STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245435	A. BUILDING _____ B. WING _____	10/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KNUTE NELSON	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 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to notify residents, representatives and families of confirmed cases of Coronavirus Disease 2019 (COVID-19), when one resident (R5) and two employees (E1 and E2) tested positive for COVID-19, per current federal guidelines. In addition, the facility failed to provide cumulative updates weekly to residents, their representatives and families of any subsequent positive cases or respiratory illnesses. This deficient practice had the potential to affect all 66 residents, families and representatives at the facility. Findings include: Center for Medicare & Medicaid Services (CMS) Center for Clinical Standards and Quality/Quality, Safety and Oversight Group (CMS QSO) memo 20-29 NH dated 5/6/20, required nursing homes to inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. The memo further directed facility's to provide cumulative updates at least weekly to residents, their representatives and families on any subsequent positive cases or respiratory illnesses. R2's quarterly Minimum Data Set ((MDS) dated [DATE], identified R2 had intact cognition and had [DIAGNOSES REDACTED]. R3's quarterly MDS dated [DATE], identified R3 had intact cognition and had [DIAGNOSES REDACTED]. R5's quarterly MDS dated [DATE], identified R5 had severe impaired cognition and had [DIAGNOSES REDACTED]. R5's [DIAGNOSES REDACTED]-COV-2 RNA (severe acute respiratory syndrome coronavirus 2 ([DIAGNOSES REDACTED]-CoV-2) [MEDICAL CONDITION] RNA (COVID-19), lab results dated 9/18/20, and resulted positive on 9/18/20. Review of facility spreadsheet titled COVID-19 per month identified the following columns present: first name, last name, medical record number (MRN), date, med, dose, route, frequency of administration, duration, diagnosis, provider, outcome, and date resolved. The spreadsheet identified R5 had tested positive for COVID-19 on 9/18/20 and lacked identification of symptoms. Review of facility spreadsheet titled COVID-19 Test Tracking had the following columns: name of staff member, date of test, date results confirmed, positive/negative, quarantine, date started and date ended. The spreadsheet identified E1 developed symptoms of cough and runny nose on 9/17/20. The spreadsheet identified E2 was asymptomatic. E1 was tested for COVID-19 on 9/17/20. E1's [DIAGNOSES REDACTED]-COV-2 sample was collected on 9/17/20, and resulted positive on 9/19/20. E2 was routinely tested for COVID-19 on 9/22/20. E2's [DIAGNOSES REDACTED]-COV-2 sample was collected on 9/22/20, and resulted positive on 9/25/20. Review of untitled informational sheet undated, identified the communication portal was a secured website portal that provided real time information which included updates to residents and their families. The sheet identified information found on the communication portal was what traditionally was present in a mailed letter. The sheet identified the residents would continue to receive paper notices in addition to having portal access. Further, the sheet provided log in information for the communication portal. The sheet lacked information about the portal being the primary method of communication when COVID-19 cases are present in the facility. Review of resident council meeting minutes for 8/1/20, and 9/30/20, revealed the meetings were conducted via resident interviews and not in a group setting. The minutes lacked information shared regarding the presence of positive COVID-19 cases in the facility. On 10/7/20, at 11:39 a.m. the chief operating officer (COO) indicated she was responsible for updating the residents, representatives and families when a positive COVID-19 case occurred in the facility. The COO stated the facility had an online communication portal where the information was placed and it was expected residents, representatives and families accessed this online portal to receive that information. The COO confirmed the facility did not have another mechanism for reporting the positive results. On 10/7/20, at 1:53 pm. R2 stated she had not been informed of any positive COVID-19 cases in the facility and was not aware the facility had any. R2 further stated she would have remembered news of that nature if she had been informed. R2 stated she was not aware of the communication portal or the facility expected residents to access the portal to receive information on the COVID-19 status in the facility. R2 stated she had not received a letter or a personal visit from anyone within the facility informing her of the positive cases. On 10/7/20, at 1:55 p.m. R3 stated she had been told of the positive cases in the facility when staff obtained consent to test her for COVID-19. R3 stated she could not remember what date that was and indicated she was not aware the facility expected residents to access the communication portal to obtain information on the status of COVID-19 within the facility. R3 stated she had not received a letter or a personal visit from anyone within the facility informing her of the positive cases. On 10/7/20, at 2:52 p.m. during a telephone interview family member (FM)-A indicated she was the primary contact for her mother who resided in the facility. FM-A stated she had not been notified of the positive COVID-19 cases in the facility and was not aware of the communication portal the facility had in place. On 10/7/20, at 3:00 p.m. during a telephone interview FM-B indicated he was the primary contact for his mother who resided in the facility. FM-B stated he was aware the facility had completed COVID-19 testing on the residents and he believed the facility was just ruling out the presence of COVID-19 in the facility. FM-B stated the facility had not informed him of any positive cases and he was not aware of the facility's communication portal. On 10/8/20, at 9:07 a.m. during a telephone interview FM-C indicated she was the primary contact for her uncle who resided in the facility. FM-C stated she had not been informed by the facility of the positive COVID-19 cases. FM-C stated she was aware the facility had an online communication portal, however, she was not aware the portal was the notification mechanism the facility used to communicate the positive cases. Further, FM-C stated she had heard from a member in the community the facility had positive cases. On 10/8/20, at 9:27 a.m. during a telephone interview FM-D indicated she was the primary contact for her mother who resided in the facility. FM-D indicated she had learned of a positive COVID-19 case in the facility when she called the facility and asked if there were any positive cases. FM-D stated she was not sure if she had been informed about an online communication portal the facility had in place. On 10/8/20, at 3:08 p.m. the director of nursing (DON) indicated the COO was responsible for the COVID-19 positive notifications to residents, families and representatives. On 10/8/20, at 3:41 p.m. in a follow-up interview the COO confirmed the facility's primary mechanism for notifying residents, families and representatives of COVID-19 positive cases in the facility was via the letter posted to the facility's online communication portal by 5:00 p.m. the next day after the confirmed case was identified. The COO stated the facility sent out an informational sheet about the communication portal which included information on how to access the portal in monthly statements. The COO confirmed the sheet lacked information indicating the portal would be the reporting mechanism when a COVID-19 positive case was identified in the facility. The COO stated the facility did not have a back-up notification method if a resident, family or representative lacked internet access or was not familiar with how to access the internet. The COO confirmed the facility did not provide residents with a personal visit or a paper copy of the letter which was posted on the communication portal. Review of the facility flow chart titled Care Center Communication Tree dated 5/6/20, identified when a presumptive or positive COVID-19 case was identified, the facility would provide residents with a personal visit and bulletin and families would receive the COVID bulletin via the web portal.

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

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.