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	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knute Nelson Care Center	420 12th Avenue East Alexandria, MN 56308

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to comprehensively assess the use of a restrictive device as a potential restraint for 1 of 1 resident (R6) reviewed for restraints. Findings include: Review of R6's annual Minimum Data Set, dated dated dated [DATE], identified R6 had severe cognitive impairment and had diagnoses which included Parkinson's, Diabetes Mellitus, and anxiety disorder. Indicated R6 required extensive assistance for activities of daily living (ADL's) which included bed mobility, transfers, and toileting. Identified R6 had one fall with no injury since the last assessment, three months prior and required a wheelchair for mobility. Indicated R6 did not use any restraints. Review of R6's annual Care Area Assessment (CAA) dated 3/6/24, identified R6 had severe cognitive impairment, was a high fall risk and had one fall with no injury since last assessment. CAA identified R6 did not use any restraints. Review of R6's quarterly fall assessment dated [DATE], identified R6 was at risk for falls related to Parkinsons and repeated falls. Fall assessment identified R6 did not require the use of a Velcro release belt. Review of R6's current physician orders signed 4/5/24, did not identify an order for a restraint. R6's medical record lacked any evidence a restraint assessment had been completed. Review of R6's care plan revised 7/13/23, identified R6 had a self care deficit related to cognitive impairment, weakness and falls. Care plan identified R6 was given a new non-restraint belt for her wheelchair, with this belt R6 was allowed to be in her room in her wheelchair. Indicated the belt in the wheelchair should prevent falls and allow for what family requested on behalf of the resident. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/20/24 at 6:45 p.m., R6 was seated in her wheelchair in the day room with a Velcro belt around her waist that contained two straps that were fastened behind R6's wheelchair. R6 had the Velcro belt in her hand and was squeezing the belt with her hand while the belt remained fastened. R6 was attempting to lean forward in her chair however, was having difficulty and was only able to partially lean forward in her chair. During an observation on 5/21/24 at 8:05 a.m., R6 was seated in her wheelchair in the dining room with a Velcro belt around her waist with the straps fastened behind her wheelchair. During an observation on 5/21/24 at 9:50 a.m.,R6 was seated in her wheelchair in the activity room and continued to have the Velcro belt placed around her waist with the straps fastened behind her wheelchair. During an observation on on 5/21/24 at 12:35 p.m., R6 was seated in her wheelchair in the day room. Velcro belt continued to be placed around R6 waist with the straps fastened behind her wheelchair. R6 had the Velcro belt in her hand and was attempting to twist her upper body while attempting to lean forward in her chair however, was having difficulty leaning forward. During an interview on 5/21/24 at 12:46 p.m., nursing assistant (NA)-A stated R6 was cognitively impaired and required staff assistance with her ADL's. NA-A indicated R6 required the Velcro belt across her waist to prevent falls. NA-A stated he had never seen R6 remove the Velcro belt on her own and did not believe she would be able to related to her impaired cognition. During an observation on 5/21/24 at 12:52 p.m., licensed practical nurse (LPN)-A brought R6 to her room and asked R6 to remove the Velcro belt from around her waist. After several minutes of attempting, R6 was unable to remove the belt from around her waist. During an interview on 5/21/24 at 12:58 p.m., LPN-A verified R6 was unable to remove the Velcro belt from around her waist. LPN-A stated she had seen R6 remove the Velcro belt from her waist in the past however, was unsure of the last time R6 was able to remove the Velcro belt from around her waist. During an interview on 5/21/24 at 1:14 p.m., registered nurse (RN)-A stated R6 had severe cognitive impairment and a history of falls. RN-A stated the Velcro belt was placed per family request to keep R6 in her chair because R6 would lean too far forward and fall out of her wheelchair. RN-A stated she did not believe the Velcro belt was a restraint as R6 had previously been able to remove the Velcro belt. RN-A indicated she was unsure if R6 could still remove the Velcro belt. RN-A stated she was unsure if a restraint assessment had been completed. RN-A indicated the only interventions attempted prior to the use of the belt that she was aware of was an alarm in R6's doorway and hourly checks on R6. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 3:39 p.m., director of nursing (DON) confirmed R6's care plan revealed a Velcro belt had been applied to R6's wheelchair. DON stated the Velcro was placed in R6's wheelchair as a reminder for when R6 leaned forward to help her stay positioned and was not meant to be a restraint. DON stated R6 had been able to remove the Velcro belt in the past however, may not have been able to remove upon command. DON verified a restraint assessment had not been completed prior to the placement of the Velcro belt and the use of the Velcro belt had not been reassessed to determine if R6 was able to remove the Velcro belt. DON stated her expectation was that the proper assessments would have been completed. During an interview on 5/21/24 at 4:10 p.m., family member (FM)-A stated R6 had a history of attempting to get out of her wheelchair and falling. FM-A stated the facility came up with the Velcro belt as an intervention about 10 months ago so R6 would not fall. FM-A stated she came to visit often and had never seen R6 remove the Velcro belt. FM-A stated she realized the Velcro belt may have been a restraint since it prevented R6 from sliding to the floor when she leaned too far forward however, she continued to want R6 to utilize the Velcro belt to prevent falls. Review of a facility policy titled identifying involuntary seclusion and unauthorized restraint revised 9/22, identified residents would be free from the use of any physical restraints not required to treat their medical condition. Identified a physical restraint was defined as any manual method, physical, mechanical device, equipment or material that met all of the following criteria: was attached or adjacent to a residents body, could not be easily removed by the resident (in the same manner it was applied by the staff) and restricted the residents freedom of movement or access to his or her body. Inappropriate or unauthorized use of a restraint occurred when it unnecessarily inhibited a residents freedom of movement or activity, was not the least restrictive option or used for the least amount of time, or was not accompanied by ongoing re-evaluation of the need for the restraint. Further identified examples of physical restraints were using devices in conjunction with a chair, such as trays, tables, cushions, bars, or belts, that the resident could not remove and prevented the resident from rising.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48740 Based on observation, interview and document review, the facility failed to ensure physician orders were implemented to prevent potential fluid retention for 1 of 1 resident reviewed for quality of care. Findings include: R33's quarterly Minimum Data Set (MDS) dated [DATE], identified R33 was cognitively intact. Diagnoses included atrial fibrillation and hypertension. Review of Nurse practitioner (NP) signed orders from 4/1/24, revealed an active order for Torsemide (loop diuretic to treat fluid retention and high blood pressure) oral tablet 20 milligrams (mg). Order to give 20 mg one tablet by mouth PRN (as needed) for weight gain > three pounds (lbs) overnight or > five lbs in seven days every day as needed. Order date 3/6/24, start date 3/6/24. Review of the electronic medication administration record (EMAR) dated 3/6/24, the Torsemide order was added to the EMAR. Order read: Torsemide oral tablet 20 mg give one tablet by mouth as needed for weight gain >three lbs overnight or > five lbs in seven days every day as needed. In addition, another order dated 3/7/24, identified an order for daily weights was added to the EMAR. The order stated: daily weights (see prn Torsemide order) update provider with an increase of > three lbs overnight or > five lbs in one week, in the mornings for MD order. Review of the pharmacist's recommendation from Guardian Pharmacy on 4/11/24, the pharmacist gave recommendations to nursing to: Please ensure daily weights were obtained due to parameters for PRN Torsemide. It was recommended weights were obtained right away in the morning before breakfast or liquid intake to help maintain consistency. Review of R33's EMAR from March 2024 through May 2024, revealed the following: -March 2024 EMAR, there were no weights for these dates on the March MAR: March 9, 10, 11, 13, 14, 15, 16, 18, 19, 22, 23, 24, 25, 27, 28, 31. -April 2024 EMAR, there were no weights listed for April 1, 2, 3, 5, 6, 8, 9, 14, 15, 18, 19, 20, 24. -May 2024 EMAR, there were no weights listed for May 3, 4,5,8,9,12,13,14,18,19. Review of R33's weight and vital summary from 3/7/24 to 5/19/24, revealed the following: -March 2024, no weights were entered on the following days: March, 9, 10, 13, 14, 15, 16, 18, 19, 22, 23, 24, 25, 27, 28. -April 2024, no weights were entered for April 5, 6, 8, 9, 14, 15, 18, 19, 24. -May 2024, no weights entered for May 3, 4, 5, 8, 9, 10, 12, 13, 14, 18, 19. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R33's progress notes from 3/7/24 through 5/20/24, lacked documentation R33 refused to be weighed. In addition, the progress notes lacked documentation the NP had been updated about the missing weights. During an interview on 5/22/24 at 10:29 a.m., nursing assistant (NA)-B stated R33 was to have a daily weight. R33 had not refused a weight for NA-B. NA-B indicated the facility had a process for daily weights that included a daily weight sheet at the nurse's station for staff to refer to. NA-B stated the weights were recorded on the sheet and then nursing assistants would document the weight in the vital section of EMAR. In addition, NA-B indicated the nurses documented the weight in the EMAR. During an interview on 5/21/24 at 4:00 p.m., NA-C stated her process for ensuring daily weights were completed was to write them down on the daily weight sheet and then enter them into the vital section of the EMAR. During an interview on 5/21/24 at 4:11 p.m., licensed practical nurse (LPN)-A stated obtaining daily weights was everyone's responsibility. LPN-A indicated daily weights should have been obtained before breakfast as most residents on daily weights had parameters for medications. During an interview on 5/21/24 at 5:07 p.m., registered nurse (RN)-A stated R33 was on a diuretic due to excess fluid build-up. RN-A indicated the process for daily weights was the nursing assistants obtained the weights and licensed nurses followed-up. RN-A stated the NA's charted the weights in EMAR. RN-A indicated if R33 had refused a weight, there would have been a note in the EMAR identifying that. RN-A stated nursing staff were responsible for updating the doctor when or if R33 refused to obtain a weight. RN-A indicated daily weights were important to ensure R33 received the proper dose of Torsemide to prevent excess fluid build-up. During an interview on 5/22/2024 at 11:42 a.m., RN-B stated R33 had an order to be weighed daily. RN-B indicated weights were written on the daily weight sheet at the nurse's station desk and then were recorded into the EMAR. RN-B stated the goal was to obtain the weight before the end of the shift. If staff did not obtain the weight on the day shift, the evening shift would attempt to obtain the weight. RN-B indicated it was important for staff to obtain a daily weight on R33 since the administration of the Torsemide depended on the daily weights. During an interview on 5/22/2024 at 11:49 a.m., LPN-B stated R33 received Torsemide to prevent fluid build-up. LPN-B indicated daily weights were charted in the vital section in the EMR. If the day shift did not obtain the daily weight, the evening shift staff were expected to obtain the weight. LPN-B stated staff had missed obtaining R33's weights on a daily basis the past few months. LPN-B indicated daily weights were important as the Torsemide administration was dependent on the daily weights. LPN-B stated if R33 gained more than five lbs staff were expected notify the doctor. During an interview on 5/22/2024 at 11:59 a.m., the nurse practitioner (NP) stated the facility had not informed NP about the daily weights not being completed as ordered. NP indicated the lack of daily weights and not receiving Torsemide as needed could contribute to health issues. NP stated R33's recent health issues were related to pneumonia and infection. NP's expectation would be the facility would obtain the weights as ordered and administer the medications as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/24 at 12:30 p.m., the pharmacist indicated the expectation would be to follow the provider's order. Pharmacist stated providers should have been contacted if weights were not being obtained as ordered and medications not being administered as ordered. During an interview on 5/22/24 at 12:50 p.m., the director of nursing (DON) confirmed R33 had an order for a daily weight and for Torsemide based on the weight. DON stated the daily weight was obtained by a mechanical lift unless R33 refused. DON indicated if there had been refusals, they should have been documented in the EMAR. DON stated it was important to follow the physician's orders and indicated staff were expected to follow the physician's orders. A policy regarding vitals and weights was requested however one was not provided.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure timely assistance with repositioning occurred for 1 of 5 residents (R6) with a history of pressure ulcers and at risk for further development of pressure ulcers. Findings include: Review of R6's annual Minimum Data Set (MDS) dated [DATE], identified R6 had severe cognitive impairment and diagnoses which included Parkinson's, Diabetes Mellitus, and anxiety disorder. Indicated R6 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. Identified R6 had a turning and repositioning program, was at risk for pressure ulcers and had a scar over a bony prominence from a previous pressure ulcer. R6's annual Care Area Assessment (CAA) dated 3/6/24, identified R6 was at risk for skin breakdown related to diagnosis of Parkinson's, anxiety, and diabetes mellitus (DM). Identified R6 required extensive assistance with ADL's. R6's care plan dated 8/6/2019, identified R6 was at risk for skin breakdown related to medical diagnosis and history of pressure ulcers. Care plan directed staff to reposition R6 every two hours. R6's nursing assistant task sheet undated, directed staff to reposition R6 every two hours. During a continuous observation on 5/21/24 from 9:50 a.m., to 12:50 p.m., the following was revealed: - at 9:50 a.m., R6 was seated in her wheelchair in the activity room - at 10:30 a.m., R6 continued to be seated in her wheelchair in the activity room. - at 10:49 a.m., activity aide (AA)-A wheeled R6 back to the unit and placed R6 in the day room. -at 11:30 a.m., R6 continued to be seated in her wheelchair in the dayroom. -at 12:00 p.m. registered nurse (RN)-A wheeled R6 to the dining room for lunch. -at 12:25 p.m., R6 remained in the dining room eating lunch. -at 12:35 p.m., licensed practical nurse (LPN)-A wheeled res back to the day room and R6 remained seated in her wheelchair as several staff walked by R6. -at 12:50 p.m., R6 remained seated in her wheelchair in the day room and surveyor requested LPN -A to reposition R6 after R6 had remained seated in her wheelchair and had not been repositioned for at least three hours. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/21/24 at 12:52 p.m. LPN-A wheeled R6 back to her room and R6 stated she needed to poo. LPN hooked R6 up to the pal and placed R6 on the toilet. Once R6 was done using the bathroom, LPN-A applied gloves and assisted R6 to wipe. LPN-then sanitized hands and assisted R6 off the toilet using the pal lift. During an interview on 5/21/24 at 1:00 p.m., nursing assistant (NA)-A stated R6 was at risk for skin breakdown and required extensive assist to reposition. NA-A indicated he was unsure the last time R6 had been repositioned however, according to the care plan, R6 should have been repositioned at least every two hours. During an interview on 5/21/24 at 1:05 p.m., LPN-A confirmed the last time R6 had been repositioned was at 7:30 a.m. LPN-A confirmed R6 required extensive assistance to reposition. LPN-A stated R6 was at risk for skin breakdown and should have been repositioned every two hours. During an interview on 5/21/24 at 1:14 p.m., RN-A confirmed R6 required extensive assistance to reposition. RN-A stated R6 had a history of pressure ulcers on her buttocks which would have placed her at risk for acquiring a pressure ulcer. R6 stated her expectation was R6 would have been repositioned every two hours. During an interview on 5/21/24 at 3:29 p.m., director of nursing (DON) stated R6 was able to slightly offload on her own however required staff assistance to fully reposition. DON stated R6 was at risk for pressure ulcers and her expectation was that R6's care plan for repositioning would have been followed. Review of a facility policy titled Repositioning in Bed and Chair; Applying Lift Sheets Policy revised 2/24, directed staff to check the resident's care plan or Kardex to identify the resident's specific repositioning needs and encourage the resident to change position or shift weight as often as possible.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620 Based on observation, interview and document review, the facility failed to comprehensively assess smoking safety for 1 of 1 residents (R38) who currently smoked. Findings include: R38's quarterly Minimum Data Set (MDS) dated [DATE], indicated R38 was moderately cognitively impaired and had diagnoses which included tracheostomy (also known as a tracheotomy, was a small surgical opening that was made through the front of the neck into the windpipe, or trachea. A curved plastic tube, known as a tracheostomy tube, was placed through the hole allowing air to flow in and out of the windpipe) anxiety, depression, history of falling, weakness, hypertension (high blood pressure) and history of alcohol dependence. Identified R38 was independent with transfers, toileting, bed mobility, locomotion with use of cane, dressing and personal hygiene. The MDS did not identify R38 as a smoker. R38's care plan prior to 5/21/24, lacked documentation R38 was a cigarette smoker. On 5/21/24, R38's care plan was then updated and identified R38 was a cigarette smoker. He was alert and oriented, able to light and extinguish his cigarettes safely. He was educated and understood he needs to go off-property to smoke. Education provided regarding programs to help with cessation and smoking safety. An initial smoking assessment dated [DATE], identified R38 was not a smoker. R38's electronic health record (EHR) lacked any additional smoking assessments prior to 5/21/24. During an interview on 5/21/24 at 2:39 p.m., R38 stated he was a cigarette smoker prior to admission. R38 indicated he began to smoke cigarettes again shortly after admission when he regained strength. R38 indicated he usually smoked four times a day however, had not gone outside that week due to the weather. R38 stated he exited the building through different doors and stood in the grass. R38 verified there was not a designated smoking area off the facility property and that there was no place to sit or extinguish his cigarette. R38 confirmed he managed his cigarettes and lighter himself, kept them in his room, extinguished his cigarettes with his fingers and then threw the butts in the garbage can in his room. During an interview on 5/21/24 at 3:01 p.m., licensed practical nurse (LPN)-C confirmed R38 was a smoker and he would usually go outside after each meal to smoke. LPN-C stated R38 should have been assessed for smoking safety and supervised while smoking due to a history of falls and weakness. LPN-C verified R38's electronic heath record (EHR) lacked a smoking assessment and the care plan lacked interventions prior to when the care plan was updated on 5/21/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 3:06 p.m., clinical manager (CA)-A confirmed R38 was a smoker. CA-A confirmed R38's EHR lacked a smoking assessment or a care plan with interventions for smoking prior to when the care plan was updated o 5/21/24. CA-A stated the facility was a non-smoking facility and R38 would have to go off-property to smoke. CA-A verified the facility lacked a designated smoking area. CA-A was unaware R38 used his cane to prop open the facility door when going outside to smoke or that he brought his extinguished cigarette butts inside and threw them in his garbage can. CA-A verified R38 should not have been disposing his cigarette butts in the garbage can due to a fire risk. During an observation/interview on 5/22/24 at 8:04 a.m., R38 walked out a back door of the facility and utilized his cane to prop the door open and prevent the door from locking behind him. R38 indicated he would walk across the parking lot over the curb without his cane and stand in the grass off the facility property. During an observation on 5/22/24 at 11:29 a.m., cigarette butts were observed in R38's garbage can in his room. MDS Coordinator confirmed the cigarette butts were in R38's garbage can and stated she was unaware R38 was disposing of them there. MDS Coordinator verified throwing the cigarette butts in the garbage can was a fire risk for everyone in the facility. During an interview on 5/22/24 at 9:52 a.m., nursing assistant (NA)-D confirmed R38 was a smoker and was unaware of the location R38 went to smoke as there was no smoking allowed on the facility property. During an interview on 5/22/24 at 11:47 a.m., director of nursing (DON) stated the facility expectation would be R38 would go off site to smoke and she would expect R38 to let staff know when he was exiting the building and where he was going. DON confirmed it was a fire risk for R38 to be throwing his cigarette butts in the garbage can. Review of the facility policy titled Resident Smoking/Tobacco Policy revised 2/24, identified tobacco products were prohibited throughout the facility and on the grounds. Residents who chose to use tobacco products needed to go off facility grounds. All tobacco products were be kept at the nursing station and distributed by the nursing staff. The interdisciplinary team (IDT) were to assess the mental, physical and visual ability of the resident to possess tobacco products. If the tobacco product were kept in the resident room, it must have been kept in a secure location.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 4 of 4 residents (R 21, R29, R48 and R52) who resided on the Pines unit reviewed for food. This deficient practice had the potential to affect all 42 residents residing on this unit. Findings include: R21's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had intact cognition ad was able to feed herself after staff set up her tray. R29's quarterly MDS dated [DATE], indicated R29 had intact cognition and could feed himself after staff set up his tray. R48's admission MDS dated [DATE], indicated R48 had impaired cognition and required staff supervision to eat. R52's significant change MDS dated [DATE], indicated R52 had intact cognition ad could feed herself after staff set up her tray. During an interview on 5/20/24 at 1:05 p.m., R52 stated the food was often cold. During an interview on 5/20/24 at 1:25 p.m., R29 stated the food did not taste very good and the hot items were usually served cold. During an observation on 5/20/24 at 4:45 p.m., a cart containing plates of food were wheeled to the kitchen. The cart had a cord however, was not plugged in. The plates were removed from the cart and staff brought them to the tables to be served to the residents in the dining room. At 5:25 p.m., as the last plates were being passed from the cart, a test tray was requested from DA-A. The meal consisted of individual cheese pizzas, mashed potatoes, pureed pizza and pureed carrots. The tray was tested for temperatures and results were as follows: -cheese pizza was 88 degrees Fahrenheit (F). -mashed potatoes were 125 degrees Fahrenheit (F). -pureed pizza was 116 degrees Fahrenheit (F). -pureed carrots were 114 degrees Fahrenheit (F). Surveyor tasted the food from the tray: the pizza was cold, the mashed potatoes, pureed pizza and carrots were luke warm. Dietary aide (DA-A) confirmed the pizza was cold and the remaining items were barely warm. (continued on next page)

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	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knute Nelson Care Center	420 12th Avenue East Alexandria, MN 56308

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/24 at 5:30 p.m., R52 stated the pizza was cold tonight however, he was hungry so he ate it. During an observation and interview on 5/20/24 at 5:32 p.m., R48 was sitting with her plate in front of her and she had only eaten 1/4 of her pizza and stated her food was cold. On 5/20/24 at 5:34 p.m., as R21 left the dining room she stated to the surveyor that the pizza was cold tonight. During an interview on 5/20/24 at 5:33 p.m., DA-A stated the usual process was to plate the food in the main dining room and serve the food from the warming cart. DA-A confirmed the warming cart had not been plugged in during the meal service as it was easier to move around when it was not plugged in. DA-A stated she was unsure of what the holding temps of food should have been at. During an interview on 5/21/24 at 10:37 a.m., dietary manager (DM) stated the normal process for serving the supper meal was to plate the food in the main dining room, place the food in the warming cart and serve to the long term care unit from the warming cart. DM stated his expectation was that the warming cart would have been plugged in and the holding temperature of the food would have remained at or above 140 degrees Fahrenheit (F). Review of a facility policy titled Food Temperature Policy revised 3/5/20, indicated all hot food items must be served to the resident at a temperature if at least 140 degrees Fahrenheit at the time the resident received the food.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on interview and document review, the facility failed to ensure 4 of 5 residents (R6, R36, R41 and R44) received pneumococcal vaccinations based on shared clinical decision-making in accordance with the Center for Disease Control (CDC) recommendations reviewed for immunizations. Findings include: Review of the current CDC recommendations 3/15/2023, revealed The CDC identified Adults [AGE] years of age or older received the (PPSV23) or (PCV13) at any age and who have not received the Pneumo 20-valent conjugate Vaccine (PCV20) should receive a dose of the PCV20 at least one year after the most recent PPSV23 or PCV13 vaccine. In addition, the CDC identified adults 65 and older who had previously received both PCV13 and PPSV23 at age 65 and older, based on shared clinical decision-making with the patient and the provider one dose of PCV20 at least five years after the last pneumococcal vaccine dose. Review of R6's facesheet identified R6, age 84 was admitted to the facility on [DATE]. Review of R6's Minnesota Immunization Information Connection (MIIC) undated, identified R6 received the PPSV23 on 10/16/1996 and 6/7/2006, and received the PCV13 on 10/16/96 and 5/20/2016. R6's medical record lacked documentation R6 had been offered or received the PCV20 based on shared clinical decision-making. Review of R36's facesheet identified R36, age 76 was admitted to the facility on [DATE]. Review of R36's MIIC record undated, identified R36 received the PPSV23 on 5/23/2014, and the PCV13 on 12/8/2015. R36's medical record lacked documentation R36 had been offered or received the PCV20 based on shared clinical decision-making. Review of R41's facesheet identified R41, age 89 was admitted to the facility on [DATE]. Review of R41's MIIC record undated, identified R41 received the PPSV23 on 11/1/2000, and the PCV13 on 1/25/2015. R41's medical record lacked documentation R41 had been offered or received the PCV20 based on shared clinical decision- making. Review of R44's facesheet identified R44, age 89 was admitted to the facility on [DATE]. Review of R 44's MIIC record undated identified R44 received the PPSV23 on 1/4/2009, and the PCV13 on 1/16/2015. R 44's medical record lacked documentation R44 had been offered or received the PCV20 based on shared clinical decision-making. During an interview on 5/21/24 at 3:15 p.m., director of nursing (DON) verified she was also the infection preventionist (IP). DON confirmed R6, R36, R41, and R44 had not received the pneumococcal vaccinations as recommended by the CDC. DON stated her expectation would have been that all residents had been offered or received all pneumococcal vaccines per CDC recommendations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy titled Pneumococcal Vaccine dated 2001, identified all residents were to be offered the pneumococcal vaccine to aid in preventing pneumonia/pneumococcal infections. Identified residents were assessed of eligibility to receive the Pneumovax within five working days of the admission to the facility. Further identified administration of the pneumonia vaccine was made in accordance with the Center For Disease Control (CDC) recommendations.