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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IBJ4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00321

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245247**

2.STATE VENDOR OR MEDICAID NO.
(L2) **738745801**

3. NAME AND ADDRESS OF FACILITY
(L3) **KITTSON MEMORIAL HEALTHCARE CENTER**
(L4) **1010 SOUTH BIRCH**
(L5) **HALLOCK, MN** (L6) **56728**

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 **04/25/2014** (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 **70** (L18)

13.Total Certified Beds **70** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jane Aandal, HFE NEII 05/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/06/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 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
07/01/1982
(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

CCN: 24-5247

On April 25, 2014, an extended survey was completed at this facility. Deficiencies were found whereby corrections are required. Conditions in the facility constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to resident health or safety. the condition resulting in our notification of IJ has been removed. As a result of the survey findings, this Department imposed State monitoring, effective May 18, 2014.

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V office for imposition:

-Civil money penalty for deficiency cited at F323

The facility is prohibited from offering or conducting Nurse Assistanct Training / Compentency Evaluations Programs (NATCEP) for two years effective April 25, 2014.

Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Submitted
May 13, 2014

Mr. Todd Christensen, Administrator
Kittson Memorial Healthcare Center
1010 South Birch
Hallock, Minnesota 56728

RE: Project Number S5247025

Dear Mr. Christensen:

On April 25, 2014, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on April 25, 2014, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Lyla Burkman Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective May 18, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Kittson Memorial Healthcare Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 25, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility.
  Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the

acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

• 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.

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 PoC 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 July 25, 2014 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 25, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
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 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

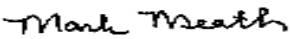
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	04/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On April 21st, 22nd, 23rd, 24th and 25th, 2014, the surveyors of this department's staff, visited the above provider and the following correction orders are issued. An extended survey was completed on 4/25/14. The facility's plan of correction (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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted by the Minnesota Department of Health on April 21st, 22nd, 23rd, 24th and 25th, 2014. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to comprehensively assess for causal factors and risks related to falls which resulted in harm and the high potential for further harm or death. Facility staff had been notified of the IJ on April 24th, 2014, at 3:25 p.m. for the IJ that began on January 20th, 2014. The IJ was removed on April 25th 2014, at 2:10 p.m., however, non-compliance remained at the lower scope and severity level of a G, actual harm.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or	F 225		6/11/14

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

Electronically Signed | 05/23/2014

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

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F 225	Continued From page 1 mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 immediately report potential mistreatment to the state agency (SA), related to	F 225	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or	

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F 225	Continued From page 2 an unwitnessed fall which resulted in significant injuries to a cognitively impaired resident for 1 of 3 residents (R19) reviewed for accidents. Findings include: R19's significant change Minimum Data Set (MDS) dated 11/12/13, indicated she was diagnosed with dementia, osteoarthritis, stroke and heart failure. The MDS also indicated she had a moderate cognitive impairment and required extensive assistance with transferring, toileting and locomotion on and off the unit. The MDS also indicated R19 required extensive assistance with ambulation in the corridor and had sustained one fall without injury. Review of an incident report dated 3/23/14, at 9:00 p.m. indicated R19 was found on the floor next to her bed with a "gash" (laceration) on the right side of her forehead along with significant facial bruising. R19 was unable to state what had happened. R19's bed alarm was sounding at the time of the fall. R19 was taken to the emergency room where she received seven stitches to her forehead. The administrator was notified of this incident on 3/23/14. However, the SA was not notified of the incident until 3/24/14, at 10:00 a.m., 13 hours after the incident had occurred. On 4/24/14, at 2:40 p.m. social service designee (SSD)-A stated the facility had notified her of the incident on 3/23/14, (a Sunday) right after the incident. SSD-A stated the nursing staff had indicated they were nervous about completing the report to the SA. She stated the nursing staff had all received education on how to report to the SA but since she was at home she had instructed the staff she would complete report the following	F 225	agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility□s allegation of compliance. F225 It is the policy of KMHC to immediately report allegations of potential mistreatment. This has the potential to affect all KMCC residents. The staff involved with the 03/23/14 incident were instructed on the definition of immediate in relation to vulnerable adult reporting and re-education was provided on KMHC's policy on Abuse Prohibition and Vulnerable Adult Reporting. Training will be provided on KMHC's Vulnerable Adult Abuse Prohibition Policy & reporting requirements with all Staff, Administrator and Human Resources by the SSD. The training will include staff demonstration of how to submit the initial report to SA immediately. KMHC staff will be educated on KMHC's Abuse Prohibition Plan at a Mandatory Plan of Correction In-services on May 20th and 21st. ALL Vulnerable Adult Incident reports will be reviewed by the SSD, DON, & Administrator for timely reporting and the results reported and acted on as needed at the monthly Quality Assurance Meeting. The Administrator and DON are responsible for compliance.	

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F 225	Continued From page 3 morning, on 3/24/14. The facility's Reporting Maltreatment of Vulnerable Adults Policy and Procedure dated 7/30/13, directed the staff to immediately report any potential allegations of abuse and/or neglect to the SA, via the SA's website. The policy included the website address along with the facility identification and passwords required to make a report. On 4/24/14, at 2:45 p.m. SSD-A confirmed the report had not been reported to the SA according to the facility's policy.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement thier own abuse prohibition policies related to an unwitnessed fall which resulted in significant injuries to a cognitively impaired resident which was not immediately reported to the state agency (SA) for 1 of 3 residents (R19) reviewed for accidents. Findings include: The facility's Reporting Maltreatment of Vulnerable Adults Policy and Procedure dated	F 226	F226 It is the policy of KMHC to develop and implement an Abuse Prohibition Policy that includes immediate notification to the State agency following allegations of potential mistreatment. It is also KMHC's policy to do a thorough investigation to determine whether mistreatment or neglect of care has occurred. This has the potential to affect all KMHC□s residents. To ensure compliance with this plan, staff will be educated on KMHC's Abuse Prohibition	6/11/14

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F 226	Continued From page 4 7/30/13, directed staff to immediately report any potential allegations of abuse and/or neglect to the SA, via the SA's website. The policy included the website address along with the facility identification and passwords required to make a report. R19's significant change Minimum Data Set (MDS) dated 11/12/13, indicated she was diagnosed with dementia, osteoarthritis, a stroke and heart failure. The MDS also indicated she had moderate cognitive impairment and required extensive assistance with transferring, toileting and locomotion on and off the unit. The MDS also indicated R19 required extensive assistance with ambulation in the corridor and had sustained one fall without injury. Review of an incident report dated 3/23/14, at 9:00 p.m. indicated R19 was found on the floor next to her bed with a "gash" (laceration) on the right side of her forehead, along with significant facial bruising. R19 was unable to state what had happened. R19's bed alarm was sounding at the time of the fall. R19 was taken to the emergency room where she received seven stitches to her forehead. The administrator was notified of this incident on 3/23/14. However, the SA was not notified of the incident until 3/24/14, at 10:00 a.m., 13 hours after the incident had occurred. On 4/24/14, at 2:40 p.m. social service designee (SSD)-A stated the facility had notified her of the incident on 3/23/14, (a Sunday) right after the incident. SSD-A stated the nursing staff had indicated they were nervous about completing the report to the SA. She stated the nursing staff had all received education on how to report to the SA but since she was at home she had instructed the	F 226	Policy at mandatory in-services presented on 05/20/14 and 05/21/14. The in-service will include the definitions of and what constitutes abuse and neglect and it will include education on the investigative policy for unwitnessed falls with injury. To ensure compliance with this plan, all suspected abuse, neglect and significant unwitnessed injury reports will be reviewed by the SSD, DON, & Administrator to ensure that they have been properly investigated and that KMHC's policies are being followed. The results of these audits will be reported and acted on as needed at KMHC's monthly Quality Assurance Meetings. DON, Administrator are responsible for compliance.	

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	245247	A. BUILDING _____ B. WING _____	04/25/2014

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F 226	Continued From page 5 staff she would complete report the following morning, on 3/24/14. At 2:45 p.m. SSD-A confirmed the report had not been reported to the SA according to the facility's policy.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified dining experience was provided during observation of dining in the facility's upper level dining room for 2 of 22 residents (R19, R55) related to untimely eating assistance and condescending comments made to R19 by facility staff during meal service and serving R55 liquids from a cup from which R19 had already drank. Findings include: R19's significant change Minimum Data Set (MDS) dated 11/12/13, indicated she was diagnosed with dementia and had a moderate cognitive impairment. The quarterly MDS dated 2/4/14, indicated she required supervision with eating. The current care plan reviewed on 2/18/14, indicated R19 was to be seated at a table and instructed staff to provide assistance and supervision as needed. Cues were to be provided	F 241	F241 It is the policy of KMHC that all residents are treated with dignity. This has the potential to affect all KMHC residents. KMHC has provided re-education to staff that made comments to R19 during survey and the need to treat residents with dignity and respect. In addition, re-education has been provided to staff that did not remove the liquids from the table regarding the need to remove liquids promptly after a resident is seen leaving the table to prevent other cognitively impaired residents from drinking them. A policy has been developed to ensure this does not occur for other residents on our memory unit at meal times. This policy will be reviewed at an all staff in-services on 05/20/14 & 05/21/14. Those not able to attend will watch a DVD of the in-service and receive the handouts. Also at this in-service education will be provided to all staff regarding treating residents with dignity.	6/11/14

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F 241	Continued From page 6 during meals, along with the use of a tissue if R19 needed to spit. On 4/23/14, at 7:47 a.m. nursing assistant (NA)-K brought R19 to the breakfast table and then left to assist other residents. Glasses of apple juice, milk, and water were provided as part of her table setting. R19 took a drink of water and spit it out to the right side of her wheelchair, onto the floor. Then R19 took a drink of apple juice and spit it out to the left side of her wheelchair, onto the floor. At 7:50 a.m. upon notification of R19's spitting, licensed practical nurse (LPN)-D, who was passing medications, took R19 away from the table and stated she would wait until a staff member was available who could sit with her, before bringing her back to the table. LPN-D took a clothing protector to wipe up the liquids from the floor and did not remove the liquids from the table. At 8:12 a.m. R19 remained off to the side of the dining room, by the kitchenette area, with no staff yet available to sit with her. At 8:14 a.m. NA-K gave R19 a half of banana to eat on a napkin by the kitchenette area. At 8:18 a.m. registered nurse (RN)-A told R19 she was going to bring her over by her so she could "keep an eye on her." RN-A stated again, "I am going to bring you over by me so I can watch you." R19 asked, RN-A why she needed to be watched, to which RN-A responded, "Because you spit out your liquids ... I am going to bring you over by me so I can watch you." R19 was then brought over to a different table from where she sat at the start of this observation. R19 picked up a piece of toast from the plate and took a bite. RN-A asked where R19's liquids were and activity aide (AA)-A brought her a new glass of water. At 8:20 a.m. R19 had to be moved from the table to get another resident around the back side of the	F 241	Random audits will be conducted to ensure compliance and the results of the audits reported and acted on as needed at KMHC's monthly Quality Assurance Meeting. SSD and DON are responsible for compliance.	

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F 241	Continued From page 7	F 241		

table. At this time, R19 took a drink of water and spit it out onto the floor. NA-K went over to R19 and whispered to her not to spit. At 8:31 a.m., NA-I placed R55 at the breakfast table where R19 was seated, earlier in the meal service. R19's liquids remained on the table. At 8:41 a.m. R19 was overheard asking NA-D something. NA-D stated, "We will get you back over there," referring to the table where R19 had previously sat. R19 remained in seated in her wheelchair, across from the kitchenette, apart from where the other residents were seated. At 8:50 a.m. NA-I assisted R55 with her breakfast meal and gave her a drink of apple Juice from the same glass that R19 had drank out of earlier.

During a second observation of the breakfast meal on 4/25/14, at 8:00 a.m. NA-J stated to R19 that she was going to take her over to the table for the breakfast meal so she could "watch her." R19 stated, "Why do you have to watch me." At 1:30 p.m. NA-J verified she had made the comment to R19 during the breakfast meal. NA-J stated she did not mean for the statement to sound derogatory. NA-J stated she just wanted the dietary staff to know R19 needed a staff member present prior to her food being served.

On 4/25/14, at 11:09 a.m. RN-A stated she did not know that R19 had already drank out of the apple juice glass she had given to R55. RN-A stated, "I was not aware of it." RN-A stated all the liquids for breakfast were placed on the tables by AA-A. RN-A stated she thought the liquids should not have been placed on the table in front of R19 as she would sweep the liquids off the table and spit the liquids out. RN-A stated she never meant the statements to R19 to sound derogatory. RN-A confirmed her statements did not "sound

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F 241	Continued From page 8 good." At 11:22 a.m. the director of nursing (DON) verified the facility did not have a policy related to resident dignity.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide residents the opportunity to choose the type of bath they preferred, their preferred daily waking times and their preferred bathing schedule, for 3 of 3 residents (R19, R66 and R52) reviewed with concerns regarding these choices. Findings include: R19's quarterly Minimum Data Set (MDS) dated 2/4/14, indicated she had a moderate cognitive impairment. The current care plan reviewed on 2/18/14, indicated R19 required extensive assistance of one staff, to get in and out of the tub. On 4/21/14, at 6:08 p.m. R19 stated she would have liked to take a shower sometimes. She	F 242	F242 It is the policy of KMHC that residents have the right to choose activities, schedules and healthcare consistent with their interests, assessments and plan of care. It is also the policy Of KMHC that residents are allowed to make choices about aspects of his or her life in the facility that is significant to the resident. This has the potential to affect all residents of KMHC. KMHC has followed up with R19, R52 and R66 about the choices available and their preferences for baths, showers and times for waking up in the morning. These preferences have been documented and communicated to the direct care givers. R52 was put on the bath schedule for a second bath. To ensure all residents of KMHC are able to make bath choices	6/11/14

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F 242	Continued From page 9 reported that the staff always gave her a tub bath. On 4/23/14, at 6:22 a.m. licensed practical nurse (LPN)-D stated there was a working shower on the unit. LPN-D reported the facility did not have any residents that currently used the shower as they all used the bath tub. Upon inspection of the shower area, there were several wheelchairs in the shower stall. LPN-D verified that wheelchairs were being stored in the shower stall. On 4/25/14, at 11:27 a.m. registered nurse (RN)-A contacted social service designee (SSD)-A to find out if any bathing preference type had been identified for R19. At 1:35 p.m., RN-A provided a Resident Satisfaction feedback form dated 8/6/13. One of the questions read, "Can you change your bath time if you don't [do not] like it?" R19 responded, "I'd [I would] ask if I could." RN-A indicated that a new form was implemented in 7/13, which addressed a resident's preference between a bath or shower. However, RN-A stated this new form was not completed for R19. Review of the undated, Getting to Know and Understand Our Residents form, revealed a bathing preference question, where the resident could select their preferred day and time for a bath. However, the form did not address the preference between a shower or bath. R66's quarterly MDS dated 1/21/14, indicated cognition was intact. On 4/22/14, at 8:56 a.m. R66 stated staff came into her room at 7:00 a.m. to wake her up each day. R66 was yawning during the interview and stated she preferred to sleep until 8:00 a.m.	F 242	staff will ask prior to each bath if they want a bath or a shower. All residents that are able to be interviewed will be interviewed by the SSD to make sure their preferences for clothing, preference for type of bath, wake-up time and bed-time are honored. The information given to residents at our January resident council meeting was repeated at resident council on 05/19/14 to ensure the residents are aware that this is their home and that they have choices. To ensure compliance continues, residents will be asked quarterly at the time of the MDS if they feel their choices are being honored or if they wish to change something in regards to their care. This will be documented on the back of the Getting to Know and Understand our Residents form which is done on admission. Staff were educated on the resident's rights to choice at mandatory in-services held 05/20/14 and 05/21/14.A quarterly residnet satisfaction report regarding choices will be reported and acted on as needed at KMHC's monthly Quality Assurance Meetings. SSD and DON are responsible for compliance.	

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F 242	Continued From page 10 On 4/23/14, at 6:26 a.m. nursing assistant (NA)-I was observed to enter R66's room. At 6:54 a.m. LPN-D stated she gave R66 her thyroid pill and checked her blood sugar (BS). LPN-D stated R66's blood sugar was checked daily at 7:00 a.m. and that R66 slept really hard in the morning. LPN-D stated she asked R66 if she was going to get up and come out for breakfast when she checked her blood sugar. At 7:06 a.m. the door to R66's resident room was opened by NA-I. R66 was dressed for the day and ambulated with her walker to the dining room. At 7:44 a.m. breakfast had not been served yet. R66 was observed, seated in the dining room with only her beverages set up for her. R66 had her eyes shut at the table. At 7:55 a.m. R66 had still not been served and was again noted with her eyes shut at the table. R66's breakfast was served to her at 7:56 a.m. However, R66 remained at the dining table with her eyes shut past 8:43 a.m. During interview on 4/23/14, at 12:35 p.m. LPN-D stated R66's BS had been running low in the morning and adjustments were made to her sliding scale insulin. LPN-D stated R66 was always tired and could have slept all day and all night. LPN-D stated R66 went right back to sleep after her BS was checked. LPN-D stated R66 could sleep as long as she wanted in the morning. On 4/24/14, at 2:12 p.m. NA-I stated he tried to go in to R66's room in the morning when the LPN went in for her BS check. NA-I stated R66 liked to sleep all the time and when she did ask to stay in bed longer, her preference was honored. On 4/24/14, at 2:22 p.m. R66 stated she preferred when her BS was low in the morning,	F 242		

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F 242	Continued From page 11 that she be given a glass of juice or milk and then be able to go back to sleep until 8:00 a.m. R66 stated she did not believe that anyone had ever asked her a wake-up time preference. On 4/25/14, at 10:40 a.m. RN-A stated there was no documentation of R66's wake-up time preference in the clinical record. RN-A stated R66 required the assistance of one staff for morning cares. R52's quarterly MDS dated 3/4/14, identified R52 was alert, oriented and had diagnoses including Parkinson's disease and back pain. The assessment identified R52 as independent in bed mobility, ambulation and transfers. The MDS noted R52 required extensive assistance with baths. The care plan dated 12/3/13, directed the staff to assist R52 with a weekly tub bath. On 4/21/14, at 6:12 p.m. R52 stated she received a weekly tub bath. She indicated she did not wish to ask for more baths because the staff would charge extra to assist her with an additional bath. She stated she would like more, but did not wish to incur an additional charge. The undated Getting to Know and Understand Our Residents form indicated that at some point a facility staff member asked R52 about her bathing preferences. The staff (unknown) indicated "A.M." as her bathing time preference. On 4/23/14, at 12:53 p.m. NA-L stated the baths were determined according to the resident room number. She stated when a new resident was admitted to the facility, the room had an assigned bath day and that was when a resident received their bath.	F 242		

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F 242	Continued From page 12 On 4/23/14, at 12:55 p.m. NA-M stated the residents were placed on the bath schedule according to the room number. She stated residents were allowed to have more than one bath upon request. On 4/23/14, at 1:00 p.m. registered nurse (RN)-B stated the bath schedule had been established according to what room the residents were assigned to. She stated if a resident wished to have more than one bath, the facility was able to accommodate the additional bath. She stated upon admission, the staff asked about bathing preference but confirmed the residents were not given choices regarding the bathing schedule as to the frequency or the choice to take a bath or a shower. She stated the facility did not charge for additional baths. She stated she would talk to R52 and offer an additional bathing time. On 4/25/14, at 9:10 a.m. the social service designee (SSD)-A and SSD-B stated the nursing staff offered the residents bath choices upon admission to the facility. They stated they were unaware the bathing schedule was preset according to the room number and the preset schedule did not allow for the residents to choose the frequency, the day of the week or whether they wished to have a bath or a shower. SSD-A and SSD-B confirmed all residents should be given choices regarding bath schedules. The Bath Policy and Procedure dated 7/30/13, read, "Residents shall be offered choice in scheduling of bath services. Choice shall be offered as to time, and type: shower verses tub baths. Resident have a right to chair their schedule upon request."	F 242		

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise a written care plan to reflect a change in ambulation abilities for 1 of 3 residents (R19) reviewed for accidents. Findings include: R19's current care plan reviewed on 2/18/14, indicated R19 required assistance with ambulation three times a day with staff assistance and a walker. During observation on 4/23/14, at 7:35 a.m.	F 280	F280 It is the policy of KMHC to review and revise resident care plans in regard to accidents and to implement interventions in order to minimize the risk for further falls and injury. All KMHC residents have the potential to be affected. R19's care plan was reviewed and updated on 04/22/14. Staff caring for this resident were educated on her plan of care in relation to falls. The care plans of all residents with recent accidents will be reviewed for accuracy and updated if needed. All residents at risk for falls have	6/11/14

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F 280	Continued From page 14 nursing assistant (NA)-K and NA-D assisted R19 to transfer from her bed to her wheelchair, using a pivot disc and gait belt. On 4/23/14, at 1:24 p.m. NA-K stated when R19 was moved to the upper level (UL) on 3/27/14, she required the use of a mechanical lift. NA-K stated R19 was evaluated by occupational therapy and was then a two person transfer with the pivot disc. On 4/25/14, at 11:29 a.m. registered nurse (RN)-A stated when R19 came to the UL on 3/27/14, she was non-ambulatory. RN-A stated she should have reviewed R19's care plan for revisions needed when she was moved to the UL. At 11:43 a.m. RN-A stated since R19 sustained a pelvic fracture on 1/20/14, she had not ambulated. RN-A stated she did not know why the care plan had not been revised when the pelvic fracture occurred. She confirmed, the care plan was not accurate regarding ambulation and needed to be revised. The Resident Assessment Policy revised 1/29/04, indicated care plans were revised as necessary to address the current needs of each resident.	F 280	the potential to be affected. To ensure compliance for all residents with accidents, incident forms will be reviewed weekly by a fall team consisting of the DON (or acting DON in her absence), a Unit Coordinator, a member of OT or PT and a member of the SS department. Care plans will be reviewed for accuracy at the time of the meeting this will serve as an audit to ensure all resident care plans are reviewed and revised in relation to accidents.The results of these audits will be reported and acted on as needed at KMHC's monthly Quality Assurance Meetings. DON responsible for compliance.	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the standard of	F 281	F281 It is the policy of KMHC to follow standard of practice when administering	6/11/14

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F 281	Continued From page 15 practice when administering medications for 4 of 4 residents (R63, R32, R47, R41) reviewed during the medication administration observation. Findings include: On 4/21/14, at 4:54 p.m. licensed practical nurse (LPN)-E, prepared a medication and placed it in a plastic medication cup. LPN-E then handed the medication to LPN-F and told her to administer it to R63. LPN-F placed the medication into R63's mouth and held a glass of water for R63 to drink. R63's medication administration record (MAR) indicated he received Lisiopril (a blood pressure medication) 5 milligrams (mg) in the evening. At 5:33 p.m. LPN-E prepared medications in two plastic medication cups and a 90 cubic centimeters (cc) glass of liquid medication (Arginaid-for increased protein). LPN-E handed the medications to LPN-F and she administered the medications to R32. R32's MAR indicated she received Keppra (a seizure medication) 500 mg, Metoprolol (a blood pressure medication) 25 mg, Crestor (a cholesterol lowering medication) 20 mg, and Probiotic (a dietary supplement), one capsule in the evening. At 5:35 p.m. LPN-E prepared medications in a paper cup. LPN-E handed the medications to LPN-F and she administered the medications to R47. R47's MAR indicated he received Tramadol (pain medication) 50 mg, Metformin (used to treat diabetes) 1000 mg, and Tylenol (pain medication) 650 mg in the evening. At 5:36 p.m. LPN-F was observed standing in front of the medication cart, as LPN-E prepared medications for residents. LPN-E prepared	F 281	medications. The staff that did not follow the standard of practice during medication pass were re-educated that dispensing medication they did not dish up is not an acceptable. Nurses were re-educated on safe medication pass and prevention of medication errors by our consulting Pharmacist, Eric Christianson, Pharm. D., CGP, BCPS at an in-service on May 7th, 2014. The deficient practice of administration that occurred during survey was addressed at this in-service. The nurses that were unable to attend were given copies of the in-service handouts and the re-education was reviewed with them by DON. KMHC Medication Administration Policy will be revised and education will be provided to all nurses. To ensure continued compliance, a policy for orientation of new staff will be developed and all nurses will be educated on this policy. A copy onf the orientation policy will be given to all new nurses on thier first day of orientation. Audits will be done to ensure employees receive this information and the auidit results will be reviewed at KMHC's monthly Quality Assurance Meetings. DON is responsible for compliance.	

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	245247	A. BUILDING _____ B. WING _____	04/25/2014

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F 281	Continued From page 16 medications and handed them to LPN-F and she administered the medications to R41. R41's MAR indicated she received Metformin (used to treat diabetes)1000 mg, Aspirin 81 mg, and Tramadol (pain medication) 50 mg in the evening. At 7:20 p.m. LPN-E stated this was the first evening she was orienting LPN-F. LPN-E stated she found it helpful to know how each resident took their medications. LPN-E stated she felt it was a "time crunch" so she handed the prepared medications to LPN-F. LPN-E stated did not think registered nurse (RN)-A knew she gave the prepared medications to LPN-F to administer and then LPN-E initialed off the medications. LPN-E stated they needed guidelines when training in new employees. On 4/23/14, at 12:00 p.m. RN-A stated LPN-E had not been a nurse for a long time, RN-A stated LPN-E should have had LPN-F prepare the medications and then administer them to the residents. RN-A stated, "I know that is not right." RN-A stated she was not aware the staff were doing this. On 4/24/14, at 11:40 a.m. the director of nursing (DON) stated the medication delivery policy would not address LPNs handing off medications to another LPN to administer. The DON stated it was not an acceptable practice.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		6/11/14

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F 282	Continued From page 17 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement fall prevention interventions in accordance with the resident's written plan of care for 1 of 3 residents (R19) reviewed for accidents. Findings include: R19's care plan reviewed 2/18/14, indicated she had a mobility deficit and had multiple falls at her home, prior to her admission to the facility. The care plan directed staff to place fall mats at her bedside and recliner, maintain an uncluttered pathway, remind R19 to call for assist as needed and to monitor her for unsafe transfers. The care plan also instructed bed, wheelchair and recliner alarms were to be utilized, the electrical cord for her lift chair was to be unplugged after positioning, and staff were to ensure she wore appropriate foot wear at all times. On 4/24/14, at 2:40 p.m. R19 was observed in her recliner in her room with family member (FM)-A. The clip alarm was observed not attached to R19. FM-A stated R19 was placed in the recliner about 1:40 p.m. by occupational therapist (OT)-A. At 2:50 p.m. nursing assistant (NA)-K was informed the clip alarm was not attached to R19 in the recliner. NA-K stated it was to be attached to R19. In addition, NA-K noticed the recliner chair was plugged into the wall when R19 was in the recliner. NA-K unplugged the recliner, and	F 282	F282 It is the policy of KMHC to provide services in accordance with a resident□s written plan of care. To ensure compliance for R19 staff caring for this resident staff have been re-educated on her care plan. To ensure compliance for all residents of KMHC a fall intervention form has been established and fall interventions will be recorded on this form and reviewed by staff at the start of each shift. This form will also be routed to the SS, Housekeeping, activities and dietary staff so that all departments are aware of fall interventions that are to be in place. A form has also been developed to update CNA and nursing staff of other changes made to the residents care plans. This will also be reviewed at the start of each shift. Random audits will be done to ensure continued compliance throughout all shifts.The results of these audits will be reported and acted on as needed at KMHC's monthly Quality Assurance Meetings. DON and Unit Coordinators are responsible for compliance.	

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F 282	Continued From page 18 stated she had plugged the recliner in at 11:45 a.m. when R19 was placed in the wheelchair for lunch. NA-K stated they must have forgotten to unplug it in at 1:40 p.m. when she was placed back in the recliner. On 4/25/14, at 11:43 a.m. registered nurse (RN)-A stated the clip alarm was to be on when R19 was in the recliner. Also, RN-A verified the lift recliner was to be unplugged after R19 was positioned according to the care plan. The Resident Assessment Policy revised 1/29/04, indicated the services provided by the facility must be provided by qualified persons.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess the on-going issue of halitosis (a condition of having stale or foul smelling breath) for 1 of 1 resident (R43) reviewed with a family concern. In addition, the facility failed to provide proper wheelchair positioning for 1 of 3 residents (R45) reviewed for positioning needs.	F 309	F309 It is the policy of KMHC to provide proper wheel chair positioning for all of its residents. R45 was evaluated by OT on 05/01/14 and a drop seat put in the resident□s w/c. All residents who use wheelchairs as their primary mode of transportation have the potential to be affected. To ensure proper w/c positioning screening has been performed by OT for	6/11/14

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F 309	Continued From page 19 Findings include: R43's quarterly Minimum Data Set (MDS) dated 3/14/14, indicated she had dementia with a severe cognitive impairment and required extensive assistance with personal hygiene. Review of R43's dental consultation reports revealed the following: · A consultation report dated 1/2/13, indicated R43 had dental x-rays completed. · A consultation report dated 12/12/13, indicated R43 received a dental cleaning. The results noted a lot of calculus (hardened dental plaque). · A consultation report dated 3/5/14, indicated R43 received a dental cleaning per the family's request. The results noted moderate calculus and gingival inflammation with hemorrhaging (gum tissue disease and bleeding). Recommendations included use of staff assistance every evening with brushing and flossing. The dental consultation reports lacked indication that R43's halitosis was addressed by her dentist. The current care plan reviewed on 4/1/14, directed staff to provide oral cares twice daily and as needed. The plan of care did not address R43's halitosis. During observation on 4/21/14, at 6:55 p.m. R43 was noted to have mouth odor. On 4/21/14, at 7:07 p.m. family member (FM)-B was interviewed via telephone. FM-B indicated that she visited R43 regularly and reported R43 had an on-going issue with her breath. FM-B stated R43 did receive dental cleanings and staff tried to get R43's teeth brushed. FM-B stated on	F 309	all residents that routinely use wheelchairs for proper w/c positioning and referrals will be made as needed. To ensure continued compliance monthly audits will be done for appropriate w/c positioning. In addition to this, OT will add a screen of proper w/c positioning to its quarterly screen for ADL changes. Staff will be educated on proper w/c positioning at a mandatory in-services on 05/20/14 and 05/21/14. R43 was examined by Karen Warner PA on 04/30/14 for possible systemic reasons for the halitosis. R43 was also checked for H pylori, which was negative. R43□s PA suggested the R43 be offered with meals. Dental exam was performed on R43 by Dr. Ostrosky on 05/06/14. Dr. Ostrosky reported cavities and reported that the R43 was uncooperative with exam and resistant to opening her mouth so they could not be filled. Care plan has been revised to reflect that R43 is often resistive to oral cares. Staff will continue to attempt to provide oral care twice a day. Random audits will be done of staff to ensure compliance of providing or attempting to provide oral cares.The results of these audits will be reported and acted on as needed at KMHC's monthly Quality Assurance Meetings. Staff will be educated on oral care at mandatory in-services on 05/20 and 05/21/14. DON and Unit Coordinators are responsible for compliance. Completion date 06/16/14.	

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F 309	Continued From page 20 Easter morning they took R43 to church and her breath was bad so they "popped" gum in her mouth. During subsequent observations on 4/22/14, at 2:19 p.m. and on 4/23/14, at 6:19 a.m. R43 was again noted to have foul smelling breath. On 423/14, at 11:12 a.m. nursing assistant (NA)-I stated between 5:00 to 5:30 a.m., the night staff should have dressed R43 and done oral cares. NA-I stated oral cares were done by the night staff because she was already dressed for the day. NA-I stated there was no report that R43 had refused oral cares. In addition, NA-I stated R43 had all her own teeth. NA-I stated he had attempted to brush R43's teeth during day shifts in the past and R43 had refused oral cares. NA-I stated when refusals occurred, he tried to swab her mouth. NA-I added, R43 stated the toothbrush hurt her gums, and then became agitated when he attempted to brush her teeth. NA-I stated he had not checked R43's breath today. The daily behavior observation forms (DBOF) completed by the NAs were reviewed for March and April 2014. RN-A stated the behavior tracking forms completed by the NAs only addressed resistance with cares and not specifically resisting oral hygiene. The March 2014, DBOF indicated 17 occasions of resistance with cares. The April 2014, DBOF indicated five occasions of resistance with cares. On 4/23/14, at 12:48 p.m. licensed practical nurse (LPN)-D stated the nurses were initialing on the medication administration record (MAR) to ensure oral cares were done. Review of the March and April 2014, MARs indicated the nurses had initialed to indicate oral cares were done.	F 309		

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F 309	Continued From page 21 On 4/23/14, at 3:12 p.m. NA-B who worked as a night NA stated she placed toothpaste on the toothbrush for R43 and she then brushed her own teeth. NA-B confirmed she did report off to the nurses when she completed oral cares for R43. NA-B stated R43's breath smelled okay for a short while after tooth brushing and then the bad breath returned. NA-B stated she also used diluted mouthwash with R43. On 4/25/14, at 8:57 a.m. registered nurse (RN)-A stated R43 had been to the dental office for a cleaning. RN-A stated on 3/4/14, FM-C called her and complained that R43's teeth were not cleaned when he visited. RN-A stated that was when she put the oral cares on the MAR for the nurses to monitor. RN-A stated R43 could be very resistive. At 9:10 a.m. RN-A stated R43's care plan did not address her refusals of oral hygiene. RN-A stated FM-C had never complained to her about R43 having had bed breath. RN-A stated she had sent R43 to the dental office. However, she had never addressed R43's halitosis with her physician. On 4/25/14, at 9:29 a.m. NA-B stated she had done oral hygiene with R43 that morning at 5:00 a.m. NA-B stated she had put toothpaste on the toothbrush and R43 had brushed her teeth. NA-B then gave R43 diluted mouthwash. At 9:55 a.m. NA-B stated she was having R43 brush her teeth again due to foul breath. NA-B stated, "It was if she had never brushed her teeth this morning." R45's plan of care dated 1/22/14, identified her with limited mobility and directed the staff to use her wheelchair. The plan also identified the staff were to ensure R45 had gripper socks on as she refused to keep her shoes on.	F 309		

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F 309	Continued From page 22 Review of R45's occupational therapy referral form dated 3/3/14, directed the staff to utilize a wheelchair with a cushion and no leg rests. The plan directed the staff to ensure R45 had shoes on while in the wheelchair to ensure she was able to touch the floor properly. The referral form did not address R45's resistance toward keeping her shoes on. R45's significant change MDS dated 3/25/14, identified she had severe cognitive impairments and diagnoses including dementia, anxiety, diabetes mellitus, arthritis and osteoporosis. The assessment identified R45 required extensive assistance with all activities of daily living and she utilized a wheelchair for mobility. The Care Area Assessment (CAA) dated 4/1/14, identified R45 utilized a wheelchair as her primary mode of mobility and was able to propel herself short distances. The CAA lacked resolution for integration of the occupational therapy instructions of ensuring R45 had her shoes on while in her wheelchair, with her known resistance toward keeping her shoes on. On 4/24/14, at 9:00 a.m. R45 was observed sitting in her wheelchair in the dining room. The wheelchair had a thick pressure redistribution cushion on it. R45 was noted as wearing gripper socks without shoes. R45's feet were not able to touch the floor while seated in her chair. NA-K was observed to transfer R45 from the wheelchair into a recliner. NA-K reported R45 was able to place her feet on the floor, but often held them up on her own. On 4/24/14, at 9:18 a.m. NA-D stated R45 was able to put her feet on the ground, but she pulled	F 309		

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F 309	Continued From page 23 her feet up when she wanted to. She stated R45 had trialed several different wheelchairs, and the staff had been directed to use her current wheelchair, without leg rests. NA-D reported that if R45 had leg rests on her wheelchair, she would have attempted to stand on them, which put her at a higher risk for falls. On 4/24/14, at 9:50 a.m. NA-I stated R45 was not to use leg rests because she was able to self-propel with her feet while seated in the wheelchair. On 4/24/14, at 10:00 a.m. NA-J stated R45 was able to sit in her wheelchair with her feet on the floor. On 4/25/14, at 7:51 a.m. R45 was again observed sitting in her wheelchair with gripper socks on. R45's toes were observed to be on the floor. However, she was not able to place her heels on the floor. Registered nurse (RN)-A confirmed R45 was not able to sit in the chair with her feet on the floor. RN-A reviewed the occupational therapy referral form and stated R45 did not allow her shoes to be left on as identified on the care plan. She stated R45 had not tolerated shoes for a long time. She stated R45 routinely kicked her shoes off. A policy related to wheelchair positioning was requested but was not provided.	F 309		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		6/11/14

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F 323	Continued From page 24 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility demonstrated a systematic failure to comprehensively assess and effectively implement interventions in order to minimize the risk of serious injury or death from a fall for 1 of 3 residents (R19) reviewed with a history of falls, resulting in immediate jeopardy. In addition, the facility's failure to comprehensively assess and effectively implement interventions for falls resulted in actual harm for 1 of 3 residents (R19) reviewed with a history of falls, who sustained a pelvic fracture and two scalp lacerations following three separate falls. The immediate jeopardy began on 1/20/14, when R19 sustained a pelvic fracture as a result of a fall. The facility's systematic failure to comprehensively assess and effectively implement interventions for R19's falls was identified on 4/24/14. The Administrator and the director of nursing (DON) were notified of the immediate jeopardy on 4/24/14, at 3:25 p.m. The immediate jeopardy was removed on 4/25/14, at 2:10 p.m. however, non-compliance remained at the lower scope and severity level of a G, which indicated actual harm that was not immediate jeopardy. Findings include: R19's significant change Minimum Data Set	F 323	F323 It is the policy of KMHC to comprehensively assess residents at risk for falls and to implement interventions in order to minimize the risk for further falls and injury. All residents of KMHC have the potential to be affected. Resident 19 was interviewed and assessed regarding falls and prevention of falls related injuries. As of April 24th, 2014 R19 was placed on every hour monitoring while up in wheelchair or recliner (she has had no falls from bed where she sleeps at night) until she had been comprehensively assessed and a comprehensive interdisciplinary plan of care implemented to maintain her safety and prevent falls whenever possible and minimize injury from unavoidable falls. R19 is currently being cared for in a safe manner. As of April 24th, 2014, R19 has been comprehensively assessed. The comprehensive assessment included history of falls; underlying conditions; medications; functional status; wheelchair seating system, fall alarm string length; neurological status; psychological status; and environmental factors. R19 was assessed by her primary physician on 04/25/14 for medications and physical assessment. Based on this comprehensive assessment a	

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F 323	Continued From page 25 (MDS) dated 11/12/13, indicated R19's diagnoses included dementia, osteoarthritis, a stroke and heart failure. The MDS also indicated R19 had a moderate cognitive impairment and required extensive assistance with transferring, toileting locomotion on and off the unit, and ambulation in the corridor and had sustained one fall with no injury. Review of R19's Fall Risk Assessment dated 11/19/13, indicated she was at high risk for falls. R19's Care Area Assessment (CAA) dated 11/19/13, identified R19 at high risk for falls related to a balance deficit and use of an antidepressant. The CAA revealed R19 required extensive assistance of one, to two staff when ambulating with a front wheeled walker and she was on an ambulation list for distances as tolerated. The CAA indicated R19 experienced a fall on 10/22/13, with no injury. However, she had experienced orthostatic hypotension (a drop in blood pressure upon standing) during the fall. R19's quarterly MDS dated 2/4/14, indicated R19 required extensive assistance with bed mobility and was non-ambulatory. The MDS failed to identify a fall had occurred on 1/20/14, which resulted in a pelvic fracture. R19's 14-day MDS dated 2/14/14, indicated R19 had a severe cognitive impairment. R19s care plan reviewed 2/18/14, indicated she had a mobility deficit, with multiple falls prior to her admission to the facility. The care plan noted	F 323	comprehensive interdisciplinary plan of care was implemented to maintain her safety and prevent falls whenever possible. Interventions added to care plan include the following: R19 will continue to be offered toileting every 3 hours. R19 agrees to rest in a recliner in the day rooms rather than in her own room for increased staff observation. An anti-roll back device was placed on her wheel chair. PT and OT referrals were made. Activities will provide increased one-to-one visits. The length of the w/c chair alarm cord will be monitored in ensure it is no longer than if her nose were over her knees. Nurses will monitor for pain and provide PRN analgesics as needed. R19 currently has a Fentanyl patch ordered. On 02/24/14 staff were immediately educated prior to reporting for duty of changes to the comprehensive interdisciplinary plan of care to maintain R19□s safety and prevent falls whenever possible. On 04/25/14 an in-service was provide by OT on the appropriate length of the fall alarm string. On April 25th, 2014 additional education was provided to all staff from the Upper level where R19 resides and the additional changes to the comprehensive interdisciplinary plan of care to maintain R 19□s safety and prevent falls whenever possible. This training will be continued until all staff that work in the unit that R19 resides on are alerted to the care plan changes prior to reporting for duty. Unit Coordinators were educated April 24th about the components of a comprehensive fall assessment and comprehensive care plan to maintain	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

(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 323	Continued From page 26 her skin bruised easily, with an increased risk related to her use of Xarelto (an anticoagulant medication used to reduce the risk of stroke and blood clots). The care plan directed staff to place a fall mat at her bedside and next to her recliner. The plan also included maintaining an uncluttered pathway, reminders to call for assistance as needed, monitoring for unsafe transfers, and placement of alarms for her bed, wheelchair and recliner. In addition, the care plan directed staff to unplug the lift chair after positioning, ensure she wore appropriate foot wear at all times and ambulate with her three times daily, with staff assist. During observation and interview on 4/21/14, at 6:29 p.m. R19 was observed in her room, with bruising on both of her cheeks. The bruising was observed to be yellow and green in color. R19 stated she had fallen approximately one month prior. During observation of morning cares on 4/23/14, at 7:35 a.m. nursing assistant (NA)-K stated she typically called for help and put R19 in her wheelchair after cares were completed. At 7:37 a.m., NA-D entered the room. At 7:38 a.m., NA-K assisted R19 to the edge of her bed and NA-D applied a gait belt. At 7:39 a.m., R19 was assisted by NA-D and NA-K to stand and pivot on a disc, then sit in her wheelchair. The bed alarm sounded and a clip alarm was attached to R19's shirt. On 4/23/14, at 2:48 p.m. R19 was observed asleep in her room in the recliner with the	F 323	resident safety and prevent falls whenever possible. Fall logs have been reviewed for the past quarter for those residents at risk for multiple falls. Those residents identified as being at greater risk will have comprehensive assessments completed, individual risk factors identified, and interventions care planned with staff education on changes. All staff will receive training on Fall Prevention and Management prior to or during their shift beginning April 24th, 2014. Resident comprehensive fall assessments and care plans are currently being reviewed and updated as necessary. All staff involved in resident care will receive resident care plan change training prior to reporting for duty in the changes to the comprehensive care plan of care to maintain resident safety and prevent falls whenever possible. All residents of KMHC have the potential to be affected. Eric Christiansen, Pharm. D. assessed potential medication concerns in relation to falls on our memory Care unit 05/08/14. The interventions of increasing supervision and 1:1 activity visits have been added to our fall intervention form and they have been added to our Fall Prevention Policy. To ensure continued compliance, random audits will be done for proper string length of clip alarms. In addition to the fall huddle done at the time of a fall, there will be a daily fall meeting to review any falls that have occurred and to ensure appropriate measures have been taken to prevent further falls. Random audits will be done of the Fall Scene Investigation forms to ensure completeness.The results	

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F 323	Continued From page 27 newspaper on her lap. The call light was attached to the arm of the recliner. Bruising was still noticeable on both cheeks. Steri strips (a thin adhesive strip to close small wounds) were intact to her right upper forehead. A mat was noted on the floor in front of the recliner. The electric cord for her lift chair was noted as unplugged which inactivated the recliner. There was a clip alarm attached to R19, with Velcro hooked to a bar behind the recliner. A sensor alarm pad was also observed on the seat of her recliner. Review of R19's Fall Scene Investigation (FSI) Reports revealed the following: · On 7/20/13, at 2:10 p.m. R19 fell while attempting a self-transfer to the bathroom from her recliner. No injury was noted. The FSI indicated the chair alarm sounded and R19 was found on the floor. The call light was in reach and R19 was reminded to use her call light when needing anything. There were no changes made to R19's care plan. · On 8/15/13, at 4:45 p.m. R19 was in her recliner and fell while self-ambulating in her room. Staff had asked R19 to go for a walk at 3:15 p.m., but R19 had refused, so she was toileted and returned to the recliner. The FSI indicated R19 hit her head on the bathroom door which caused a bump on the back, right-side of her head. Staff instructed R19 to call for assistance when she needed help. There were no changes made to R19's care plan. · On 10/22/13, at 5:00 p.m. R19 was brought back to her room, toileted and was being transferred to the recliner from the wheelchair by	F 323	of these audits will be reported and acted on as needed at KMHC's monthly Quality Assurance Meetings. DON is responsible for compliance.	

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F 323	Continued From page 28 staff. R19 stood up, then stumbled to the floor. The FSI indicated R19 hit her head on the rocker. The immediate intervention was to keep R19 in the lobby at all times, while not in bed. The FSI indicated R19 experienced orthostatic hypotension during the transfer. There were no changes made to R19's care plan. However, the NA assignment sheet was updated to instruct NAs to cue R19 about moving slowly from surface to surface. · On 1/20/14, at 3:15 a.m. R19 was asleep in her recliner and then awoke confused. R19 attempted to self-transfer to her wheelchair but the brakes were not locked. The alarms sounded and R19 was found on the floor mat/floor. R19 sustained a fractured pelvis as a result of this fall. Staff were to check on R19 every two hours during the night per the care plan and on demand during the day. If R19 was antsy at night she was to be brought to the common area for supervision. R19 was reminded to call for assistance. · On 3/23/14, at 7:00 p.m. R19 was found on the floor, lying on her stomach, bleeding from her nose and the right side of her face. R19 had elevated her recliner to a nearly standing position and was still holding the remote in her hand. R19 sustained a laceration to her right forehead, which required an emergency room (ER) visit and seven stitches. The care plan was updated with direction for staff to unplug R19's recliner after positioning. In addition, on 3/27/14, R19 was moved to the facility's memory care unit. · On 4/21/14, at 9:45 p.m. R19 was found lying on the floor of her room, with blood coming from her forehead. R19 stated she was reaching	F 323		

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F 323	Continued From page 29 forward to grab an ice cream wrapper that was on the floor. R19 sustained a one-inch, superficial laceration to the right, middle forehead. Staff were alerted by the alarm that R19 was on the floor. The care plan was updated to keep the area picked up as much as possible. On 4/22/14, an X-ray report indicated bruising on R19's right foot post fall. However, no fractures were present. Review of R19's record lacked a comprehensive evaluation of her fall risk and fall history. The record lacked interventions that were pertinent, given her fall history, causal factors for her falls and her level of cognition. On 4/23/14, at 2:56 p.m. licensed practical nurse (LPN)-A stated she was aware R19 had sustained an additional fall on 4/21/14. She stated since that time, she was monitoring R19 closely and was not aware of new interventions to minimize her risk for further falls since the fall on 4/21/14. On 4/23/14, at 3:00 p.m. activity aide (AA)-A stated she was not aware of changes or interventions to prevent/minimize R19's risk for falls. On 4/23/14, at 3:01 p.m. NA-A stated if a resident was trying to get up, she would attempt to stay with the resident and keep them safe. She stated she was unaware of any changes for R19 since her fall on 4/21/14. On 4/23/14, at 3:05 p.m. NA-B stated she was aware R19 had fallen on 4/21/14, but had not heard of any changes or interventions attempted since the fall. NA-B stated no new instructions	F 323		

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F 323	Continued From page 30 were given to the staff during the shift change report on 4/23/14. On 4/23/14, at 3:10 p.m. NA-C stated R19 had a clip alarm which informed the staff when she was on the floor. NA-C stated R19 had fallen in the past and the alarm informed the staff when she was on the floor again. On 4/23/14, at 1:24 p.m. NA-K stated when R19 moved to the facility's memory care unit on 3/27/14, she required a mechanical lift to transfer, related to her fractured pelvis. NA-K stated after the fall on 4/21/14, staff were to make sure the room was clean, with nothing on the floor for R19 to reach for. NA-K stated on 4/21/14, she had brought R19 and family member (FM)-A an ice cream cone. After FM-A left, R19 reached for the ice cream paper on the floor. NA-K stated she was alerted to the fall by the alarm. NA-K stated R19's cognition varied from day-to-day. On 4/24/14, at 7:35 a.m. an interview was completed with registered nurse (RN)-A the memory care unit coordinator (UC) and RN-B, R19's previous UC, when she lived on the facility's lower level unit (LL). Upon review of R19's falls, the following statements were made: · RN-B stated the fall on 7/20/13, at 2:10 p.m. occurred on the LL. RN-B stated, at that point, ensuring the call light was within reach, was an appropriate intervention for R19. RN-A stated initially after a resident fell, the staff involved gathered for a fall huddle meeting and implemented immediate interventions as needed. RN-B stated the coordinator obtained the FSI report right away, and then weekly there was a fall meeting with the director of nursing (DON),	F 323		

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F 323	Continued From page 31 RN's, therapists, and the social service designee. RN-B stated after the fall meeting occurred, the FSI report went to the risk management meeting for a monthly review of falls. · RN-B stated the fall on 8/15/13, at 4:45 p.m. occurred on the LL. RN-B stated, at the time R19 required the assistance of one staff with ambulation. RN-B stated every morning the DON discussed any falls from the day prior with the RNs. · RN-B stated the fall on 10/22/13, at 5:00 p.m. occurred on the LL when she had just become the UC. RN-B stated initially after the fall the staff had decided to bring R19 out to the lobby. RN-B stated she did not put that as a planned intervention on R19's care plan, as she did not feel it was realistic for R19 to be in the lobby all the time. · RN-B stated the fall on 1/20/14, at 3:15 a.m. occurred on the LL. RN-B stated from time-to-time R19 slept in her recliner. RN-B stated there was not a care plan intervention for staff to have the brakes locked on R19's wheelchair. RN-B stated R19 was hospitalized from 1/23/14 through 1/28/14, diagnosed with a heart attack, pneumonia, and a urinary tract infection. RN-B stated R19's dementia had started to worsen, and stated an intervention of calling for assistance was probably not an appropriate intervention. On 4/24/14, at 8:32 a.m. NA-H stated R19 had a history of falls and the facility was utilizing a clip alarm for her. She stated the staff were attempting to keep her safe by following the care plan interventions on the assignment sheet. She	F 323		

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F 323	Continued From page 32	F 323		

was not aware of any new interventions for R19 since the fall on 4/21/14.

On 4/24/14, at 9:10 a.m. activities assistant (AA)-B stated R19 had episodes in which she would fall. She could not recall receiving any new directions related to fall interventions for R19.

On 4/24/14, at 9:20 a.m. NA-D stated R19 had fallen once since moving to the memory care unit. She stated the floor around R19 had to be clean as R19 would lean over and attempt to pick up items from the floor.

On 4/24/14, at 9:30 a.m. housekeeping (HSKP)-A stated she was aware R19 had a history of falling but was unaware of any interventions to minimize her risk of falling.

On 4/24/14, at 9:40 a.m. R19 was observed seated in a wheelchair in her room working on a puzzle. At 9:42 a.m. R19 was observed leaning down to the floor attempting to pick up a piece of the puzzle off the floor. No staff were observed in R19's room or in the hallway. The clip alarm did not sound. When approached, R19 sat up and accepted assistance to pick up the puzzle piece.

On 4/24/14, at 9:42 a.m. RN-A stated the bed alarm was implemented on 12/20/12, to alert staff of R19's self-transfer attempts. RN-B stated on 6/20/13, alarms on the wheelchair and recliner, and floor mat by her bedside were implemented as fall interventions.

On 4/24/14, at 9:44 a.m. HSKP-B stated she was aware R19 had a history of falling but was unaware of any additional monitoring or interventions to minimize R19's falls.

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F 323	Continued From page 33 On 4/24/14, at 9:53 a.m. RN-A stated they may have been at the point where they needed to bring R19 out to supervise her. The DON stated R19's family had wanted her in a private room on the LL. The DON stated the private room was at the end of the hall which required a longer response time for staff. The DON stated they would have liked to have R19 closer to the nurse's desk. However, R19 could not be relocated due to the private room. The DON stated R19's cognition was very variable, and staff tried to supervise her as much as possible. However, the DON stated if R19 wanted to go to her room this was not prevented. On 4/24/14, at 1:22 p.m. R 19 was observed seated in the dining room with the clip alarm attached to her shirt. The DON measured R19's clip alarm string and noted the string was 22 inches long. The DON stated the string was too long and would not alarm if R19 leaned over to pick up items off of the floor. The DON shortened the string by tying a knot in it, making the string approximately 11 inches long. On 4/24/14, at 1:25 p.m. RN-A stated she could not recall R19 setting off her alarm. She stated she was aware of alarms sounding off and on during the day, and could not state how often R19's alarms sounded. On 4/24/14, at 2:05 p.m. LPN-A stated the facility utilized fall interventions such as alarming Velcro seat belts in the past. However, they were not utilizing them at the time of survey. On 4/24/14, at 2:40 p.m. R19 was observed in her recliner in her room with FM-A. The clip alarm	F 323		

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F 323	Continued From page 34	F 323		

was not attached to R19. FM-A stated R19 was placed in the recliner about 1:40 p.m. by occupational therapist (OT)-A. At 2:50 p.m. NA-K was informed the clip alarm was not attached to R19 in the recliner. NA-K verified the clip alarm was supposed to be attached to R19. In addition, NA-K noticed the recliner chair was plugged into the wall when R19 was in the recliner. NA-K unplugged the recliner, and stated she had plugged the recliner in at 11:45 a.m. when R19 was placed in the wheelchair for lunch. NA-K stated they must have forgotten to unplug it at 1:40 p.m. when she was placed back in the recliner.

On 4/25/14, at 11:43 a.m. RN-A stated after R19 sustained the pelvic fracture on 1/20/14, she had never ambulated. RN-A stated the care plan needed to be revised as R19 was non-ambulatory. In addition, RN-A stated the clip alarm was to be on when R19 was in the recliner. Also, RN-A verified the lift recliner was to be unplugged after R19 was positioned according to the care plan.

The facility's Fall Assessment Policy and Procedure dated 4/06, directed staff to do a resident assessment for falls on admission. Falls that occurred would be reassessed and investigated with follow-up interventions. The assessment would include resident diagnoses, medications, history of falls, cognitive factors, environmental factors, appropriate use of assistive devices, any decline in function, and hearing/vision impairments. The policy and procedure included multiple examples for implementing interventions which may have been appropriate for a resident with falls. The potential approaches included: low bed, change of

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F 323	Continued From page 35 medication time, personal alarm systems, bedside commode, walker/wheelchair and call light within reach, physical therapy, increased lighting, assessment of balance disorder, eye exam if appropriate, and care team discussions to determine if the interventions were working. However, the identified interventions failed to include increased staff supervision of the resident, when pertinent to the causal factors of a resident's falls. The immediate jeopardy that began on 1/20/14, and identified on 4/24/14, was removed on 4/25/14, at 2:10 p.m. when the facility completed a comprehensive assessment of R19's fall risk which considered the causal factors of previous falls and effectively implemented interventions that were pertinent to those causal factors. Implemented interventions included the following: physical therapy and occupational therapy referrals were completed, anti-roll back brakes were applied to R19's wheelchair, R19 was seen by her physician on 4/25/14, for a comprehensive medication regimen review, activity staff increased their 1:1 interactions with R19 during the morning and afternoon shifts, the wheelchair clip alarm cord was shortened, an agreement was made with R19 for her to rest in a day room recliner to allow for increased staff supervision and to staff to provide encouragement to R19 to be out in the day room more often for better supervision. R19's care plan was updated to reflect the new interventions and staff members on the memory care unit verified through interview they recieved education on R19's comprehensive, interdisciplinary care plan / fall interventions. Non-compliance remained at the lower scope and severity level of a G, which indicated actual harm that was not immediate jeopardy.	F 323		

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene during meal service to prevent cross contamination for 8 of 42 residents (R8, R61, R3, R10, R56, R36, R37, R30) observed to receive meals without proper hand washing and glove changes. This had the potential to affect all 42 of 42 residents who were offered ready to eat foods in the lower level dining room on the evening of 4/21/14, and the morning of 4/23/14. The facility also failed to ensure the use of hair restraints during meal service to prevent contamination of exposed foods for 3 of 33 residents (R55, R63 and R58) who were observed to receive meal service by nursing staff without a hair restraint in place. Findings include: During observation of the evening meal in the lower level dining room (LL) on 4/21/14, at 5:06 p.m. dietary aide (DA)-B walked behind the serving counter and donned a pair of gloves. DA-B was observed holding her bare, left elbow,	F 371	F371. It is the policy of KMHC to safely serve and distribute food in a safe and sanitary manner. All residents of KMHC have the potential to be affected. The staff involved with the improper serving techniques during survey have been re-educated by the dietary manager. The dietary manager will review safe serving techniques with the dietary staff. Hair nets and serving papers are accessible to staff in both the Upper and Lower Level serving areas. Notices were posted on 04/25/14 that hairnets must be worn if staff are behind the counter in the LL while the serving cart is there and in the UL kitchenette when the steam table is in there. This memo also educated staff to sanitize hands between each resident served and that food is never to bet touched with bare hands. All staff will be educated on safe serving practices at mandatory in-services on 05/20/14 and 05/21/14.Random audits will be done for safe serving techniques.The results of	6/11/14

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F 371	Continued From page 37 with her right, gloved hand. At 5:11 p.m. cook-A wheeled a steam table into the LL. DA-B approached the steam table and picked up a plastic box of crackers and set it on a cart next to the steam table. At 5:14 p.m. the staff began serving the evening meal. The meal consisted of chili, cornbread, canned fruit and saltine crackers. Cook-A was observed to dish the chili and the cornbread from the steam table and place them onto a plate. She then handed the plate to DA-B, who added crackers to the plates. DA-B was observed to use her gloved hands to reach into the container of crackers and add them to the plates. DA-B did not change her gloves after touching her bare skin and prior to directly handling ready to eat crackers that were served to the residents in the LL. At 5:21 p.m. DA-B left the dining room and then returned, caring a loaf of bread. She changed her gloves, reached into the bag of bread, and with her gloved hands placed two slices of bread into a toaster. She then returned to the steam table and continued to dish up crackers. Cook-A handed plates with a bowl of chili and cornbread to DA-B who added crackers to the plates. The plates were then served to R8, R61 and R3. DA-B did not change her gloves after touching the toaster and prior to directly handling ready to eat crackers that were served to R8, R61 and R3. At 5:26 p.m. DA-B left the cracker cart and retrieved the toast from the toaster. She held the toast in her gloved hands as she butter it, placed it onto a plate and served R10. DA-B did not change her gloves after handling the toaster and prior to handling the ready to eat toast that was served to R10. DA-B was observed to touch R10's shoulder as she placed the plate onto the	F 371	these audits will be reported and acted on as needed at KMHC's monthly Quality Assurance Meetings. Dietary Manager is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	04/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

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F 371	Continued From page 38	F 371		

table. She then returned to the cracker station. DA-B was not observed to remove her gloves or wash her hands after handling the toaster, after contact with a resident and prior to directly handling ready to eat crackers that were served to residents in the LL.

At 5:30 p.m. all 42 residents in the LL had received their evening meals. At no time was DA-A observed to ensure she had clean gloves on prior to directly touching the resident's crackers.

During observation of the breakfast meal in the LL on 4/23/14, at 7:48 a.m. cook-B was observed to be wearing gloves as she reached into the steam table and removed toast from a steam pan. Cook-B then placed the toast on a plate and delivered the meal to a resident. Cook-B was observed to touch the resident's table as she served the meal. Wearing the same gloves, she then reached into the steam table, directly handling a slice of toast, and served it to R56. Cook-B did not change gloves after touching a resident's table and prior to directly handling the ready to eat toast that was served to R56.

At 7:53 a.m. cook-B wore the same gloves as she retrieved toast from the toaster. She held the toast with her left hand as she applied butter to it, cut the toast in half and placed the toast into the steam table. She then prepared two meals which consisted of cereal, toast and boiled eggs. Cook-B served those meals to R36 and R37. Cook-B then handled another slice of toast with the same gloved hands and served it to R30. Cook-B did not change gloves after touching the resident's table, after handling the toaster, and prior to handling ready to eat foods that were

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	245247	A. BUILDING _____ B. WING _____	04/25/2014

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KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

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F 371	Continued From page 39 served to R36, R37 and R30. Review of the facility's undated Nutritional Services Policy and Procedure directed the staff to prevent cross contamination during meal service by utilizing serving utensils or deli sheets for handling of all condiments and bread. It directed the staff to ensure their hands were clean and directed the staff not to touch the resident's food. During interview on 4/23/14, at 11:55 a.m. the certified dietary manager (CDM) stated that staff were not to directly handle food items when serving residents. The CDM stated the staff could have easily used tongs or deli papers to serve ready to eat food items. During observation of the breakfast meal in the upper level kitchenette/dining room (UL) on 4/23/14, from 8:31 a.m. to 8:44 a.m. nursing assistant (NA)-I and NA-D were observed to dish up meals for R55, R63 and R58 from a steam table in the kitchenette area. NA-I and NA-D did not have hair restraints in place to prevent their hair from contacting the exposed food. During interview on 4/23/14, at 8:38 a.m. DA-A stated she routinely dished up meals for the UL from 7:40 a.m. until 8:20 a.m., but then needed to leave the UL for other duties. DA-A stated that the NAs were responsible for dishing up meals for residents who arrived for breakfast after 8:20 a.m. DA-A confirmed she had not seen the NAs wearing hair restraints when dishing up resident meals. On 4/23/14, at 11:55 a.m. the CDM stated the nursing staff frequently entered the UL serving area without a hair restraint. She stated the	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	04/25/2014

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KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

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F 371	Continued From page 40 dietary staff always wore hairnets, but the nursing staff did not have hairnets available for use on the UL. On 4/23/14, at 2:57 p.m. the CDM stated she did not have a policy that addressed NAs serving food from the facility kitchenettes. On 4/24/14, at 9:10 a.m. activity aide (AA)-A confirmed she occasionally entered the UL kitchenette during meal times. She stated that at no time, had she been directed to wear a hair restraint when entering the serving area. On 4/24/14, at 9:18 a.m. NA-B stated she had been directed during the morning report to use a hairnet while in the UL kitchenette area. However, she stated the staff did not have hairnets available to put on prior to entering the serving area. On 4/24/14, at 9:50 a.m. NA-I stated the staff were instructed to use hairnets in the UL kitchenette area during morning report. He stated the nursing staff frequently entered the serving area during meal times and that they did not have access to hairnets/ hair restraints. He stated only the dietary staff had been instructed to use hairnets. On 4/25/14, at 8:30 a.m. registered nurse (RN)-A stated she was aware the NAs dished up food for residents that arrived late for breakfast. However, RN-A stated she did not know the NAs were supposed to wear hairnets when dishing food. RN-A added, "It makes perfect sense." Review of the facility's undated Supervising Cooks Direction List, revealed the dietary staff	F 371		

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	245247	A. BUILDING _____ B. WING _____	04/25/2014

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KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

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F 371	Continued From page 41 were to ensure all staff had their hair covered with a hairnet during meal services. The direction list did not address nursing staff entering the kitchenette areas during meal service.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441		6/11/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	04/25/2014

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F 441	Continued From page 42 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene and glove changes to minimize the risk for cross contamination during a dressing change for 1 of 1 resident (R24) observed to receive wound care. Findings include: R24's physician's order dated 3/19/14, revealed she had a pressure ulcer which required routine wound care. The order directed staff to apply a carilon barrier film (skin prep) to the area around her wound, cover the wound with an aquacel alginate dressing and cover the wound with a tegaderm (clear plastic dressing). R24's quarterly Minimum Data Set (MDS) dated 3/25/14, identified she required extensive assistance with activities of daily living and had a stage two pressure ulcer. On 4/23/14, at 8:10 a.m. registered nurse (RN)-C stated R24 had received a bath and was in the tub room waiting for a dressing to be applied to the pressure ulcer on her right ankle. RN-C entered the tub room, applied gloves and used a wound cleanser spray to wash the wound bed. She patted the wound dry with clean gauze, then removed a disposable ruler from the wall of the tub room. RN-C used the ruler to measure R24's open wound and replaced the ruler to the wall.	F 441	F441 It is the policy of KMHC to ensure appropriate infection control measures while providing direct resident contact. This has the potential to affect all KMHC residents that require dressing changes. The staff that used improper technique in a dressing change during survey was re-educated on proper technique the day of survey. Staff was also educated that the wound measurement tools are single use only. A pad of wound measuring tools has been placed in the bath bay for single use. All nurses will be educated on proper dressing change technique and single use of the measuring tool to obtain wound measurements at mandatory plan of correction in-service on 05/20/14 and 05/21/14. Random audits of dressing changes will be performed throughout the coming year. The results of these audits will be reported and acted on as needed at KMHC's monthly Quality Assurance Meetings. DON is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	04/25/2014

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KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

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F 441	Continued From page 43	F 441		

She then applied a skin prep to the wound bed. RN-C left her gloves on as she opened a large package of Aquacel (alginate dressing) and ripped off a corner of the dressing for R24's wound. She then removed the gloves and left the room to find a scissor. Upon returning to the room, she applied gloves, cut the dressing to fit the wound and covered the area with tegaderm and a foam dressing. RN-C then removed her gloves and washed her hands.

During interview on 4/23/14, at 8:20 a.m. RN-C confirmed she had not changed her gloves or washed her hands after washing and measuring R24's wound, and prior to handling the clean dressing. She stated the disposable ruler that was taped to the tub room wall, was used to measure wounds in the tub room and hung on the wall for about a month at a time. She stated the ruler did not touch R24's wound so it was okay to hang back on the wall. RN-C confirmed the facility did not have a supply of disposable rulers in the tub room for measuring resident wounds.

On 4/23/14, at 8:30 a.m. the director of nurses (DON) stated that she expected the staff to wash their hands and apply clean gloves between the removal of an old dressing and the application of a clean dressing. The DON then walked into the tub room, removed the ruler from the wall and threw it away. She stated she was unaware the staff were taping the rulers to the wall and using them on multiple residents.

The Dressing Change policy dated 4/12, directed the staff to wash hands before and after all procedures and to wear gloves when appropriate. In addition, the policy directed the staff to dispose of disposable equipment appropriately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	04/25/2014

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KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

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F 464 SS=D	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure sufficient space was available in the upper level dining room during meal service, to allow residents to leave the area freely, without physically interrupting other residents while eating, for 2 of 22 residents (R74 and R63) observed during the lunch meal on 4/23/14. Findings include: During observation of the lunch meal on 4/23/14, at 12:08 p.m. the upper level dining room (UL) was noted with four small tables, which allowed four people to sit at each table. One large table (two small tables pushed together), was also noted, which allowed six residents to sit together. While dining, nursing assistant (NA)-D approached R74 and backed her away from the table. NA-D positioned R74 next to the wall, then moved R65 up to the table. R74 was then returned to the dining table to continue eating her lunch. On 4/24/14, at 9:00 a.m. NA-K stated it was difficult to maneuver the residents around in the UL because the wheelchairs were back-to-back and if a resident needed to leave the dining room,	F 464	F464 It is the policy of KMHC to provide sufficient space in our dining areas. This has the potential to affect all KMHC residents. To ensure this in our Upper Level Unit, a suggested seating plan has been developed and a map has been made for staff of this seating plan. The plan suggests that 4 residents dine in the west end of the hall where proper assistance and supervision will be provided. The LL dining room was also assessed for adequate space. Random audits will be done to ensure compliance. Staff will be educated on the suggested seating plan and the need to supply the needed space at a mandatory in-service on 05/20/14 and 05/21/14. Audits will be done throughout the year for adequate dining room space.The results of these audits will be reported and acted on as needed at KMHC's monthly Quality Assurance Meetings. DON and Unit Coordinators are responsible for compliance.	6/11/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	04/25/2014

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KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

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F 464	Continued From page 45	F 464		

the staff had to move the wheelchairs other residents to allow that resident to pass through. She stated the facility had two day rooms on either end of the UL which had been used for dining areas in the past, but they were currently only being used by family members, upon request. NA-K stated the number of times a resident may have been moved away from the table depended upon who needed assistance. She stated that moving residents away from the tables where they were dining, in order to allow another resident to maneuver around in the dining room, was a daily occurrence.

On 4/24/14, at 9:10 a.m. activity aide (AA)-A stated she had noticed the residents having to be moved around during meals on a daily basis. She stated the dining room was not large enough to accommodate the number of residents who utilized wheelchairs on the unit. She stated the staff attempted to seat residents who frequently had to leave the dining room closer to the entrance, in effort to minimize those having to be moved.

On 4/24/14, at 9:18 a.m. NA-D stated the residents in the dining room had to be rearranged almost every meal, due to the lack of space in the area. She stated the additional day rooms on the UL were not being used for dining because the facility did not have enough staff to monitor those areas. She confirmed the residents had to be moved away from their dining tables at mealtime on a daily basis, due to space limitations.

On 4/24/13, at 9:30 a.m. housekeeper (HSKP)-A stated the residents in the UL were interrupted from their meals daily, in order to accommodate residents moving in and out of the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	04/25/2014

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F 464	Continued From page 46 On 4/24/14, at 9:50 a.m. NA-I stated the staff attempted to redirect the residents in the dining room so they did not need to disturb/rearrange the other residents who were still eating. He stated the staff frequently had to interrupt residents during the meals to allow other residents to pass though the dining space. On 4/24/13, at 10:00 a.m. NA-J stated the residents needed to be moved away from their meals every day to allow for others to move in and out of the dining room. On 4/25/14, at 7:45 a.m. registered nurse (RN)-A stated she was aware the residents in the UL were frequently moved during their meals to allow for other residents to pass through the dining room. She stated the residents who were known to leave the dining room early were positioned in the front of the room to allow them the ability to come and go from the dining room as they wished. She stated the facility preferred to keep all of the residents within eyesight during the meals, thus the smaller day rooms had not been used. RN-A confirmed the facility did not have a policy which addressed dining room accommodations.	F 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/22/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KITTSON MEMORIAL HEALTHCARE CENTER	**1010 SOUTH BIRCH** **HALLOCK, MN 56728**

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K 000	INITIAL COMMENTS FIRE SAFETY FIRE SAFETY 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire marshal Division on April 22, 2014. At the time of this survey Kittson Memorial Hospital C & NC 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/23/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/22/2014**

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KITTSON MEMORIAL HEALTHCARE CENTER	**1010 SOUTH BIRCH** **HALLOCK, MN 56728**

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K 000	Continued From page 1 St. Paul, MN 55101 Or by email to: Marian.Whitney@state.mn.us Fax Number 651-215-0525 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 The Kittson Memorial Hospital C & NC is made up of two buildings. The original building is north of and separated from, with a 2-hour fire barrier, the Kittson Memorial Hospital building. It is 1-story with a basement and was constructed in 1968. It was determined to be of Type II(000) construction and is now fully sprinkler protected and is called the upper level. In 1981 an addition was built to the north of the original building, is a 1-story building without a basement. It was determined to be of Type V (111) construction, is fully sprinkler protected and is separated with at least a 2-hour fire barrier from the original building and is called the Lower Level. The buildings are divided into 8 smoke zones. The facility is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition.	K 000		

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KITTSON MEMORIAL HEALTHCARE CENTER	**1010 SOUTH BIRCH** **HALLOCK, MN 56728**

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K 000	Continued From page 2 The facility has a fire alarm system with smoke detection in the corridor system and in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored for automatic fire department notification. All hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 70 beds and had a census of 64 at the time of the survey. Because the 1968 original building is now sprinkler protected and the buildings both meet the construction types allowed the facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide quarterly drills for each shift in the last 12-month	K 050	K50 It is the policy of KMHC to conduct monthly fire drills and that a fire drill is conducted on each shift quarterly. To	6/16/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/22/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KITTSON MEMORIAL HEALTHCARE CENTER	**1010 SOUTH BIRCH** **HALLOCK, MN 56728**

(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
K 050	Continued From page 3 period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect all 64 residents. Findings include: On facility tour between 10:00 AM and 1:00 PM on 4/22/2014, it was revealed during dcumentation review that the facility failed to conduct a Day-shift fire drill in the 3rd quarter of 2013 not in accordance with NFPA 101 LSC Section 19.7.1.2. This deficient practice was verified by the Maintenance Supervisor at the time of the inspection.	K 050	ensure compliance quarterly accounting of KMHC□s fire drills will be reviewed at KMHC□s Risk Management Meetings. Maintenance Manager is responsible for complaince.	