a day subcutaneously for DM. Orders to hold for BS (blood sugar) less than 90. R42's Medication Review Report signed 10/23/18, identified R42 had diagnoses which included type 2 diabetes mellitus. R42's orders included BS check before breakfast and at HS two times a day for DM. **per patient request** R6's Medication Review Report signed 10/15/18, identified R6 had diagnoses which included type 2 diabetes mellitus. R6's orders included blood sugar check two times a day related to type 2 diabetes mellitus. R4's Medication Review Report signed 9/19/18, identified R4 had diagnoses which lacked DM diagnoses. R4's orders included check blood sugar QAM (every morning) one time a day for DM type 2,related to type 2 diabetes mellitus without complications. On 10/26/18, at 10:34 a.m. director of nursing (DON) indicated each resident who required blood glucose testing had their own glucometers and they did not share them. DON indicated she was unaware the nursing staff were using common use glucometers from the medication cart. DON indicated if a common use glucometer was used, she would expect it to be sanitized by following the facility policy. DON indicated if the common use glucometer was not sanitized it could cause infection and could cause the wrong results for testing also.	F 880		

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F 880	Continued From page 18	F 880		

Hand Hygiene

R4's annual Minimum Data Set (MDS) dated 8/9/18, identified R4 was cognitively intact and had diagnoses which included coronary artery disease, Diabetes Mellitus, and macular degeneration. The MDS identified R4 had a functional limitation in both upper extremities and required extensive assistance for activities of daily living (ADLs) including bed mobility, toileting, and transfers.

R4's annual Care Area Assessments (CAA) dated 8/16/18, identified R4 was cognitively intact, required extensive staff assistance with ADLs, and was legally blind. The CAA indicated R4 had diagnoses which included weakness, neuropathy (a result of damage to your peripheral nerves, often causes weakness, numbness and pain), fibromyalgia (neurologic health problem that causes widespread pain and tenderness), and osteoporosis.

R4's care plan last revised 10/23/18, identified R4 required staff participation to reposition and turn slowly in bed and staff assistance to transfer on and off a toilet. The care plan indicated one of R4's strengths was her cognitive status, appropriate statements and no memory loss. The care plan further identified R4 had no pre-existing psychosocial issues, but made critical, negative comments that made it difficult for staff to be

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F 880	Continued From page 19 around her. On 10/25/18, at 7:04 a.m. R4 was seated on a commode next to her bed and wore a night gown on her upper body and had black pants near her ankles with black shoes on with nursing assistant (NA)-D present next to the bed. At 7:13 a.m. R4 stood up from the commode and NA-D completed perineal cares which included wiping R4's buttocks with incontinence wipes. NA-D then removed her gloves, but did not sanitize nor wash hands. NA-D assisted R4 to pull up her incontinence brief and pants. At 7:14 a.m. NA-D assisted R4 to a seated position in her wheelchair and removed the transfer belt from around R4's abdomen. NA-D then wrapped the transfer belt around R4's walker and walked towards the bathroom. At 7:17 a.m. NA-D placed on gloves, walked to the commode and picked up the removable basin (where stool and urine is collected), walked back to R4's bathroom and emptied the contents into R4's toilet and flushed the contents. NA-D then placed foaming soap in the basin and filled with water from R4's sink. NA-D then moved the soap and water back and forth in the basin and then poured the contents into R4's toilet. NA-D then walked back to the commode and replaced the removable basin into the commode. NA-D then removed her gloves and threw them into the garbage. NA-D did not wash her hands or use hand sanitizer. At 7:17 a.m. NA-D returned to R4, removed her gown and pushed R4 into the bathroom in front of the sink. NA-D placed gloves on her hands, dampened a towel and washed R4's back and arms. At 7:20 a.m. NA-D removed the gloves, did not sanitize or wash her hands, picked up R4's toothbrush from inside a cup, which was stored	F 880		

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F 880	Continued From page 20	F 880		

on R4's sink, applied toothpaste, and set the handle end of the toothbrush back into R4's drinking cup. NA-D then left R4 at the sink to finish washing her face and brush her teeth. At 7:24 a.m. NA-D applied gloves and gathered R4's dirty clothes off a chair, picked up two garbage bags and walked to the soiled utility room. NA-D then opened the soiled utility room with a gloved hand and placed the clothing and garbage into a large plastic bin, and then removed her gloves and then washed her hands.

On 10/25/18, at 9:35 a.m. NA-D stated R4 required assistance with ADLs, but liked to wash her face and front part of her body at the sink, and then brush her own teeth. NA-D stated staff have been educated to wear gloves with personal cares with residents and to wash or sanitize hands before resident care, between glove use, and after resident care. NA-D stated she usually carried hand sanitizer in her scrub pocket, but had forgotten to pick some up at the start of her shift that day. NA-D stated R4 liked to sit in front of her sink and staff were unable to wash their hands in R4's room. NA-D confirmed she did not wash or sanitize her hands at any point during R4's personal cares.

On 10/26/18, at 1:12 p.m. infection preventionist (IP)-A stated staff were to use gloves during any personal cares that could lead to exposure to bodily fluids. IP-A stated she would expect staff to wash or sanitize their hands when starting care with a resident, after taking gloves off, and after resident care. IP-A stated staff recently had an in-service on handwashing and glove use two months prior.

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F 880	Continued From page 21	F 880		

On 10/26/18, at 1:20 p.m. director of nursing (DON) stated she would expect staff to wear gloves with personal cares, take the gloves off and use hand sanitizer or wash their hands before placing new gloves.

Linen

On 10/25/18, at 7:25 a.m. NA-F walked down the hall from a resident room and carried an unfolded flat sheet and a soiled, cotton incontinence pad against her scrub shirt and pants and long sleeved sweatshirt that was tied around her waist. NA-F continued down the hall until she reached the soiled utility room, opened the door and placed the soiled linen into a tub. NA-F then walked into the pod room (area for staff to place personal items and for giving shift to shift reports), walked out of the pod room and walked into the clean utility room. NA-F then left the clean utility room, walked to a small desk near the chart room and blew her nose into three separate tissues and threw them into the trash bin next to the desk. NA-F then walked down the hall. NA-F was not observed to wash her hands or utilize hand sanitizer at all during the observation.

On 10/25/18, at 7:30 a.m. NA-F stated she had assisted a resident to get dressed and then assisted her to a wheelchair. NA-F stated the resident had been incontinent of bowel and bladder during the night and she had carried the soiled linen down to the soiled utility room. NA-F stated the usual practice was to place soiled linen into a plastic bag and then carry it to the soiled utility room.

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F 880	Continued From page 22 On 10/26/18, at 1:12 p.m. IP-A stated staff were expected to carry soiled linens in a plastic bag and not carry soiled linen directly against their uniform. On 10/26/18, at 1:20 p.m. the DON stated staff were expected to place soiled linen into a bag to carry and not carry soiled linen against their uniform. The facility policy titled Cleaning and Disinfecting Blood Glucose Meters, undated, identified in bold script that if a glucometer that has been used for one resident must be reused for another resident, the device must be cleansed and disinfected before it can be used for another resident. The policy procedure instructed to thoroughly clean all visible soil or organic material (e.g. blood) from glucometer prior to disinfection. Using gloves as indicted wash with the disinfect and allow for drying times as indicated per manufacturer. Use of disinfectants, antiseptics and germicides were to avoid harm to staff, residents and visitors and to ensure effectiveness. The policy further indicated all personal who perform these tasks are trained with regard to proper procedure, protective equipment required, if any, and safety precautions. Review of the facility policy Hand Hygiene Policy, undated, indicated hand hygiene was the primary means of preventing the transmission of infection. The policy indicated staff were to assume every person was potentially infected or colonized with an organism that could be transmitted in the healthcare setting. The policy	F 880		

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F 880	Continued From page 23 directed staff to perform hand hygiene before and after having direct contact with residents, after contact with blood, body fluids or excretions, mucous membrane, non-intact skin, or wound dressing and after contact with residents' intact skin. Review of facility policy titled Laundry and Bedding Soiled, reviewed 6/18, indicated soiled laundry and bedding should be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen. The policy directed staff to place contaminated laundry in a bag or container at the location where it was used. The policy further indicated that an employee whose personal clothing became soiled with blood or body fluids should cover the soiled area or remove the clothing for immediate laundering before leaving the work area.	F 880		

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	245435	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2018**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/21/2018

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

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

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K 000	Continued From page 2 monitored for automatic fire department notification. The facility has a licensed capacity of 93 beds and had a census of 86 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location	K 222		11/28/18

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	245435	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2018**

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

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K 222	Continued From page 3 within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the proper operation of exit door locking devices. NFPA 101, Life Safety Code, 2012 edition section 7.2.1.7. This deficient practice could cause the door not to open and affect an undetermined amount of residents and staff.	K 222	Fire Marshal K-Tags 2018 Survey Survey 10/24/2018 K 222 NFPA 101, Life Safety Code, 2012 edition section 7.2.1.7 Egress Doors	

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K 222	Continued From page 4 Findings include: On the facility tour between 8:00 am to 1:00 pm on 10/24/2018 observations revealed the delayed egress door by the memory care unit did not operate properly when tested. This deficient condition was confirmed by the facility Administrator and the Lead Maintenance.	K 222	We will have a licensed contractor, Summit Fire Protection Company, come and repair the egress door so that it operates properly when tested. Completion Date: November 28, 2018 Responsible Person: John Hew Len - Lead Maintenance	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 321		11/30/18

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	245435	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2018**

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K 321	Continued From page 5 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility to maintain a hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for 14 of the 93 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 10/24/2018 observations revealed resident room 408 was converted to combustible storage over 50 sq ft and did not have a self closing door. This deficient condition was confirmed by the facility Administrator and the Lead Maintenance.	K 321	K 321 NFPA 101, Life Safety Code, 2012 edition, section 19.3.2.1.3 Hazardous Areas - Enclosure Resident room 408, which was converted into a storage room that is over 50 sq ft of combustible storage will have a self-closure put on the door. Completion Date: November 30, 2018 Responsible Person: John Hew Len - Lead Maintenance	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353		12/14/18

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K 353	Continued From page 6 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 93 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 10/24/2018 observations revealed. 1. Two sprinkler heads in the employee break room were painted. 2. One sprinkler head in the laundry room behind the dryers was corroded. 3. Two ceiling tiles in the mechanical room by the reception area were not in place. This deficient condition was confirmed by the facility Administrator and the Lead Maintenance.	K 353	K 353 NFPA 101 □ 2012 Edition Life Safety Code and NFPA 25 Section 5.2.1.1.2 Sprinkler System □ Maintenance and Testing Knute Nelson will have a licensed contractor, Summit Fire Protection Company, come and repair two sprinkler heads in the employee break room that had paint on them. The same contractor will also repair one sprinkler head in the laundry room behind the dryers that was corroded. Knute Nelson□s IT department will replace the two missing ceiling tiles in the mechanical room by the reception area. Completion Date: December 14,2018 Responsible Person: John Hew Len □ Lead Maintenance	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 372		11/30/18

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K 372	Continued From page 7 Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain two of seven smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 14 of the 93 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 10/24/2018 observations revealed penetrations of two smoke barriers above the ceiling at the following locations. 1. By resident room 301 a 1 inch hole. 2. By the memory care a 2 inch hole. This deficient condition was confirmed by the facility Administrator and the Lead Maintenance.	K 372	K 372 NFPA 101 - 2012 Life Safety Code Edition, Section 19.3.7.3, 8.8.7.1 (1) Smoke Barrier Construction Knute Nelson maintenance team will repair the two locations that revealed penetrations in the smoke barrier above the ceilings. The area by room 301 will be repaired with fire cocking. The area by memory care will be repaired with sheetrock and fire cocking. Date Completed: November 30, 2018 Responsible Person: John Hew Len - Lead Maintenance	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 374		12/14/18

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K 374	Continued From page 8 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain 3 of the four smoke barrier doors in accordance with the Life Safety Code (NFPA 101) 2012 edition section 101.8.5.4.1 and NFPA 80 the Standard for Fire Doors and Other Opening Protective's, 2010 edition, section 6.3.1.7. This deficient practice could allow the transfer of smoke from one smoke compartment to another making the corridors untenable. This condition could affect 29 of the 93 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 10/24/2018 observations revealed the smoke barrier doors in the Maple wing had an astragal, swung in the same direction and did not have a door coordinator. This deficient condition was confirmed by the	K 374	K 374 NFPA 101 - 2012 Edition Life Safety Code, Section 101.8.5.4.1 and NFPA 80 the Standard for Fire Doors and Other Opening Protective□s, 2010 Edition, Section 6.3.1.7 Smoke Barrier Doors The door going to the Maples hallway has an astragal, doors that swing in the same direction. A licensed contractor, Alex Glass and Glazing, will come and put a door coordinator on these doors. Date Completed: December 14,2018 Responsible Person: John Hew Len - Lead Maintenance	

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K 374	Continued From page 9 facility Administrator and the Lead Maintenance.	K 374		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain proper bathroom exhaust as required by the 2012 Life Safety Code (NFPA 101) section 9.2.2 and NFPA 91 Standard for Exhaust Systems for Air Conveying of Vapors, Gases, Mists and Noncombustible Particulate Solids and 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could negatively affect all of the 93 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 1:00 pm on 10/24/2018: 1. Observations revealed the bath fans did not operate in the 400 and 500 wings. 2. Documentation review revealed there was no record of a fire damper test in the last 4 years. This deficient condition was confirmed by the	K 521	K 521 NFPA 101 □ 2012 Edition Life Safety Code Section 9.2.2 and NFPA 91 Standard for Exhaust Systems for Air Conveying of Vapors, Gases, Mists and Noncombustible Particulate Solids and 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A HVAC Knute Nelson will have a licensed contractor, Ellingson Plumbing, Heating, A/C & Electrical, come fix the fans above the 400 and 500 wings and insure that they are in proper operating conditions. Knute Nelson will have the same licensed contractor complete a fire damper test which is supposed to be done every 4 years. Date Completed: December 14, 2018 Responsible Person: John Hew Len -	12/14/18

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K 521	Continued From page 10 facility Administrator and the Lead Maintenance.	K 521	Lead Maintenance	