CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: R6V4

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PARTI	- TO BE COMP	LEIEDDYI	HE SIA	IE SURVET AGENCY	Facility ID: 00321
MEDICARE/MEDICAID PROVIDER (L1) 245247	NO.	3. NAME AND AD (L3) KITTSON M	MEMORIAL HE		RE CENTER	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO.		(L4) 1010 SOUTH	H BIRCH			3. Termination 4. CHOW
(L2) 738745801		(L5) HALLOCK,	MN		(L6) 56728	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW	NERSHIP	7. PROVIDER/SU	PPLIER CATEGO	RY	<u>02</u> (L7)	7. On-Site Visit 9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 08/14/2013	(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	S:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of Th	he Following Requirements:
To (b):			Requirements		2. Technical Personnel	6. Scope of Services Limit
		•	ice Based On:		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	70 (L18)	1	Acceptable POC		4. 7-Day RN (Rural SNF5. Life Safety Code	F) 8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	70 (L17)	B. Not in Cor	mpliance with Progr	ram	5. Life Safety Code	9. Beus/Rooni
13. Total Certified Beds	70 (L17)		ents and/or Applied		* Code: A *	(L12)
14. LTC CERTIFIED BED BREAKDOW	/N				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
70						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMAR	RKS (IF APPLICABL	E SHOW LTC CANCI	ELLATION DATE):		
Post Certification Revisit by	review of the fa	cility's plan of co	orrection, to ve	erify that	the facility has achieved and	d maintained compliance with Federal
						or 70 skilled nursing facility beds.
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Lyla Burkman, Unit	Supervisor	08/20/2013		(L19)	Colleen B. Leach, Pro	ogram Specialist 12/20/2013
P	ART II - TO BE	E COMPLETED	BY HCFA RE	` ′	L OFFICE OR SINGLE ST	'ATE AGENCY
19. DETERMINATION OF ELIGIBILIT	Y	20. CON	MPLIANCE WITH	CIVIL	21. 1. Statement of Finar	ncial Solvency (HCFA-2572)
 Y 1. Facility is Eligible to Pa 	articinate	RI	GHTS ACT:		 Ownership/Contro Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	инограно					·
2. Tachky is not Englore	(L21)					
22. ORIGINAL DATE	23. LTC AGREEM	IENT 2	4. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Έ	VOLUNTARY 00	<u>INVOLUNTARY</u>
07/01/1982					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	ent 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(1.27)			(L44)			00-Active
(L27)	B. Rescind Sus	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/0	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	ATE		
		08/22/2013				
	(L32)			(L33)	DETERMINATION APPR	KOVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5247

December 20, 2013

Mr. Richard Failing, Administrator Kittson Memorial Healthcare Center 1010 South Birch Hallock, Minnesota 56728

Dear Mr. Failing:

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

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

Effective August 5, 2013, the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Colleen B. Leach, Program Specialist

Colleen Feach

Program Assurance Unit, Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health

P.O. Box 64900, St. Paul, MN 55164-0900

Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

Kittson Memorial Healthcare Center December 20, 2013 Page 2



Protecting, Maintaining and Improving the Health of Minnesotans

Mr. Richard Failing, Administrator Kittson Memorial Healthcare Center 1010 South Birch Hallock, Minnesota 56728 August 20, 2013

RE: Project Number S5247024

Dear Mr. Failing:

On July 10, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 27, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 14, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 26, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 27, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 5, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 27, 2013, effective August 5, 2013 and therefore remedies outlined in our letter to you dated July 10, 2013, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach, Program Specialist Licensing and Certification Program

Colleen Jeach

Division of Compliance Monitoring

PO Box 64900

Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245247	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 8/14/2013	
Name	e of Facility		Street Address, City, State, Zip Code	
KITTSON MEMORIAL HEALTHCARE CENTER			1010 SOUTH BIRCH HALLOCK, MN 56728	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Yŧ	i) Date	(Y4) Item	(Y	'5) Date	(Y4) Item		(Y5)	Date
	F0164 483.10(e), 483.75(I)(4)	Correction Completed 08/05/2013		F0225 483.13(c)(1)(ii)-(iii), (d		Reg. #	F0226 483.13(c)		Correction Completed 08/05/2013
	F0241 483.15(a)	Correction Completed 08/05/2013	ID Prefix Reg. #		Correction Completed 08/05/2013	ID Prefix Reg. #	F0323 483.25(h)		Correction Completed 08/05/2013
ID Prefix Reg. # LSC	F0371 483.35(i)	Correction Completed 08/05/2013	ID Prefix Reg. # LSC	F0406 483.45(a)	Correction Completed 08/05/2013	Reg. #	F0441 483.65		Correction Completed 08/05/2013
ID Prefix Reg. # LSC									Correction Completed
D #						D "			
Reviewed E		d By	Date: 08/20/20	Signature of S	-	035		Date:	08/14/2013
Reviewed E	Reviewe	d By	Date:	Signature of S		<i>.</i>		Date:	
Followup t	o Survey Completed o 6/27/2013	n:		Check for any Und Uncorrected De				YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245247	(Y2) Multiple Con A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 8/6/2013	
Name of Facility			Street Address, City, State, Zip Code	
KITTSON MEMORIAL HEALTHCARE CENTER			1010 SOUTH BIRCH	
			HALLOCK MN 56728	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
			Correction				Correction					Correction
ID Prefix			Ompleted 07/16/2013	ID Prefix			Ompleted 07/16/2013		ID Prefix			Completed 07/16/2013
Reg.#	NFPA 101				NFPA 101		_		•	NFPA 101		
LSC	K0018			LSC	K0029				LSC	K0033		_
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			07/16/2013	ID Prefix	-		07/16/2013		ID Prefix	-		07/16/2013
	NFPA 101			_	NFPA 101		=			NFPA 101		
LSC	K0062			LSC	K0066				LSC	K0076		_
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix				ID Prefix			-		ID Prefix			
Reg. #				Reg. #			=		Reg. #			_
LSC				LSC					LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix				ID Prefix			-		ID Prefix			_ `
Reg.#				Reg. #			-		Reg. #			
LSC				LSC					LSC			_
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			:	ID Prefix			=		ID Prefix			
Reg. #				Reg. #			-		Reg. #			_
LSC				LSC					LSC	<u>-</u>		
Reviewed I	Ву	Reviewed	-	Date:		ature of Su	rveyor:				Date:	
State Agen	су	PS/cbl		08/20/2	013			0	3006			08/06/2013
	Ву	Reviewed	Ву	Date:	Signa	ature of Su	rveyor:				Date:	
CMS RO												
Followup t	to Survey Cor	•	1:							Summary of	,	
	6/26/	2013			Uncor	rectea Defic	ciencies (CIV	i3-∠5(or) Sent to	the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

August 20, 2013

Mr. Richard Failing, Administrator Kittson Memorial Healthcare Center 1010 South Birch Hallock, Minnesota 56728

Re: Enclosed Reinspection Results - Project Number S5247024

Dear Mr. Failing:

On August 14, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 26, 2013, with orders received by you on July 15, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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.

Please feel free to call me with any questions.

Sincerely,

Colleen Leach, Program Specialist

Colleen Feach

Licensing and Certification Program

Division of Compliance Monitoring

PO Box 64900

Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

1010 SOUTH BIRCH

HALLOCK, MN 56728

(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5) [)ate
		Correction			Correction				Correction
ID Prefix	20015	Completed 08/05/2013	ID Prefix	21000	Completed 08/05/2013		ID Prefix	21300	Completed 08/05/2013
	MN Rule 4658.0525			MN Rule 4658.0610 Sul				MN Rule 4658.0800 Su	
Ū	MIN Rule 4050.0525			MIN Rule 4050.00 10 Sul				WIN Rule 4036.0000 Su	
		Correction			Correction				Correction
ID Prefix	21510	Completed 08/05/2013	ID Prefix	21805	Completed 08/05/2013		ID Prefix	21830	Completed 08/05/2013
Reg. # LSC	MN Rule 4658.1200		Reg. # LSC	MN St. Statute 144.651	Sul		_	MN St. Statute 144.651	Sul
		Correction			Correction				Correction
ID Prefix	21855	Completed 08/05/2013	ID Prefix	21980	Completed 08/05/2013		ID Prefix		Completed
J	MN St. Statute 144.6		Reg. # LSC	MN St. Statute 626.557			Dog #		
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg.#			Reg. #				Reg. #		_
LSC			LSC				LSC		-
		Correction Completed			Correction Completed				Correction Completed
ID Prefix							ID Prefix	-	=
Reg. # LSC		<u></u>	Reg. # LSC				Reg. # LSC		-
						,			
Reviewed I	By Review	ved By	Date:	Signature of Su	veyor:	1		Date:	
State Agen	cy LB/c	bl	08/20/20	013			00321		08/14/2013
Reviewed I	By Review	ved By	Date:	Signature of Sur	veyor:			Date:	
Followup t	to Survey Completed	I on:		Check for any Unco					NO
	O/Z1/Z010			Dana 1 of 1	•			Front ID: DCV/410	110

KITTSON MEMORIAL HEALTHCARE CENTER

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: R6V4

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I	- TO BE COMP	LETED BY T	THE STAT	ΓE SURVEY AGENCY	Facility ID: 00321
MEDICARE/MEDICAID PROVIDER (L1)	NO.	3. NAME AND AL (L3) KITTSON M (L4) 1010 SOUTH (L5) HALLOCK ,	IEMORIAL HI HBIRCH		RE CENTER (L6) 56728	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)		7. PROVIDER/SU	PPLIER CATEGO	ORY 09 ESRD	<u>O2</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 06/2 2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	7/2013 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	70 (L18) 70 (L17)	Complian1. X B. Not in Co.		gram	And/Or Approved Waivers Of T 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNI5. Life Safety Code * Code: B*	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOW	VN				15. FACILITY MEETS	
18 SNF 18/19 SNF 70 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)
At the time of the Standard si the CMS 2567 along with the 17. SURVEYOR SIGNATURE Rebecca Haberle, HFE N	e facility's plan o	of correction. Po				
P	ART II - TO BE	COMPLETED	BY HCFA R	` '	L OFFICE OR SINGLE ST	
DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Page 2. Facility is not Eligible	articipate		MPLIANCE WITH GHTS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) ::
22. ORIGINAL DATE OF PARTICIPATION 07/01/1982	23. LTC AGREEM BEGINNING		4. LTC AGREEN ENDING DAT		26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem	05-Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L25) (L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	** - **
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
31. RO RECEIPT OF CMS-1539	(L28)	. DETERMINATION	OF APPROVAL D	(L31)	Posted 8/22/2013 ML	
	(L32)			(L33)	DETERMINATION APPR	POVAL.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 3526

July 10, 2013

Mr. Richard Failing, Administrator Kittson Memorial Healthcare Center 1010 South Birch Hallock, Minnesota 56728

RE: Project Number S5247024 & H5247009

Dear Mr. Failing:

On June 27, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 27, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5247009, which was found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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.

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 Minnesota Department of Health 705 5th Street NW, Suite A Bemidji, Minnesota 56601-2933

Telephone: (218) 308-2104

Fax: (218) 308-2122

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey

and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 6, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 6, 2013 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable PoC 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 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. 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the

deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 September 27, 2013 (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 December 27, 2013 (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 a PoC 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.

Feel free to contact me if you have questions.

Sincerely,

Lyla Burkman, Unit Supervisor Licensing and Certification Program Division of Compliance Monitoring Telephone: (218) 308-2104 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File

PRINTED: 07/10/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUC (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245247 B. WING Massesson Dayanasan of Health 06/27/2013 STREET ADDRESS, CITY, STATE, ZIP NAME OF PROVIDER OR SUPPLIER 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 000 F 000 INITIAL COMMENTS 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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted and a complaint investigation was also completed at the time of the standard survey. An investigation of complaint H5247009 was completed. The complaint was unsubstantiated. F 164 483.10(e), 483.75(l)(4) PERSONAL F 164 SS=D PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical

records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:							
		245247	B. WING		06/27/2013				
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1010 SOUTH BIRCH HALLOCK, MN 56728	DE				
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F 164	and clinical records resident is transferr institution; or record. The facility must ke contained in the rest the form or storage release is required healthcare institution contract; or the resident of the resident facility faci	to refuse release of personal does not apply when the red to another health care direlease is required by law. The personal all information sident's records, regardless of methods, except when by transfer to another on; law; third party payment ident. The is not met as evidenced sion, interview and document ailed to ensure personal ined for 1 of 6 (R49) residents orning cares.	F 1	Memorial Healthcare Conthat all resident's perivacy is maintained compliance with this that forgot to close privacy curtain during was spoken to regardined to provide reside at all times, the day occurred. All of the at KMHC have the potential be affected if privacy provided. Staff will instructed at a mandatinservice on resident privacy. The staff member taped. Staff not a attend will be provided written material for and will view the preson the recorded DVD. will performed to ensured	enter ersonal . To assure the staff the g survey ng the ent privacy the incident resident's ntial to y is not be tory 's right to eeting will able to ed with the the inservice sentation Audits ure compliance.				
R49's diagnoses included Alzheimer's and Parkinson's disease. The quarterly Minimum Data Set (MDS) dated 3/26/13, indicated R49 had severe cognitive impairment and required extensive assistance with all activities of daily living.			The results of the audreviewed by the risk material team. Kim Anderson, I for compliance						
		ted 7/24/13, directed staff to activities of daily living.							
	was observed to pla (BSC) next to R49's the bed onto the BS	a.m. nursing assistant (NA)-E ace a bedside commode s bed and transfer R49 from SC. R49's roommate (R53) se in bed. NA-E did not pull the							

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TO CONTRACTOR		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245247	B. WING		2		06/27/2013	
	ROVIDER OR SUPPLIER	HCARE CENTER		1010	T ADDRESS, CITY, STATE, ZIP CODE SOUTH BIRCH LLOCK, MN 56728		00,21,120,10	
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F 164	7:02 a.m. NA-E was pajama top, expose proceed to wash ar 7:08 a.m. NA-E was stand and hold onto NA-E was observed also dress R49's lost to have a conversal providing R49's mo R49's cares were conversal wheeled out of the observation, NA-E curtain between the On 6/26/13, at 8:55	veen the two residents. At a observed to remove R49's e R49's bare chest and and dress R49's upper body. At a observed to assist R49 to o the bed rail. Once standing, and to provide perineal care and wer body. R53 was observed tion with NA-E while NA-E was rning cares. At 7:20 a.m. ompleted and she was double room. Throughout the had not pulled the privacy	F	64				
a.	-C verified it was the personal privacy du	0 p.m. registered nurse (RN) e facility policy to provide uring cares. RN-C also stated should have been utilized nal cares.		8			e e	
F 225 SS=D	policy dated 5/2011 and drape resident 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/INI The facility must no been found guilty of	PORT DIVIDUALS It employ individuals who have fabusing, neglecting, or	F2	25			6) 2)	
	had a finding entere registry concerning	ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment		25				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245247	B. WING			06/	27/2013
	OVIDER OR SUPPLIER MEMORIAL HEAL	THCARE CENTER	and the second s	101	ET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH BIRCH LLOCK, MN 56728		
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F 225 Continued From page 3

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 observation, interview and document review, the facility failed to ensure that all alleged violations of mistreatment, abuse or neglect, including injuries of unknown origin were investigated and reported to the appropriate State agency in accordance with State law for 3 of 6

F 225

It is the policy of Kittson Memorial Healthcare Center that all alleged violations involving mistreatment, neglect or abuse, including episodes of unknown source are reported immediately to the administrator and are thoroughly investigated, and that further potential abuse is prevented while the investigation is in progress. This has the potential to affect all residents of KMHC. To assure compliance, R9's injuries were thoroughly investigated and reported to the state. The foot cradle on his bed has been padded to prevent further injury. Staff are following R4's care plan and she is not left along with R20. KMHC's Vulnerable Adult Policy was reviewed and revised. Staff will be educated on the policy at a mandatory inservice. The staff meeting will be taped. Staff not able to attend will be provided with the written material for the inservice and will view the presentation on the recorded DVD. The SSD and DON will monitor to assure all reports of unknown injury are reported and investigated. SS will do an audit and thorough review of all incident reports. Results of this monitoring will be reviewed at facility Risk Management Meetings. SS and DON responsible for compliance 8/5/13

OFILE	10 1 OIT WEDTOTTILE	WILDIONID OFFICE	1			
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	HCARE CENTER		101	ET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH BIRCH LLOCK, MN 56728	
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F 225	Continued From paresident (R9, R4, R	nge 4 120) incidents reviewed.	F:	225		·
	Findings include:		1			
		own origin had not been pated in a timely manner.		•		
	R9's diagnoses included depression, stroke, diabetes mellitus and degeneration arthritis. The significant change Minimum Data Set (MDS) dated 5/28/13, indicated R9 had cognitive impairment and required total assistance with all activities of daily living. On 6/26/13, at 8:10 a.m. nursing assistant (NA)-H and NA-G was observed to assist R9 with morning cares. R9's second toe on the left foot was observed to be red, swollen and with a deep purple bruise by the nail and the base of the toe. NA-H stated the swelling and bruising was a new concern that she was not aware of.					
		es Notes (NN) from 6/1/13 - cumentation related to the and toe.				
	The Skin Observation Charting dated 6/24/13, indicated R9's 2nd toe was swollen and purple. The cause of the bruise was noted as: "unknown how."					
	updated on 6/24/13 toe as being bruise a tendency to kick a bed cradle (metal fi	POC) dated 12/25/12, and B, indicated R9's left second d. The POC indicated R9 had at things such as the table or a rame that hold blankets off of The POC directed staff to and report changes.		a		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		(X3) DATE SURVEY COMPLETED		
		245247	B. WING			06	/27/2013
	ROVIDER OR SUPPLIER I MEMORIAL HEALT	HCARE CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH BIRCH ALLOCK, MN 56728		
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F 225	Continued From pa	age 5	F2	225			
	The facility Incident Reports for 6/2013, did not include a report related to R9's swollen bruised toe.			:			
	On 6/26/13, at 11:56 a.m. registered nurse (RN) -C verified she was aware of R9's bruised and swollen left, second toe. RN-C stated R9 may have kicked the table legs but was not positive as to how the bruise had occurred. RN-C also stated she had reported the bruise to the director of nursing (DON) and they both had concluded to monitor the area. Additionally, RN-C confirmed the bruise was of unknown etiology, an incident report had not been completed and the cause of the bruise had not been investigated or reported.						
	red, swollen and br the facility was "qui toe. The DON veri investigation had no Additionally, the DO	ON verified the injury of and not bee reported to the					
		a.m. RN-C stated R9 had a nt to evaluate the second toe.					
	On 6/27/13, at 1:30 p.m. licensed practical nurse (LPN)-C reported R9's second toe was fractured.			:			
	was fractured and a begun an investiga	p.m. RN-C confirmed the toe at this time, the facility had tion as to the cause of the scheduled changes in current		:			

O E I T I E I	TO TOTT MEDICATION	C INCOTOT TO CETTITION					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER I MEMORIAL HEALT	HCARE CENTER		1010	ET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH BIRCH LLOCK, MN 56728		
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F 225	Continued From pa	ge 6	F:	225			,
		R20 and the facility failed to ort the resident to resident					
	weakness, glaucon	luded low back pain, na and dementia. The MDS cated R4 had severe cognitive					
	dementia, osteoarti	cluded altered mental status, nritis and a stroke. The d 5/14/13, indicated R20 was ely impaired.					
		ant (NA) note dated 5/4/13, at licated R20 started spitting at	1				
	R20 was pushing a	5/7/13, [untimed] indicated nd ramming R4 into the linen g R4's arm and hand between neelchair.					:
	was found feeding	/13, at 5:30 p.m. indicated R20 R4 at the supper table. The R4 was crying and saying, , I don't want it."					
	indicated R20 was force feed R4 while no. The note furthe "No, " R20 shoved her mouth. The no	5/18/13, at 6:00 p.m. In the dining room trying to R4 was crying and telling R20 or indicated when R4 said, a fork full of green beans in the indicated R20 was removed m and when R20 saw R4 she					

CENTER	12 LOW MEDICAKE	A MEDICAID SERVICES				ON DIVIC	. 0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY IPLETED
		245247	B. WING	;		06	27/2013
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F 225	push her to her roo The NA note dated	e" right for her and tried to	F:	225			
	R20 tried to feed R	5/29/13, [untimed] indicated 4. The note also indicated throughout the day making able.	·				
		3, at 9:30 a.m. indicated R20 oncern, trying to force feed R4 doors and walls.					
	during lunch R20 w note indicated R20 R4 in her chair and off of R4's chair. To verbally stated she Additionally, R20 h	6/11/13, [untimed] indicated ould not leave R4 alone. The was trying to physically push also tried taking the brakes he note also indicated R4 had did not want any help. ad attempted to massage indicated R4 had asked to om.					
		6/24/13, at 9:30 a.m. attempting to push R4's front desk.	: !	:			
		otes from 3/12/13, to 6/26/13, ion of the interactions between	:				
	R20's Resident Car not be left alone wit	re Sheet indicated R20 should h R4.	:				
	R4's Resident Care	Sheet indicated R4 should					

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NC	0. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 225	Continued From pa	h R20.	f:	225				
	-B verified she was incidents between F	1 p.m. registered nurse (RN) aware of the ongoing R20 and R4, however didn't e something that would be	:					
	revealed that on se witnessed R20 tryin stated R20 seems t	p.m. NA-B and NA-C both veral occasions they have g to force feed R4. NA-B o target R4 for some reason d NA-B that it really bothers		:			,	
	witnessed R20 force this was bothersom NA-C all revealed the	p.m. NA-D stated she has e feeding R4. NA-D also felt e to R4. NA-A, NA-B, and his happens at least once harge nurses where aware of						
	aware of the ongoin R4. She stated she resident to resident	p.m. DON stated she was g incidents between R20 and would only report this as a altercation if there was an ted resident to resident be investigated.	:	:				
		p.m. administrator confirmed altercations should be ported.	:					
	(SSD)-A and SSD-E	p.m. social worker designee 3 confirmed resident to 5 should be investigated and						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	19 LOU MEDICAVE	& MEDICAID SERVICES				MB MO. 0839-0381	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245247	B. WING			06/27/2013	
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
KITTSON	MEMORIAL HEALT	ICARE CENTER			010 SOUTH BIRCH		
	·			H,	ALLOCK, MN 56728		
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F 225	Continued From pa	ge 9	F 2	225			
	Policy and Procedu skin injuries such a any event or circum person could consider to resident altercation resident abuse. It patient such as bruishoving, handling in abuse and occurren policy directed the suspected maltreat the supervisor, Director Services. The policy to notify the Administration within 24 hours of the investigation review incident required rethe policy incorrectly	eatment of Vulnerable Adult re, dated 7/27/2010, identified is bruises, welt and scars and estance which a reasonable der as maltreatment (resident ons) as potential indicators of also identified any event to a sing, emotional trauma, in a rough manner, verbal ince patterns and trends. The staff to immediately report any ment of a Vulnerable Adult to ector of Nurses or Social by incorrectly directed the staff internal report. If the internal report. If the porting to the State Agency, y directed the staff to report to					
	On 6/26/13, at 1:30 concerns related to the director of nurs designee immediate contact the adminis She reviewed the phad up to 24 hours On 6/26/13, at 1:45 abuse concerns are administrator and the to report to the State Review of the report in the past year, reviewed to the concerns are administrator and the state Review of the report in the past year, reviewed to the state of the past year, reviewed the past year.	p.m. RN-B stated any abuse would be called into ing or the social service ely. She stated they would trator and the State Agency. olicy and reported the facility to report to the State Agency. p.m. the DON reported any reported immediately to the facility had up to 24 hours e Agency.					

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 225	Continued From pa	ge 10	F 22	25		:	
	were interviewed. ago, they had been notification of the S potential abuse confacility had been no but they had not up changes. They conincorrectly directed hours and the staff regarding the immed On 6/27/13, at 8:10 confirmed he was nallegations of abuse State Agency was at He verified neither than R20 along with	a.m. the facility administrator otified immediately of any error maltreatment and the also notified of the concerns. The altercations between R4 R9's fractured toe had not					
	been reported to the 483.13(c) DEVELO ABUSE/NEGLECT,	P/IMPLMENT	F 22	6			
	policies and proced mistreatment, negle	velop and implement written ures that prohibit ect, and abuse of residents on of resident property.					
	by: Based on observat review, the facility fa procedures regardir	IT is not met as evidenced ion, interview and document ailed to implement policies and alleged violations of e or neglect, including injuries					
		or 3 of 6 resident (R9, R4,					

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	OVIDER OR SUPPLIER MEMORIAL HEALT	HCARE CENTER		1010	ET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH BIRCH LLOCK, MN 56728		
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F 226 Continued From page 11

Findings include:

Review of the Maltreatment of Vulnerable Adult Policy and Procedure, dated 7/27/2010, identified skin injuries such as bruises, welt and scars and any event or circumstance which a reasonable person could consider as maltreatment (resident to resident altercations) as potential indicators of resident abuse. It also identified any event to a patient such as bruising, emotional trauma, shoving, handling in a rough manner, verbal abuse and occurrence patterns and trends. The policy directed the staff to immediately report any suspected maltreatment of a Vulnerable Adult to the supervisor, Director of Nurses or Social Services. The policy incorrectly directed the staff to notify the Administrator/Designee immediately within 24 hours of the internal report. If the investigation review team determined the incident required reporting to the State Agency, the policy incorrectly directed the staff to report to the Stat Agency immediately within 24 hours.

On 6/26/13, at 1:30 p.m. RN-B stated any concerns related to abuse would be called into the director of nursing or the social service designee immediately. She stated they would contact the administrator and the State Agency. She reviewed the policy and reported the facility had up to 24 hours to report to the State Agency.

On 6/26/13, at 1:45 p.m. the DON reported any abuse concerns are reported immediately to the administrator and the facility had up to 24 hours to report to the State Agency.

F 226 It is the policy of Kittson Memorial Healthcare Center to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of property. This has the potential to affect all residents of KMHC. KMHC's vulnerable adult policies have been reviewed and revised. Staff will be educated on the policy at a mandatory inservice. The staff meeting will be taped. Staff not able to attend will be provided with the written material for the inservice and will view the presentation on the recorded DVD. Monitoring will be done by the SSD to ensure the policy is followed. Social services will monitor all newly hired employees to assure compliance with policy and procedures. Results of this monitoring will be revised at our facility Risk Management Meetings.

SSD and DON responsible for compliance.

8/5/2013

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245247	B. WING			06	/27/2013
	ROVIDER OR SUPPLIER	ICARE CENTER		101	ET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH BIRCH ALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)) BE	(X5) COMPLETION DATE
F 226	in the past year, revithe State Agency in On 6/26/13, at 1:50 designees (SSD)-A They reported that a been made aware of the State Agency reconcerns. They connotifying the State is updated the policy to confirmed the policy staff to report within	ge 12 ted abuse concerns reported vealed the facility had notified neediately of the concerns. p.m. the social service and SSD-B were interviewed. over a year ago, they had of the immediate notification of egarding any potential abuse infirmed the facility had been mediately, but they had not to reflect the changes. They y still incorrectly directed the 24 hours and the staff had tion regarding the immediate	F	226			
	R9's diagnoses incl stroke, diabetes me arthritis. The signifi Set (MDS) dated 5/2 cognitive impairmer assistance with all a On 6/26/13, at 8:10 and NA-G assisted During the cares RS The second toe was purple bruising by the toe. NA-H stated stated and had n	own origin had not been ated in a timely manner. uded depression, status post ellitus and degeneration cant change Minimum Data 28/13, identified R9 with hits and requiring total activities of daily living. a.m. nursing assistant (NA)-H R9 with morning cares. O's left foot was observed. It is red, swollen and had deep the nail and the base of the he had worked the previous ot noted any concerns with ated the swelling and bruising					

CENTER	19 LOV MEDICAKE	& MEDICHID SEKVICES				NAID IAC	7. 0930-0391
	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	52 5555		CONSTRUCTION		TE SURVEY MPLETED
		245247	B. WIN	3	•	06	3/27/2013
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
KITTSON	MEMORIAL HEALTH	HCARE CENTER		20000 2000	0 SOUTH BIRCH LLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREI TAG	FIX .	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X6) COMPLETION DATE
F 226	-6/15/13 (most curr	es Notes (NN) from 6/1/13	F	226			
	second toe.	ted to the braising of the	•				;
	identified the 2nd to	on Charting dated 6/24/13, be as being swollen and of the bruise was noted as:					7,
9	included an update left second toe as b care explained R9 b things such as the t frame that hold blar	of care dated 12/25/12, dated 6/24/13, identified the leing bruised. The plan of had a tendency to kick at able or a bed cradle (metal nkets off of feet while in bed.) he staff to monitor R9's skin.					
		Reports for 6/2013, did not ated to R9's swollen bruised	u.				
	-C stated she was a being bruised and s have kicked the tab positive as to how the She stated she had director of nursing (determined to monithe bruise was of ur report had not been the bruise had not be	tor the area She confirmed aknown etiology, an incident completed and the cause of een investigated or reported.					
	facility was "quite su	p.m. the DON stated the ire" R9 had bumped his toe. ad a history of kicking out					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED				
	2000		245247	B. WING			06	/27/2013
		ROVIDER OR SUPPLIER	ICARE CENTER		1010	T ADDRESS, CITY, STATE, ZIP CODE D SOUTH BIRCH LLOCK, MN 56728	50	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	F 226	bruised toe concern R9's toe. The DON swollen and bruised interview R9. R9 whappened to the toe practical nurse (LPN the bruise. LPN-D on 6/24/13, and rep (RN-C). The DON not been reported to On 6/27/13, at 8:00 doctors appointment On 6/27/13, at 1:30 (LPN)-C reported R On 6/27/13, at 1:43 was fractured, the fainvestigation as to the swolley of the DON of the second content of the DON of the Second content of the second content of the second content of the DON of the Second content of the Second conte	d not find a report of R9's ling. The DON then observed confirmed R9's toes was red, it. The DON attempted to as not able to explain what e. The DON asked licensed N)- D when she had noticed reported it had been noticed orted to the unit manager confirmed the bruised toe had to the State Agency. a.m. RN-C stated R9 had a lit to evaluate the second toe. p.m. licensed practical nurse 9's second toe was fractured. p.m. RN-C confirmed the toe	F 2	26			
			ated by R20 and the incident d or reported to the State	·				
			a and dementia. The MDS ified R4 as being severely		₫: (8)			a.
		dementia, osteoarth	luded altered mental status, ritis and a cerebral vascular he quarterly MDS dated					,

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O	MR NO.	0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- Barrier		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245247	B. WING	i		06/	27/2013	
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
KITTSON	MEMORIAL HEALTI	ICARE CENTER			010 SOUTH BIRCH ALLOCK, MN 56728			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 226	cognitively impaired	R20 as being moderately	Fí	226				
	7/27/10, identifies pallegations which not any event to a paties trauma, shoving, has verbal abuse and on The VA policy also maltreatment of a voircumstance which consider as maltreastaff to report all susupervisor immediates there would be an interview team may confirm the incident; decimeded; gather information document the described of the incident state agency.	ossible incidents or seed to be assessed to include and such as bruising, emotional andling in a rough manner, occurrence patterns and trends identifies indications of 'A to include any event or a reasonable person could atment. The VA policy directs spected maltreatment to their stely. After reporting internally, investigation. The internal onsist of the administrator, DON), social services, other staff deemed vestigation would consist of riate staff and patient involved de on a safety plan as remation on the perpetrator; ription of the maltreatment and at requires a report to the						
		VA) note dated 5/4/13, 5:00 - R20 started spitting at R4.						
	was pushing R4, ra	3, [untimed] revealed R20 mming her into the linen room arm and hand between the chair.						
	was found feeding I	at 5:30 p.m. indicated R20 R4 at the supper table. R4 ng, " No, I'm not hungry, I		10				

CENTER	KS FOR MEDICARE	& MEDICAID SERVICES				MR MC). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILU		E CONSTRUCTION		TE SURVEY MPLETED
		245247	B. WING	·		06	5/27/2013
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
KITTSON	I MEMORIAL HEALTH	ICARE CENTER		ł	010 SOUTH BIRCH IALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X6) COMPLETION DATE
F 226	Continued From pa	ge 16	F:	226			
	R20 was in the dining R4. R4 was crying R4 said no, R20 she in her mouth. R20 she room. When R20 she right for her and tries NA note dated 5/24	/13, at 6:00 p.m. indicated and room trying to force feed and telling R20, "No." When oved a fork full of green beans was removed from the dining law R4 she made a "beeline" and to push her to her room. /13, [untimed] indicated R20 R4's table and attempted to		The state of the s			
		/13, [untimed] indicated R20 20 focuses on R4 throughout very uncomfortable.					
		9:30 a.m. indicated R20 has rn, trying to force feed R4 and rs and walls.		:			
	lunch R20 would no trying to physically p taking the brakes of stated she did not w	/13, [untimed] indicated during of leave R4 alone. R20 was bush R4 in her chair and tried of R4's chair. R4 verbally want any help. R20 was age R4's legs. R4 asked to m.		:			:
		/13, at 9:30 a.m. indicated R o push R4's wheelchair when t desk.		:			
		tes from 3/12/13, to 6/26/13, on of the interactions between		 			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		245247	B. WING	i		06/27/2013
	ROVIDER OR SUPPLIER	ICARE CENTER		101	ET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH BIRCH LLOCK, MN 56728	1 00/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLÉTION
F 226	Continued From pa R20's Resident Car not be left alone wit	e Sheet indicated R20 should	F	226		
	R4's Resident Care not be left along wit	Sheet indicated R4 should h R20.				
	aware of the ongoir	1 p.m. RN-B verified she was ag incidents between R20 and not know if this would be lld be reportable.				
	revealed that on se witnessed R20 tryin stated R20 seems t	p.m. NA-B and NA-C both veral occasions they have g to force feed R4. NA-B o target R4 for some reasond NA-B that it really bothers				
	witnessed R20 force this was bothersom NA-C all revealed the	p.m. NA-D stated she has e feeding R4. NA-D also felt e to R4. NA-A, NA-B, and his happens at least once harge nurses where aware of				er Fe
	aware of the ongoin R4. She stated she resident to resident	p.m. DON stated she was g incidents between R20 and would only report this as a altercation if there was an ted resident to resident be investigated.				
		p.m. administrator confirmed altercations should be ported.		31		,
		p.m. SSD-A and SSD-B to resident altercations should		2/,	9	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245247	B. WING	i		06/27/2013			
NAME OF PROVIDER OR SUPPLIER KITTSON MEMORIAL HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COL 1010 SOUTH BIRCH HALLOCK, MN 56728	ΣE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD I	BE COMPLETION			
F 241	confirmed he was nallegations of abuse State Agency was a He verified neither tand R20 along with been reported to the 483.15(a) DIGNITY INDIVIDUALITY The facility must promanner and in an elenhances each residence.	a.m. the facility administrator at a.m. the facility administrator at a contified immediately of any a contified of the concerns. The altercations between R4 R9's fractured toe had not		F 241 It is the policy of KMHC to promote care for residents in a manner that maintains or enhances each resident's dignity and respect. This has the potential to affect all residents of KMHC. The housekeeping staff on duty was spoken to by their supervisor. Staff will be educated on Kittson Memorial's policy for					
	This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that each resident's dignity was maintained during 3 meal observations on the upper level of the facility. Staff was observed to scrape off dirty plates when residents were eating which had the potential to affect 24 residents residing on the upper level. Findings include: On 6/26/13, at 8:00 a.m. the upper level dining room was observed to be served their breakfast meal. At 8:54 a.m. housekeeping staff member (HK)-A entered the dining room with a bus cart. The cart contained a tub to place dishes in, a container for silverware and bucket to hold the left over food			clearing tables at a mandatory staff meeting. The staff meeting will be taped. Staff not able to attend will be provided with the written material for the inservice and will view the presentation on the recorded DVD. Audits will be done by the Dietary Manager to ensure compliance. These audits will be reviewed at our facility Risk Management Meetings. Dietary Manager, Mary Ryden and Housekeeping Manager, Pam Ingeman responsible for compliance. 8/5/20					

CENTERS FOR MEDICARE & MEDICAID SERVICES					NAR MO. 0838-0381		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245247			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		B. WING			06/27/2013		
NAME OF PROVIDER OR SUPPLIER				1	ET ADDRESS, CITY, STATE, ZIP CODE		
KITTSON MEMORIAL HEALTHCARE CENTER					10 SOUTH BIRCH ALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IX)	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	TION SHOULD BE COMPLETION THE APPROPRIATE DATE	
F 241	cleaning the dishes cereal, milk, juice of Three residents we meals while HK-A produced the form of the room. HK-A produced the houseked dining room while the first the room still eating she pushed the car	ed to each of the tables and dumping the left over r coffee into the bucket. The observed to be eating their pushed the cart throughout the positioned the cart directly craped the left over food into ate his meal. The directical nurse (LPN)-D beging staff usually clear the here are still residents eating stated she began clearing the here were a few residents in their meal. She confirmed through the dining room	Fí	241			
	dining room with the room. She again be residents were presidents were presidents were presidents were presidents were presidents were presidents were presidents. The residents were president were president with the table, picked up R3 wiped off the table at the table for R39 to away. R39 was obsidited and drink from the next table. At 12:50 p.m. HK-A the dining room, contact table.	6 p.m. HK-A entered the e bus cart in the upper dining egan clearing the tables while tent in the dining room. At 12:47 p.m., HK-A walked ed R39's plate, wiped off the 9's glasses of juice and milk, and placed the liquids back on finish. HK-A then walked served to pick up her glass of it after HK-A had walked to wheeled the bus cart out of R39 continued to be sitting					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		245247	B. WING		06/27/2013
	ROVIDER OR SUPPLIER	HCARE CENTER		STREET ADDRESS, CITY, STATE 1010 SOUTH BIRCH HALLOCK, MN 56728	E, ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) EACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE IENCY)
F 241	Continued From pa	ge 20	F2	241	
	stated she was not upper level were st	p.m. the director of nurses aware the residents in the ill eating while the bus cart ghout the dining room.			
	stated it is not prefe dining room while the She stated the staff out of the dining room	p.m. the dietary technician erred to use the bus cart in the ne residents were still eating. If could carry the dirty dishes om, or wait until the residents rior to clearing the tables.	i i		
F 242 SS=D	upper level dining r seated in the dining HK-B used the bus throughout the roor bucket and placing appropriate contain around the dining re survey staff in the r bus cart to the side cleared the remaini dishes to the cart a were still eating.	3 p.m. HK-B entered the com. Two residents were room eating their meals. cart as she wheeled the cart in scraping the dishes into the the dirty dishes into the ers. HK-B cleared the dishes com until she noticed the com. She then wheeled the of the dining room and ing tables by carrying the dirty way for the residents who	F 2	242	19
	schedules, and hea her interests, asses interact with memb- inside and outside t	e right to choose activities, alth care consistent with his or esments, and plans of care; ers of the community both the facility; and make choices is or her life in the facility that the resident.			i.

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	245247	B. WIN	3	06	3/27/2013
OVIDER OR SUPPLIER MEMORIAL HEALTI	HCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1010 SOUTH BIRCH HALLOCK, MN 56728	ODE	7. %
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PRE	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	CORRECTION DVIDER OR SUPPLIER MEMORIAL HEALTH SUMMARY STA (EACH DEFICIENCY	CORRECTION IDENTIFICATION NUMBER:	DVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL IDENTIFICATION NUMBER: A. BUIL B. WING CACH DEFICIENCY B. WING A. BUIL B. WING CACH DEFICIENCY B. WING A. BUIL PREF	A. BUILDING 245247 B. WING DVIDER OR SUPPLIER MEMORIAL HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP C 1010 SOUTH BIRCH HALLOCK, MN 56728 ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTIO	CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DA CO (X3) DA CO (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) DA (X6) MULTIPLE CONSTRUCTION (X6) DA (X7) DA (X7) DA (X6) DA (X7) DA (X7) DA (X8) DA (X8) DA (X9) MULTIPLE CONSTRUCTION (X1) DA (X2) MULTIPLE CONSTRUCTION (X3) DA (X3) DA (X3) DA (X3) DA (X3) DA (X1) PROVIDER STRUCTION (X3) DA (X4) DA (X4) DA (X5) DA (X6) DA (X7) DA (X7) DA (X8)

F 242 Continued From page 21

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and document review, the facility failed to provide a resident the choice regarding her morning wake up time for 1 of 3 (R78) residents reviewed with concerns regarding these choices.

Findings include:

R78 was diagnosed with osteoarthritis and anxiety. The admission Minimum Data Set dated 6/6/13, indicated the resident had moderate cognitive impairment. R78 required extensive assistance with bed mobility and transferring.

On 6/25/13, at 8:46 a.m. R78 was asked if she was able to choose what time she woke up in the morning. R78 stated staff would get her up at 7:00 a.m. and she would like to get up at 9:00 a.m.

On 6/26/13, at 6:39 a.m. R78 was asleep on her back in bed with the privacy curtain pulled around her. At 7:09 am nursing assistant (NA)-A went into the room and asked R78 if she wanted to get up for breakfast. At 7:30 a.m. NA-A transferred R78 from the toilet to the wheelchair with a gait belt, and at 7:43 a.m. NA-A wheeled R78 to the dining room.

On 6/26/13, at 1:41 p.m. social service designee (SSD)-A stated upon admission residents were told they could get up anytime they wanted. SSD-A stated she was not aware R78 wanted to sleep in.

At 1:48 p.m. NA-A stated when she went into

F 242

It is the policy of KMHC that our residents have the right to choose activities, schedules and healthcare consistent with their interests, assessments and plan of care. This has the potential to affect all residents of KMHC. The care sheet for the involved resident was updated to reflect that requests to sleep in - in the a.m. She has been made aware of the fact that she may choose what time to rise in the AM. She has been choosing to get up for the main breakfast serving times. All resident's that are interviewable will be interviewed to ensure their care preferences are being followed. A form has been developed to use on admission to identify preferences for daily routines and activities. A mandatory inservice will be held on "Resident Directed Care". The staff meeting will be taped. Staff not able to attend will be provided with the written material for the inservice and will view the presentation on the recorded DVD. SS will visit with residents quarterly to ensure their care wishes are being carried out. The results of her interviews will be reviewed at our facility Risk Management Meetings (continued)

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	<u> 10. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		245247	B. WING			06/27/2013
	PROVIDER OR SUPPLIER N MEMORIAL HEALT!	HCARE CENTER	:	STREET ADDRESS, CI 1010 SOUTH BIRC HALLOCK, MN &	H	
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F 242	NA-A stated she as up and R78 stated NA-A stated she en because the night lihad reported the renight. NA-A stated, nurses encourage upreakfast." NA-A stated would hurt to have on 6/27/13, at 9:15 stated upon admiss what time they wou morning. RN-A stated	n. the resident was asleep. sked R78 if she wanted to get she wanted to stay in bed. ncouraged R78 to get up, icensed practical nurse (LPN) sident did not sleep well at "We have a routine, and the us to get everybody up for ated, "I don't know why it	F 2	son, ranoim	a Truedson and DON on will be responsib	le 8/5/13
	Residents are enco aspects of their life significant to them. 483.25(h) FREE OF HAZARDS/SUPER. The facility must en environment remain as is possible; and adequate supervision prevent accidents. This REQUIREMENT by: Based on observat		:	that the re remains as hazards as that each radequate su assistive daccidents. to affect a transported assure comp the residen w/c leg use	ll residents l via wheelchair. T liance OT screened ut involved for prop	tial o er ns

(continued)

PRINTED: 07/10/2013

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPL 245247 B. WING O6/27 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH	ETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH	//2013
KITTSON MEMORIAL HEALTHCARE CENTER 1010 SOUTH BIRCH	
KITTSON MEMORIAL HEALTHCARE CENTER	
HALLOCK, MN 56728	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
leg rests in order to minimize the risk for injury for 1 of 3 residents (R21) reviewed for accidents and required extensive staff assistance with wheelchair mobility. Findings include: R21's diagnoses included Parkinson's with tremors, lumbosacral spondyloiss, lower extremity edema and dementia. The quarterly Minimum Data Set (MDS) dated 4/16/13, indicated R21 had severe cognitive impairment and required extensive staff assistance for locomotion throughout the facility. The MDS also indicated R21 utilized a wheelchair for mobility. The plan of care (POC) dated 7/31/12, indicated R21 had variable leg strength with ability to propel wheelchair short distances. On 6/24/13, at 5:55 p.m. a staff member was observed wheeling R21 from the dining room to R21's room. There were no leg rests on the wheelchair. R21 was observed wearing shoes with a rubber sole. During the transport R21's feet was observed to partially go under the wheelchair seat. The wheelchair was observed to come to a jerking, sudden stop when this occurred. R21 stated her feet were too heavy to hold up. The staff member also stated at times R21's feet were too heavy for her to hold up. On 6/25/13, at 8:30 a.m. R21 was observed	3/5/13

On 6/26/13, at 8:00 a.m. nursing assistant (NA)-K

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUC			(X3) DATE SURVEY COMPLETED
		245247	B. WING				06/27/2013
	ROVIDER OR SUPPLIER MEMORIAL HEALTH	ICARE CENTER		STREET ADDRESS 1010 SOUTH E HALLOCK, N		*	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	χ (EACH	OVIDER'S PLAN OF CORRI H CORRECTIVE ACTION SH- REFERENCED TO THE AP DEFICIENCY)	HOULD E	BE COMPLETION
F 323	dining room. R21 w with a rubber sole. It catch the floor twice her feet up. R21 state her feet up. On 6/26/13, at 11:1 required staff assist to all destinations. Neg rests.	eling R21 from her room to the ras observed wearing shoes R21's feet were observed to e. NA-K reminded R21 to hold ated she had difficulty holding 9 a.m. NA-B verified R21 tance with wheelchair mobility NA-B stated R21 did not utilize	F	323			
	(LPN)-A verified sta wheelchair mobility also verified R21 di- rests. LPN-A stated inability to safely ho however, stated it w	a.m. licensed practical nurse of assisted R21 with "most of the time." LPN-A do not utilize wheelchair legs he was not aware of R21's lid up her feet during transport, was possible R21's legs got too old up off the floor while being lichair.	·				
	verified leg rests we resident who require wheelchair mobility. without using leg re foot caught on the finjury. The OT also leg rests and was h feet up during trans staff to request a wlorder to properly fit Additionally, the OT screening request tigot caught on the fle	ccupational therapist (OT) ere to be utilized for any ed staff assistance with The OT stated her fear sts was a resident getting their loor which could cause an stated if a resident did not use aving difficulty holding their portation she would expect heelchair leg rest screen in a resident with leg rests. stated she would expect a he first time a residents foot oor. The OT verified she had est screening request for R21.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(3) DATE SURVEY COMPLETED
		245247	B. WING			06/27/2013
	ROVIDER OR SUPPLIER	HCARE CENTER		STREET ADDRESS, CITY, ST 1010 SOUTH BIRCH HALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENCE)	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)	
F 323	R21's leg rests fro off them, apply the adjust them for production At 12:54 p.m. registed and believe R2 during wheelchair distance. RN-A also injury without the understand the resident was usup during wheelch once, leg rests shouther facility did not be	DT was observed to retrieve m R21's closet, wipe the dust m to R21's wheelchair and oper fit. Stered nurse (RN)-A stated she is could safely hold her feet up transportation of great o stated R21 was at risk for	F3			
F 371 SS=F	483.35(i) FOOD PSTORE/PREPARE The facility must - (1) Procure food fr considered satisfar authorities; and (2) Store, prepare, under sanitary con This REQUIREME by: Based on observa review, the facility food under sanitary	e/SERVE - SANITARY om sources approved or otory by Federal, State or local distribute and serve food	F3	food under sa This has the all residents Dietary Manag in her commun on the proper she was infor practice and notified via Manager will the activity staff on serv manner at a m The staff mee Staff not abl	re and distribution itary condition potential to a so of KMHC. The ger immediately nication book ar way to handle other staff we	ate lons. affect verte verte bread when ficient ere etary caff, sing sanitary cvice. caped.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		TE SURVEY MPLETED
		245247	B. WING	·		06	/27/2013
3.4304H	ROVIDER OR SUPPLIER	HCARE CENTER		1010 \$	ADDRESS, CITY, STATE, ZIP CODE SOUTH BIRCH LOCK, MN 56728		AL-MAN DECOMPANY 123
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 371	addition, the facility microwave were clearly microwave were clearly microwave were clearly microwave were clearly. Findings include: On 6/26/13, at 8:06 meal observation or (DA)-A was observed with her hands and steam table. She that toast on a plate with At 8:10 a.m. DA-A stouch the toast with it. DA-A stated she dietary staff that it when preparing it. On 6/26/13, at 12:4 manager (CDM) and	residing in the facility. In failed to ensure the ean in the upper level ad the potential to affect 24 on the upper level of the earn. during the breakfast in the lower level, dietary aide ed to butter 4 slices of toast then carried the toast to the nen placed a half a piece of in a tong. It is a tong, is stated she knew she could not in her bare hands when serving had been taught by other was OK to touch the toast.		vie reconel A p dev of and has has mic to mic sof edu man sta pro mat and on dor	r the inservice and will ew the presentation on corded DVD. Audits will don proper serving te policy and procedure haveloped on the cleaning the facility microwaved a daily cleaning sches been set up. A memos been posted on the crowaves reminding staf wipe up splatters in the crowave immediately whe iled. Staff will be ucated on this at a modatory staff meeting will be tapaff not able to attend ovided with the written terial for the inserviced will view the present the recorded DVD. Audine to ensure compliance dits will be reviewed as	the 1 be chnique s been s dule f he n The ed. will be e tation its wil . Thes	1 be
	stated they were no could not be touche stated she would m. On 6/27/13, at 10:33	ot aware that bread/ toast ed with bare hands. The DT hake a policy. 2 a.m. the kitchenette on the		fac DON	cility Risk Management N and Dietary Manager sponsible for complianc	Meeting	s. 8/5/2013
		served. The inside of the y with dried food and crumbs.					

cleaning of the microwave.

At 10:42 a.m. the CDM stated she thought the housekeeping staff was responsible for the

At 11:00 a.m. the housekeeping/laundry manager stated the bed maker was responsible for the

<u> </u>	COLON MEDIOMICE	G MEDIO ND OLITAIOLO				1110 110.	. 0000 0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245247	B. WING	i		06/	27/2013
	ROVIDER OR SUPPLIER I MEMORIAL HEALTI	ICARE CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH HALLOCK, MN 56728	Manufacture deliverance and the second second	
				<u> </u>	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
⊏ 271	Continued From no	an 97	٦,	אלינ			
F 3/ I	Continued From pa	-	ŀ,	371			
		rowave every Sunday. The			1		
		e did not have a cleaning					
	policy related to the	microwave.					
		į					
	0= 0/04/40 =+ 4:40				:		
		p.m. the evening meal was			!		
		level dining room for the 24 notes that the unit. The dietary staff					
		e main meal items from the					
		in the kitchenette. The					
		I the plates to the nursing and					
		ers who added condiment and					
		The nursing and activity staff					
		lishing the meals. The			:		
	following observation						
	At 4:45 p.m. activity	assistant (AA)-A donned					
		d a plate from the dietary			:		
		gloved hand to pick up a slice					
	of bread and delive	red the plate to a resident. As					ŀ
		ate, she was observed to			:		
		resident and her uniform with					
		She then returned to the			:		
		and received a second plate			:		
		ent. AA-A was observed to			· !		
		d hand to pick up a slice of					
	bread for the secon	g assistant (NA)-N donned			•		
		d a plate for the dietary staff.					
		red hand to pick up the bread					
		ate to a resident. NA-N			<u> </u>		
		s drinking glasses, arranged					
		served the plate to the					
		s not observed to change her					
		ved the second plate of food,					
		with her dirty gloves.					
		lonned gloves and assisted a					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 50 50		LE CONSTRUCȚION	(X3) DATE SURVEY COMPLETED	
		245247	B. WING			06/2	7/2013
	ROVIDER OR SUPPLIER	HCARE CENTER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH HALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	D BE	(X5) COMPLETION DATE
F 371	then walked to the plate of food and us pick up bread for a second resident. At 4:47 p.m. AA-A r window, AA-A was gloves prior to picki hand and delivering At 4:48 p.m. NA-M window wearing glothe dietary staff me bread with her glove delivered the meal at 4:50 p.m. NA-L p	ng a clothing protector, AA-B kitchenette window, received a seed the same gloved hand to resident and delivered it to a returned to the kitchenette not observed to change her ng up bread with her gloved the meal to a resident. walked to the kitchenette oves, took a plate of food from mber and picked up a slice of ed hands. NA-M then	F	371			
	the break. At 4:55 p.m. the state consistently use the from the kitchenette. On 6/26/13, at 8:35 assist R9 to the din wheelchair. At 8:40 upper level kitchener R9, NA-H used her remove bread from toaster. At 8:41 a.m. the kitchenette, can returned to the kitchen door and remove She used her unwatoast as applied but	off were observed to e fork to pick up the bread				3	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245247	B. WING			06	/27/2013
	ROVIDER OR SUPPLIER	HCARE CENTER		1010	ET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH BIRCH LLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 406	•	rectly touching R9's bread. E/OBTAIN SPECIALIZED		371 106			
	not limited to, phys pathology, occupat health rehabilitative and mental retarda resident's compreh must provide the required services fraccordance with §2	cilitative services such as, but ical therapy, speech-language ional therapy, and mental e services for mental illness tion, are required in the ensive plan of care, the facility equired services; or obtain the rom an outside resource (in 183.75(h) of this part) from a zeed rehabilitative services.					
	by: Based on observa review, the facility f rehabilitative servic positioning was ma	NT is not met as evidenced tion, interview, and document ailed to provide specialized es to ensure wheelchair intained for 1 of 3 residents wheelchair positioning.					
	post stroke. The q (MDS) dated 5/28/cognitive impairme assistance with act dependence upon was not ambulatory. The plan of care darequiring an wheeld nursing unit. The p	luded dementia and status uarterly Minimum Data Set 13, identified R9 with severe nts and requiring extensive ivities of daily living and total the staff for transferring. R9 //. Inted 12/25/12, identified R9 as chair for mobility while on the olan was updated on 6/6/13, as to utilize a rock and go					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	Y		<u>OMB NO. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		245247	B. WING _		06/27/2013
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
KITTSON	MEMORIAL HEALTI	HCARE CENTER		1010 SOUTH BIRCH HALLOCK, MN 56728	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 406	the dining room. H Go wheelchair. (A wheelchair with a re residents to rock be chair.) R9 was slig were not able to too was being wheeled to have foot pedals R9's feet while it we dining room. On 6/25/13, at 9:24 the dining room by was positioned in a and Go chair and R floor as the chair we noticed that R9's fe so NA-F turned the out of the dinning ro across the floor as Review of the occu 1/15/13, indicated the valuated R9 for a new wheelchair cus alignment while in t therapy department to changing R9 into	p.m. R9 was wheeled out of e was seated in a Rock and Rock and Go chair is a eclining seat that allows ack and forth like a rocking htly reclined and R9's feet ach the floor while the chair. The chair was not observed or any other device to support as being wheeled out of the a.m. R9 was wheeled out of nursing assistant (NA)-F. R9 in upright position in the Rock 19's feet were dragging on the las being pushed. NA-F et were dragging on the floor chair around and pulled R9 from backwards. R9's feet slid R9 was pulled out of the room. Pational therapy notes dated the therapy department had wheelchair and had placed a shion to ensure proper seating the chair. The occupational thad not been contacted prior the Rock and Go wheelchair.	F 40	if specialized services rehabilitative services such as physical therapy, occupational therapy are required in resident's comprehensive plan of car the facility must provide the required services. The has the potential to affer	e, is is is is is is is it it it ith the ecorded it
	staff had changed F	R9's wheelchair to a Rock and			

Go to provide better positioning while in the chair since he was no longer able to propel himself in

On 6/26/13, at 8:37 a.m. R9 was wheeled from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245247	B. WING			06/27/2013	
	ROVIDER OR SUPPLIER	HCARE CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH BIRCH ALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 406	a reclining position while being wheele On 6/26/13, at 11:3	ing room by NA-H. R9 was in as he feet dangled in the air d down the hallway.	F.	406			
		clined position. R9's feet were able to touch the floor.	!	:			
	-C stated R9's whe R9 had been place wheelchair to enha She stated R9 has and when he is posable to touch the flooccupational therapaware of placing R facility had not require therapy department concerns related to chair. RN-C stated pedals to assist wit RN-C did not know located, but stated On 6/26/13, at 12:4 room by NA-H. R9	elchair had been removed and d in the Rock and Go nce comfort and positioning. been very happy with the chair sitioned upright, R9's feet are por. She stated the by department had been made 9 in the Rock and Go but the dested an evaluation by the t. RN-C was not aware of any R9's current Rock and Go the chair does have foot h positioning in the chair. Where the pedals were she could find them.					
	therapist stated she any positioning cor She stated at that t wheelchair and had pressure redistribut alignment in the ch	00 a.m. the occupational a had not been made aware of occupations with R9 since 1/2013. The R9 was using a standard been given an alternative tion cushion to ensure air. She stated the therapy theen contacted prior to					

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>	<u>MB NO.</u>	<u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245247	B. WING_			06/2	27/2013
NAME OF P	ROVIDER OR SUPPLIER		;	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
KITTSON	I MEMORIAL HEALT	ICARE CENTER			010 SOUTH BIRCH ALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 406	and Go chair. She had received a whe the morning of 6/27	he standard chair to the Rock added the therapy department elchair positioning referral on /13, and was going to	F 4(It is the policy of KMHC to handle, store, process and transport linens so as to prevent the spread of infection. This has		
	re-evaluate R9's po 483.65 INFECTION SPREAD, LINENS	SIGON. CONTROL, PREVENT	F 44	41	the potential to affect all residents of KMHC. Laundry immediately discont	tinued	
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a omfortable environment and development and transmission otion.			the laundering of the cushions and a memo was posted that they should be covered and thrown if heavily soiled. New		
	Program under whie (1) Investigates, coin the facility; (2) Decides what preshould be applied to	tablish an Infection Control ch it - ntrols, and prevents infections ocedures, such as isolation, o an individual resident; and ord of incidents and corrective			cushions have been ordered that have a protective cover and the manufactures instructions for cleaning them will be followed. A policy and procedure has been developed for the cleaning of w/c cushion Staff will be educated on the policy at a mandator		
	determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will track (3) The facility must	ion Control Program esident needs isolation to of infection, the facility must prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their rect resident contact for which icated by accepted			staff meeting. The staff meeting will be taped. Staff not able to attend will be provided with the written material for the inservice and will view the presentation on the recorded DVD. Audi of the condition of w/c cushions will be done to ensure compliance. These audits will be reviewed.	ts	

at facility Risk Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245247	B. WING_		06/27/2013	
	PROVIDER OR SUPPLIER	ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH HALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 441		ge 33 ndle, store, process and as to prevent the spread of	F 44	Meetings. Housekeeping Supervisor, Pam Ingeman will be responsible for compliance	8/5/2013	
	by: Based on observat review, the facility fa recommendations f wheelchair cushion: R60) residents obse	ion, interview, and document ailed to follow manufacturer's or the cleaning of foam s for 4 of 4 (R49, R45, R44, erved with soiled cushions. ial to affect 25 residents on r level.				
	Findings include:		:			
	room on 6/24/13, at residents were obsethick foam wheelch	s of the upper level dining 5:00 p.m. several of the erved to be sitting on four inch air cushions. The cushions to have any type of covering			5) 5)	
		ushion was observed to be by was not cleaning it unufacturer's				
	and Parkinson disection Data Set (MDS) data with severe cognitive total assistance with The plan of care data.	cluded Alzheimer's disease ase. The quarterly Minimum and 3/26/13, identified R49 impairments and requiring all activities of daily living. ted 7/24/12, directed the staff relief foam cushion on the	٠		5	

OLITICI	TO FOR THE BIOFITE	G MILDIO/ ND OLIVIOLO	1			THE IT	3. 0000 0001
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A 1851		CONSTRUCTION		ATE SURVEY OMPLETED
		245247	B. WING	;		00	6/27/2013
	ROVIDER OR SUPPLIER N MEMORIAL HEALTI	HCARE CENTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH BIRCH ALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa wheelchair.	ge 34	F.	441			
*	sitting in her wheeld wheelchair was equ cushion. The cushi	p.m. R49 was observed chair in the dining room. The lipped with a four inch foam ion was observed to have nt edges which were purple in					0 00 00
	assisted R49 to tran wheelchair cushion stains on it. A pad (a.m. nursing assistant (NA)-E nsfer into her wheelchair. The continued to have purple thick quilted sheet) was of the cushion as R49 was air.					÷
	R45's wheelchair cu to clean it.	ushion did not have a system					
	and diabetes. The 5/14/13, identified F impairments and as staff for all activities care dated 5/28/13,	cluded Alzheimer's dementia significant change MDS dated 845 with severe cognitive being totally dependant upon of daily living. The plan of directed the staff to provide a sion on her wheelchair.		E			
	sitting in a wheelcha	p.m. R45 was observed air with a four inch foam cushions were not observed to					
	 C stated the wheel used for several year soiled the staff place 	0 p.m. registered nurse (RN) chair cushions have been ars and when they became ed them in the dirty utility ry staff cared for them.					

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			· (MR MO	. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
 		245247	B. WING)		06/	27/2013
	PROVIDER OR SUPPLIER N MEMORIAL HEALTI	HCARE CENTER		101	ET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH BIRCH LLLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	cushions were was and placed in the d some of the moistu	ge 35 Iry staff member -A stated the hed in the washing machine ryer for a few minutes to get re out of them. She stated it is for the cushions to dry	, F.	441			
	were observed on c RN-C stated the two cushions on the din R60. RN-C explain cushions on the din	4 p.m. two random cushions chairs in the dining room. or residents who utilized the ing room chairs were R44 and ed the two residents used the ing room chairs per their ecame soiled, they were sent					and the second s
	(LPN)-D stated all o	p.m. licensed practical nurse sushions were to be thrown She stated the facility was not ions.		And the state of t			
,	Relief Cushion (ma "Easy Care - Clean	ted MediChoice Pressure nufacture instructions) stated: the cushion cover with a solution or soap and water. or launder."		The state of the s			:
	(DON) revealed the residents' wheelche facility's laundry. The are not always returnif they are grossly so The DON confirmed	9 a.m. director of nursing foam cushions placed in the airs are laundered in the ne DON stated the cushions ned to the same resident and oiled they are to be tossed. If the facility lacked a policy ning of these foam wheelchair		2 × 4 × 1000			

STATEMENT AND PLAN C	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DAT COM	3) DATE SURVEY COMPLETED			
		245247	B. WING		· · · · · · · · · · · · · · · · · · ·	06/	27/2013
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PRINTED: 07/10/2013 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B-WING 245247 06/26/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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 FILENIC SOLL PAGE OF THE CMS-2567 WILL BE USED AS FIRE MARKETAL DYGO VERIFICATION OF COMPLIANCE. POC ok 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. 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 St. Paul, MN 55101

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

CED/Administrato

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.

Or by email to:

(X6) DATE

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION - MAIN BUILDING 01	(X3) DATE SURVE COMPLETED	
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	DEFICIENCY MUST FOLLOWING INFO 1. A description of we to correct the deficiency. The actual, or proceed a responsible for corresponsible for corr	tate mn.us and Destate mn.us 15-0525 RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. poposed, completion date. If title of the person ection and monitoring to ence of the deficiency ial Hospital C & NC is made The original building is north pm, with a 2-hour fire barrier, all Hospital building. It is ment and was constructed in tined to be of Type II(000) now fully sprinkler protected per level. In 1981 an addition h of the original building, is a lout a basement. It was Type V (111) construction, is		000			
	least a 2-hour fire be building and is called buildings are divided. The facility is fully sp accordance with NFI Installation of Sprink	eted and is separated with at carrier from the original of the Lower Level. The dinto 8 smoke zones. Description of the carrier for the carrier from the carrier for the carrier systems 1999 edition.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 01 - MAIN BUILDING 01 245247 B: WING 06/26/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 000 Continued From page 2 K 000 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 66 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 018 Lower level dining room doors and room 48 K 018 NFPA 101 LIFE SAFETY CODE STANDARD door were adjusted to insure proper SS=F latching. Monitoring of proper door Doors protecting corridor openings in other than closure will be conducted by required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as Terry Anderson, Maintenance Manager those constructed of 1% inch solid-bonded core 7/16/2013 wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations

in all health care facilities.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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NFPA 101 LIFE SAFETY CODE STANDARD K 029 SS=F

> One hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed

K 029

conference.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 245247 06/26/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 029 Continued From page 4 K 029 Storage Room door was adjusted to insure proper latching. Monitoring of proper 48 inches from the bottom of the door are permitted. 19.3.2.1 door closure will be conducted by Terry Anderson, Maintenance Manager 7/16/2013 This STANDARD is not met as evidenced by: Observations revealed that one of twenty hazardous area doors tested was not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.2.1. This deficient practice could allow the products of combustion to travel from this hazardous area into the corridor system if a fire occurs within the laundry or soiled linen room, which could negatively impac tall residents, staff and visitors of the facility. Findings include: During the facility tour on June 26, 2013, between 10:35 am and 12:15 pm, observations and tests of corridor doors by surveyor 03006, revealed that the door to the storage room off the family room on the lower level did not close and latch. The Director of Maintenance verified this finding during the facility tour and during the exit conference. K 033 NFPA 101 LIFE SAFETY CODE STANDARD K 033 SS=F Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape. and provide protection against fire or smoke from

other parts of the building 8.2.5.2, 19.3.1.1

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A: BUILDING 01 - MAIN BUILDING 01 245247 B. WING 06/26/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRFFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 033 Continued From page 5 K 033 Upper Level stairway door was adjusted to insure proper latching, Monitoring of proper latching will be conducted by Terry Anderson This STANDARD is not met as evidenced by: Observations revealed that one of four stairway Maintenance Manager 7/16/13 doors tested is not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.1.1. This deficient practice could affect all residents, staff and visitors of the facility if a fire occurs. Findings include: During the facility tour on June 26, 2013, between 10:35 am and 12:15 pm, observations and testing of stairway doors by surveyor 03006, revealed that the west upper level stairway door did not latch. The Director of Maintenance verified this finding during the facility tour and during the exit conference. K 062 NFPA 101 LIFE SAFETY CODE STANDARD K 062 SS=F Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested 19.7.6, 4.6.12, NFPA 13, NFPA periodically. 25, 9.7.5 This STANDARD is not met as evidenced by: Observations revealed that the automatic fire sprinkler system has not been maintained in accordance with NFPA 25 Standard for the Inspection, Testing and Maintenance of

Water-Based Fire Protection Systems 1999 edition section 9.7.5. Failing to maintain the

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B-WING 245247 06/26/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) K 062 Continued From page 6 K 062 Escutcheon rings have been ordered to replace the ones missing. Rings will automatic fire sprinkler system could affect all residents, staff and visitors of the facility, if the be installed upon receipt. sprinkler system fails to function properly in a fire sprinkler head box has been attached to emergency. the wall and filled with two types and temperature heads. Monitoring of Findings include: Escutcheon rings and sprinkler head box During the facility tour on June 26, 2013, between will be conducted by Terry Anderson 10:35 am and 12:15 pm, observations by Maintenance Manager. 7/16/2013 surveyor 03006, revealed that: 1) Various sprinkler heads are missing the escutcheon rings including the heads in the janitor's closet by the DON office, room 131, room 122, the upper bathing room and the west day room, and 2) The spare head box was laying on the floor and did not contain 2 of each type and temperature heads used in the building as required by section of NFPA 25 section 2-4-1.4 The Director of Maintenance verified these findings during the facility tour and during the exit conference. "No Smoking/Oxygen In Use" and "No Smoking K 066 NFPA 101 LIFE SAFETY CODE STANDARD K 066 Within 10 Feet Of This Area" signs have SS=F been ordered and will be installed upon Smoking regulations are adopted and include no receipt. Monitoring of signs will be less than the following provisions: conducted by Terry Anderson, Maintenance Manager 7/16/13 (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.

(2) Smoking by patients classified as not responsible is prohibited, except when under

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K 066	direct supervision. (3) Ashtrays of none design are provided permitted. (4) Metal containers devices into which a	combustible material and safe d in all areas where smoking is s with self-closing cover ashtrays can be emptied are all areas where smoking is	K	066			
	An interview with th and observations re are not properly pos Use, signs in accord Protection Associati Safety Code" (LSC) This deficient practic	s not met as evidenced by: ne Director of Maintenance evealed that the facility staff sting NO SMOKING Oxygen in dance with National Fire ion (NFPA) 101 "The Life 2000 edition, Section 19.7.4. ce could negatively affect all visitors of the facility by cur.		The second section of the second seco			
	Findings include: During the facility tour on June 26, 2013, between 10:35 am and 12:15 pm, observations and an interview with the Director of Maintenance by surveyor 03006, revealed that:			The state of the s			
	signs on the doors (I nor are all of the ma	120 had oxygen in use and no No Smoking Oxygen In Use) ijor entrances into the facility oking Oxygen in Use, and		1			

2) The outdoor smoking area is within 10 feet of

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245247 B. WING 06/26/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (ÉACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) K 066 Continued From page 8 K 066 the emergency generator's fuel tank. The Director of Maintenance verified these findings during the facility tour and during the exit conference. K 076 NFPA 101 LIFE SAFETY CODE STANDARD K 076 Full oxygen tanks were removed from SS=F Lower Level west storage room and placed Medical gas storage and administration areas are in the east storage room. All oxygen protected in accordance with NFPA 99. tanks will be at least five feet from Standards for Health Care Facilities. combustibles. Compliance will be monitored by Terry Anderson, Maintenance (a) Oxygen storage locations of greater than Manager. 7/16/13 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Observations of oxygen storage rooms within the facility revealed compressed oxygen cylinders are not stored in accordance with NFPA 99 "Health Care Facilities" 1999 edition section 8-6.2.1.4. This deficient practice can negatively affect all residents, staff and visitors of the facility. Findings include: During the facility tour on June 26, 2013, between 10:35 am and 12:15 pm, observations by surveyor 03006, revealed that the oxygen storage was within 5 feet of combustibles in the lower west storage area.

	TO TOTT INLESTOR IT	A MEDICAID SERVICES	-			THE ITO	. 0930-038
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - MAIN BUILDING 01		E SURVEY IPLETED
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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 3526

July 10, 2013

Mr. Richard Failing, Administrator Kittson Memorial Healthcare Center 1010 South Birch Hallock, Minnesota 56728

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5247024 & H5247009

Dear Mr. Failing:

The above facility was surveyed on June 24, 2013 through June 27, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5247009, which was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

Kittson Memorial Healthcare Center July 10, 2013 Page 2

and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to Lyla Burkman at Minnesota Department of Health, 705 5th Street NW, Suite A, Bemidji, Minnesota 56601-2933. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please 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.

Please feel free to call me with any questions.

Sincerely,

Lyla Burkman, Unit Supervisor Licensing and Certification Program Division of Compliance Monitoring Telephone: (218) 308-2104 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File

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Minnesota Department of Health

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
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	****ATTE	NTION*****								
	NH LICENSING	CORRECTION ORD)ER							
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall with a schedule of f the Minnesota Department of the corrected requires or requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has compliance with all e rule provided at the ale number indicated ns several items, fail the items will be con- Lack of compliance any item of multi-part ament of a fine even i	issued ion, it is cited violation rdance rule of s been tag below. ure to sidered e upon rule will if the item							
	You may request a that may result fron orders provided that the Department with	hearing on any asse n non-compliance wi at a written request is hin 15 days of receip ent for non-compliance	essments th these made to t of a							
	Department's staff, the following licensi corrections are con make a copy of the original to the Minn	TS: 3, surveyors of this visited the above proing orders were issuent pleted, please sign as orders and return esota Department of ince Monitoring, Lice	ed. When and date, the Health,		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware.				

Minnesota Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

AND DIAN OF CORRECTION IN IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
		00321		B. WING	VING 06/27/201		7/2013		
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	Certification Program; 705 5th St. N.W., Suite A, Bemidji, MN 56601-2933				The assigned tag number appear far left column entitled "ID Prefix The state statute/rule out of complisted in the "Summary Statement Deficiencies" column and replace Comply" portion of the correction This column also includes the find which are in violation of the state after the statement, "This Rule is as evidence by." Following the sufindings are the Suggested Method Correction and Time period for Correction." THIS APPLIES FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." oliance is of s the "To order. dings statute not met rveyors od of orrection. DING OF TO TO ON FOR			
2 915	MN Rule 4658.0525	5 Subp. 6 A Rehab -	ADLs	2 915					
	comprehensive res home must ensure A. a resident is treatments and ser abilities in activities deterioration is a not the resident's condi	given the appropria vices to maintain or i of daily living unless ormal or characterist ition. For purposes o illy living includes the ss, and groom; d ambulate;	nursing te mprove s ic part of of this						

Minnesota Department of Health

STATE FORM R6V411 If continuation sheet 2 of 29

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00321			B. WING		06/2	27/2013
NAME OF P	E OF PROVIDER OR SUPPLIER STREET A		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 00/2	172010
	I MEMORIAL HEALTH	HCARE CENTER		JTH BIRCH K, MN 56728	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 2		2 915			
	(4) eat; and (5) use speech	n, language, or other ication systems; and					
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement wheelchair leg rests in order to minimize the risk for injury for 1 of 3 residents (R21) reviewed for accidents and required extensive staff assistance with wheelchair mobility.						
	Findings include:						
	R21's diagnoses included Parkinson's with tremors, lumbosacral spondylosis, lower extremity edema and dementia. The quarterly Minimum Data Set (MDS) dated 4/16/13, indicated R21 had severe cognitive impairment and required extensive staff assistance for locomotion throughout the facility. The MDS also indicated R21 utilized a wheelchair for mobility.						
		OC) dated 7/31/12, in the strength with ability stances.					
	observed wheeling R21's room. There wheelchair. R21 wa with a rubber sole. was observed to ge times. Three of the	p.m. a staff membe R21 from the dining were no leg rests on as observed wearing During the transport of caught on the floor five times R21's feey go under the whee	room to the shoes R21's feet five t was				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
	00321			B. WING		06/	06/27/2013		
NAME OF B	ROVIDER OR SUPPLIER	00021	STREET AD	DRESS CITY S	STATE, ZIP CODE	1 00/2	21/2013		
NAIVIE OF F	ROVIDER OR SUPPLIER			JTH BIRCH	STATE, ZII GODE				
KITTSON	N MEMORIAL HEALTH	HCARE CENTER		K, MN 56728					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE		
2 915	Continued From pa	ge 3		2 915					
	seat. The wheelchair was observed to come to a jerking, sudden stop when this occurred. R21 stated her feet were too heavy to hold up. The staff member also stated at times R21's feet were too heavy for her to hold up. On 6/25/13, at 8:30 a.m. R21 was observed								
	On 6/26/13, at 8:00 was observed whee dining room. R21 w with a rubber sole. I catch the floor twice	ated in the wheelchair without leg rests. 1 6/26/13, at 8:00 a.m. nursing assistant (NA)-K is observed wheeling R21 from her room to the ning room. R21 was observed wearing shoes tha rubber sole. R21's feet were observed to toth the floor twice. NA-K reminded R21 to hold in feet up. R21 stated she had difficulty holding							
	required staff assist	9 a.m. NA-B verified tance with wheelcha NA-B stated R21 did	ir mobility						
	On 6/27/13, at 7:23 a.m. licensed practical nurse (LPN)-A verified staff assisted R21 with wheelchair mobility "most of the time." LPN-A also verified R21 did not utilize wheelchair legs rests. LPN-A stated he was not aware of R21's inability to safely hold up her feet during transport, however, stated it was possible R21's legs got too heavy for R21 to hold up off the floor while being pushed in the wheelchair.								
	verified leg rests we resident who requir wheelchair mobility without using leg re foot caught on the finjury. The OT also	ccupational therapisere to be utilized for a ed staff assistance was a resident garage was a resident garage which could caustated if a resident a aving difficulty holding	any vith fear etting their use an did not use						

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				A. BUILDING:				
		00321		B. WING		06/2	06/27/2013	
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
KITTSOI	N MEMORIAL HEALTH	HCARE CENTER		UTH BIRCH K, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 915	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			2 915	DELIGITATION OF THE PROPERTY O			

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Minnesota Department of Health STATE FORM

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00321		B. WING		06/	27/2013	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DDRESS, CITY, STATE, ZIP CODE				
1010 SOU			UTH BIRCH K, 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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
2 915	Continued From page 5			2 915				
	TIME PERIOD FOR CORRECTION: Twenty One (21) Days.							
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed.			21000				
	by: Based on observati review, the facility food under sanitary food handling of bre affect 67 residents addition, the facility microwave were cle kitchenette which he	In Requirement is not met as evidenced on observation, interview, and document on, the facility failed to distribute and serve under sanitary conditions related to improper andling of bread which had the potential to 67 residents residing in the facility. In on, the facility failed to ensure the wave were clean in the upper level nette which had the potential to affect 24 nts residing on the upper level of the						
	Findings include:							
	meal observation of (DA)-A was observed with her hands and steam table. She the toast on a plate with	a.m. during the brean the lower level, die ed to butter 4 slices then carried the toaten placed a half a property a tong.	etary aide of toast st to the iece of					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPP IDENTIFICATION			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED			
	00321			B. WING		06/	06/27/2013		
NAME OF F	PROVIDER OR SUPPLIER	l	STREET AD	ADDRESS, CITY, STATE, ZIP CODE					
VITTONI MEMORIAL HEALTHCARE CENTER 1010			1010 SOL	OUTH BIRCH CK, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	LD BE COMPLETE		
21000	Continued From page 6			21000					
	touch the toast with her bare hands when serving it. DA-A stated she had been taught by other dietary staff that it was OK to touch the toast when preparing it.								
	On 6/26/13, at 12:47 p.m. the certified dietary manager (CDM) and the dietary technician (DT) stated they were not aware that bread/ toast could not be touched with bare hands. The DT stated she would make a policy.								
	On 6/27/13, at 10:32 a.m. the kitchenette on the upper level was observed. The inside of the microwave was dirty with dried food and crumbs.								
	At 10:42 a.m. the CDM stated she thought the housekeeping staff was responsible for the cleaning of the microwave.								
	At 11:00 a.m. the housekeeping/laundry manager stated the bed maker was responsible for the cleaning of the microwave every Sunday. The manager stated she did not have a cleaning policy related to the microwave.								
	served in the upper residents residing in member severed the steam table located dietary staff handed activity staff member bread to the plates.	is p.m. the evening manager level dining room for the unit. The dietance main meal items of the highest in the kitchenette. It is the plates to the nuters who added conditions and addishing the meals. The plates is the nursing and addishing the meals.	r the 24 ry staff rom the The irsing and iment and ctivity staff						
	At 4:45 p.m. activity assistant (AA)-A donned gloves and accepted a plate from the dietary staff. She used her gloved hand to pick up a slice of bread and delivered the plate to a resident. As								

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	F CORRECTION IDENTIFICATION NUMBER:			A. BUILDING:				
		00321		B. WING 06/2			7/2013	
NAME OF F	ROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE				
KITTSON	N MEMORIAL HEALTH	HCARE CENTER		OUTH BIRCH CK, MN 56728				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21000	touch the table, the her gloved hands. kitchenette window of for another residuse the same glove bread for the secon At 4:46 p.m. nursing gloves and received NA-N used her glovand delivered the pmoved the resident the table items and resident. NA-N was gloves as she receipicked up the bread At 4:47 p.m. AA-B or resident with applyithen walked to the plate of food and us pick up bread for a second resident. At 4:47 p.m. AA-A was gloves prior to picki	late, she was observed resident and her un She then returned to and received a second received a second. AA-A was observed hand to pick up a	iform with of the ond plate rved to slice of onned ary staff. he bread A-N arranged he ange her e of food, s. assisted a or, AA-B received a l hand to ed it to a enette nge her r gloved	21000				
	At 4:48 p.m. NA-M walked to the kitchenette window wearing gloves, took a plate of food from the dietary staff member and picked up a slice of bread with her gloved hands. NA-M then delivered the meal to a resident.							
	At 4:50 p.m. NA-L placed a clean fork next to the bread and directed the staff to use the fork to dish the break.							
	At 4:55 p.m. the sta	aff were observed to						

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	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	COMP	SURVEY	
		00321		B. WING		06/2	27/2013	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		.,	
KITTSON	I MEMORIAL HEALTH	HCARE CENTER		UTH BIRCH K, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
21000	Continued From page 8			21000				
	consistently use the fork to pick up the bread from the kitchenette window.							
	assist R9 to the din wheelchair. At 8:40 upper level kitchene R9. NA-H used her remove bread from toaster. At 8:41 a.r. the kitchenette, car returned to the kitch door and remove She used her unwatoast as applied but served it to R9. NA	a.m. NA-H was obsing room by pushing a.m. NA-H was entette to prepare break bare unwashed han a bag and place it ir m. NA-H opened the ried a bowl of cereal nenette, used a key to detect the toast from the shed bare hand to have a not observed rectly touching R9's larger and to have a shed to have a shed bare and to	the ered the cfast for ds to n the door to to R9, to open e toaster. old the r and d to wash					
	The Director of Diet policy and procedur served in a sanitary training regarding hensure knowledge serving residents for	THOD OF CORREC- tary Services could on the to ensure that food to manner. Staff could thank washing and glo of safe food handling tood. Monitoring could therved in a safe and s	develop a d was d receive ove use to g while d occur to					
	TIME PERIOD FOR (21) days.	R CORRECTION: T	wenty one					
21390	Subp. 4. Policies a	O Subp. 4 A-I Infection and procedures. The last include policies a	e infection	21390				
	procedures which p A. surveillance	provide for the follow based on systematic nosocomial infection	ving: c data					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00321		B. WING		06/:	27/2013	
NAME OF F	PROVIDER OR SUPPLIER STREET		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
	N MEMORIAL HEALTH	HCARE CENTER	1010 SOL	OUTH BIRCH CK, 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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21390	Continued From page 9			21390				
	B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.							
	by: Based on observation review, the facility for recommendations of wheelchair cushion R60) residents observations had the potent the upper and lower Findings include: During observations room on 6/24/13, as residents were observations.	ent is not met as evident, interview, and do ailed to follow manuffor the cleaning of for s for 4 of 4 (R49, R4) erved with soiled custial to affect 25 resident level. Is of the upper level of t5:00 p.m. several of erved to be sitting or lair cushions. The custion, interved to the sitting or lair cushions.	ocument facturer's am 5, R44, shions. ents on lining f the n four inch					

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	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPF IDENTIFICATION			` ′	E CONSTRUCTION		E SURVEY PLETED
		00321		B. WING		06/	27/2013
NAME OF F	PROVIDER OR SUPPLIER	l.	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	N MEMORIAL HEALTI	HCARE CENTER	1010 SOI	UTH BIRCH K, MN 56728			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21390	Continued From page 10			21390			
	were not observed to have any type of covering on them.						
	R49's wheelchair cushion was observed to be soiled and the facility was not cleaning it according to the manufacturer's recommendations.						
	R49's diagnoses included Alzheimer's disease and Parkinson disease. The quarterly Minimum Data Set (MDS) dated 3/26/13, identified R49 with severe cognitive impairments and requiring total assistance with all activities of daily living. The plan of care dated 7/24/12, directed the staff to have a pressure relief foam cushion on the wheelchair.						
	sitting in her wheeld wheelchair was equ cushion. The cush	p.m. R49 was obsection in the dining rouipped with a four indicate to make the control of the co	om. The ch foam have				
	On 6/26/13, at 7:10 a.m. nursing assistant (NA)-E assisted R49 to transfer into her wheelchair. The wheelchair cushion continued to have purple stains on it. A pad (thick quilted sheet) was placed over the top of the cushion as R49 was assisted into the chair.						
	R45's wheelchair cushion did not have a system to clean it.		a system				
	and diabetes. The 5/14/13, identified F impairments and as staff for all activities	cluded Alzheimer's of significant change NR45 with severe cogs being totally depends of daily living. The directed the staff to	MDS dated nitive dant upon plan of				

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	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00321		B. WING		06/:	27/2013	
NAME OF F				DRESS, CITY, S	STATE, ZIP CODE	1 30/1		
	N MEMORIAL HEALTH	HCARE CENTER		UTH BIRCH K, MN 56728				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
21390	Continued From page 11			21390				
	pressure relief cush	nion on her wheelcha	air.					
	On 6/24/13, at 7:15 p.m. R45 was observed sitting in a wheelchair with a four inch foam cushion on it. The cushions were not observed to be covered.							
	On 6/26/13, at 12:20 p.m. registered nurse (RN) -C stated the wheelchair cushions have been used for several years and when they became soiled the staff placed them in the dirty utility room and the laundry staff cared for them.							
	At 12:30 p.m. laundry staff member -A stated the cushions were washed in the washing machine and placed in the dryer for a few minutes to get some of the moisture out of them. She stated it took about 48 hours for the cushions to dry completely.							
	On 6/26/13, at 12:24 p.m. two random cushions were observed on chairs in the dining room. RN-C stated the two residents who utilized the cushions on the dining room chairs were R44 and R60. RN-C explained the two residents used the cushions on the dining room chairs per their choice and if they became soiled, they were sent to the laundry.							
	On 6/27/13, at 1:10 p.m. licensed practical nurse (LPN)-D stated all cushions were to be thrown away when soiled She stated the facility was not to launder the cushions.							
	Relief Cushion (ma "Easy Care - Clean	ted MediChoice Pres nufacture instruction the cushion cover w solution or soap and or launder."	is) stated: vith a					

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	IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00321		B. WING		06/2	27/2013	
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE			
KITTSON	I MEMORIAL HEALTH	HCARE CENTER		OUTH BIRCH CK, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21390	On 6/26/13, at 11:29 a.m. director of nursing (DON) revealed the foam cushions placed in the			21390				
	(DON) revealed the foam cushions placed in the residents' wheelchairs are laundered in the facility's laundry. The DON stated the cushions are not always returned to the same resident and if they are grossly soiled they are to be tossed. The DON confirmed the facility lacked a policy addressing the cleaning of these foam wheelchair cushions.							
		2 a.m. DON confirm d 25 foam wheelchai lents.						
	Suggested Method of Correction: The administrator or designee could review policies and procedures to ensure proper infection control techniques are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance.							
	Time Period for Coldays.	rrection: Twenty one	e (21)					
21510	MN Rule 4658.1200 SpecializedRehabili	O Subp. 2 A.B. itative Services; Prov	vision	21510				
	rehabilitative service resident's comprehenursing home must A. provide the requirements.	uired services; or ob om an outside sourc	e the tain the					
	This MN Requirements	ent is not met as evi	denced					

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	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPP IDENTIFICATION I			(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00321		B. WING		06/	27/2013
NAME OF F	PROVIDER OR SUPPLIER	ER OR SUPPLIER STREE		DRESS, CITY, S	STATE, ZIP CODE		
	N MEMORIAL HEALTI	HCARE CENTER	1010 SOI	JTH BIRCH K, 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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21510	Continued From page 13			21510			
	Based on observation, interview, and document review, the facility failed to provide specialized rehabilitative services to ensure wheelchair positioning was maintained for 1 of 3 residents (R9) reviewed for wheelchair positioning.						
	Findings include:						
	R9's diagnoses included dementia and status post stroke. The quarterly Minimum Data Set (MDS) dated 5/28/13, identified R9 with severe cognitive impairments and requiring extensive assistance with activities of daily living and total dependence upon the staff for transferring. R9 was not ambulatory. The plan of care dated 12/25/12, identified R9 as requiring an wheelchair for mobility while on the nursing unit. The plan was updated on 6/6/13,						
	wheelchair for mob	as to utilize a rock a lility.	na go				
	On 6/24/13, at 7:14 p.m. R9 was wheeled out of the dining room. He was seated in a Rock and Go wheelchair. (A Rock and Go chair is a wheelchair with a reclining seat that allows residents to rock back and forth like a rocking chair.) R9 was slightly reclined and R9's feet were not able to touch the floor while the chair was being wheeled. The chair was not observed to have foot pedals or any other device to support R9's feet while it was being wheeled out of the dining room.						
	the dining room by was positioned in a and Go chair and F floor as the chair w	a.m. R9 was wheelenursing assistant (Non upright position in R9's feet were draggias being pushed. Non the were dragging on	A)-F. R9 the Rock ng on the A-F				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPF IDENTIFICATION			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00321		B. WING		06/	27/2013
NAME OF F			STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 00/	
	N MEMORIAL HEALTH	HCARE CENTER	1010 SOL	JTH BIRCH K, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21510	so NA-F turned the chair around and pulled R9			21510			
	out of the dinning room backwards. R9's feet slid across the floor as R9 was pulled out of the room.						
	Review of the occupational therapy notes dated 1/15/13, indicated the therapy department had evaluated R9 for a wheelchair and had placed a new wheelchair cushion to ensure proper seating alignment while in the chair. The occupational therapy department had not been contacted prior to changing R9 into the Rock and Go wheelchair.						
	The Nurses Notes dated 6/6/13, indicated the staff had changed R9's wheelchair to a Rock and Go to provide better positioning while in the chair since he was no longer able to propel himself in						
	his room to the dini	a.m. R9 was wheelding room by NA-H. Fas he feet dangled in down the hallway.	R9 was in				
	dining room in a red	0 am. R9 was sitting clined position. R9's able to touch the floo	feet were				
	-C stated R9's when R9 had been placed wheelchair to enhal She stated R9 has and when he is possable to touch the flooccupational therapaware of placing R9 facility had not require the rapy department concerns related to chair. RN-C stated	5 a.m. registered nu elchair had been rend in the Rock and Gonce comfort and posteen very happy with itioned upright, R9's for. She stated the by department had be in the Rock and Goncested an evaluation to RN-C was not award R9's current Rock at the chair does have hositioning in the conditional control of the control of the chair does have the positioning in the conditional control of the chair does have the chair does h	noved and o itioning. In the chair feet are een made o but the by the are of any and Go foot				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPI IDENTIFICATION N			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00321		B. WING		06/	27/2013
NAME OF P	ROVIDER OR SUPPLIER	l	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1	
	I MEMORIAL HEALTI	HCARE CENTER		JTH BIRCH K, MN 56728	· }		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21510	Continued From pa	ige 15		21510			
	RN-C did not know where the pedals were located, but stated she could find them. On 6/26/13, at 12:40 p.m. R9 was wheeled to his room by NA-H. R9's feet were over 4 inches off of the floor dangling as he was assisted down the hallway. On 6/27/13, at 11:00 a.m. the occupational therapist stated she had not been made aware of any positioning concerns with R9 since 1/2013. She stated at that time R9 was using a standard wheelchair and had been given an alternative pressure redistribution cushion to ensure alignment in the chair. She stated the therapy department had not been contacted prior to changing R9 from the standard chair to the Rock and Go chair. She added the therapy department had received a wheelchair positioning referral on the morning of 6/27/13, and was going to re-evaluate R9's position.						
	SUGGESTED METHOD FOR CORRECTION: The DON and Rehabilitation Director could review and revise as necessary the policies and procedures related to wheel chair provisions, provide training for all appropriate staff on these policies and procedures and monitor to ensure residents receive adequate program services.						
	TIME PERIOD FOR Twenty-One (21) da						
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patient ac.Bill of Rights	s &	21805			
		us treatment. Patier					

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPI IDENTIFICATION			` ′	JLTIPLE CONSTRUCTION DING:		(X3) DATE SURVEY COMPLETED	
		00321				06/	27/2013	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY S	STATE, ZIP CODE	1 337	2172010	
	N MEMORIAL HEALTI	HCARE CENTER	1010 SOL	JTH BIRCH K, 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
21805	5 Continued From page 16			21805				
	courtesy and respect for their individuality by employees of or persons providing service in a health care facility.							
	This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure that each resident's dignity was maintained during 3 meal observations on the upper level of the facility. Staff was observed to scrape off dirty plates when residents were eating which had the potential to affect 24 residents residing on the upper level.							
	Findings include:							
		a.m. the upper leve						
	At 8:54 a.m. housekeeping staff member (HK)-A entered the dining room with a bus cart. The cart contained a tub to place dishes in, a container for silverware and bucket to hold the left over food items. HK-A walked to each of the tables cleaning the dishes and dumping the left over cereal, milk, juice or coffee into the bucket. Three residents were observed to be eating their meals while HK-A pushed the cart throughout the dining room. HK-A positioned the cart directly beside R9 as she scraped the left over food into the bucket while R9 ate his meal.							
	At 8:57 a.m. licensed practical nurse (LPN)-D stated the housekeeping staff usually clear the dining room while there are still residents eating in the room.							
	At 9:00 a.m. HK-A	stated she began cle	aring the					

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-	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEPLAY OF CORRECTION IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00321		B. WING		06/:	27/2013	
NAME OF F	OF PROVIDER OR SUPPLIER STREE			DRESS. CITY. S	STATE, ZIP CODE	1 30/1	-17-010	
	N MEMORIAL HEALTH	HCARE CENTER	1010 SOL	JTH BIRCH K, MN 56728				
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21805	05 Continued From page 17			21805				
	dining room when there were a few residents in the room still eating their meal. She confirmed she pushed the cart through the dining room while the residents were still eating.							
	On 6/26/13, at 12:46 p.m. HK-A entered the dining room with the bus cart in the upper dining room. She again began clearing the tables while residents were present in the dining room finishing their meal. At 12:47 p.m., HK-A walked over to R39, removed R39's plate, wiped off the table, picked up R39's glasses of juice and milk, wiped off the table and placed the liquids back on the table for R39 to finish. HK-A then walked away. R39 was observed to pick up her glass of juice and drink from it after HK-A had walked to the next table.							
	the dining room, co	wheeled the bus ca vered it and wheeled R39 continued to b g her liquids.	d it out of					
	On 6/26/13, at 1:46 p.m. the director of nurses stated she was not aware the residents in the upper level were still eating while the bus cart was wheeled throughout the dining room.							
	On 6/26/13, at 2:50 p.m. the dietary technician stated it is not preferred to use the bus cart in the dining room while the residents were still eating. She stated the staff could carry the dirty dishes out of the dining room, or wait until the residents were done eating prior to clearing the tables.							
	upper level dining reseated in the dining	3 p.m. HK-B entered oom. Two residents room eating their m cart as she wheeled	were eals.					

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	NT OF DEFICIENCIES OF CORRECTION	· /		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00321		B. WING		06/2	27/2013	
NAME OF P	ROVIDER OR SUPPLIER	•	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		.,	
KITTSON	N MEMORIAL HEALTH	HCARE CENTER		OUTH BIRCH CK, MN 56728				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21805	Continued From page 18			21805				
	bucket and placing appropriate contain around the dining resurvey staff in the rebus cart to the side cleared the remainidishes to the cart awere still eating. SUGGESTED MET director of nursing opolicies and proced assisted in the dinir conditions. The director of could educate all agent the processes. The	m scraping the disher the dirty dishes into the dirty dishes into the sers. HK-B cleared the common of the dining room and tables by carrying way for the residents. THOD OF CORRECTOR designee could deflures to ensure residing room under dignification of nursing or depropriate staff memory director of nursing or depropriate.	the ne dishes d the eled the and g the dirty s who FION: The evelop ents are ied esignee bers on or					
	TIME PERIOD FOR (21) Days	R CORRECTION: TV	venty-One					
21830	MN St. Statute 144 Residents of HC Fa		nts &	21830				
	Subd. 10. Particip notification of family	pation in planning tre y members.	atment;					
	in the planning of the includes the opport alternatives with incorportunity to requestare conferences, a family member or oboth. In the event to present, a family member or oboth.	Il have the right to paneir health care. This unity to discuss treat dividual caregivers, the st and participate in and the right to include the chosen represe that the resident can be ember or other represedent may be included	s right ment and ne formal de a ntative or not be esentative					

Minnesota Department of Health

STATE FORM R6V411 If continuation sheet 19 of 29

PRINTED: 07/10/2013 FORM APPROVED

Minnesota Department of Health

	IDENTIFICATION NU	ER/CLIA	` '	E CONSTRUCTION		SURVEY LETED
AND PLAN OF CORRECTION	IDENTIFICATION NO	IVIDER.	A. BUILDING:		COIVIE	LETED
	00321		B. WING		06/2	27/2013
NAME OF PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KITTSON MEMORIAL HEALTH	CARE CENTER		JTH BIRCH K, MN 56728			
(V4) ID SUMMARY STAT	EMENT OF DEFICIENCIE	9	ID	PROVIDER'S PLAN OF CORRECT	ION	(VE)
PREFIX (EACH DEFICIENCY I	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21830 Continued From pag	je 19		21830			
conferences. (b) If a resident who unconscious or communicate, the farefforts as required uneither a family member writing by the resident an emergency that the admitted to the facilities family member to paragraph, unless the to believe the resident directive to the contrappediffer in writing the member included in notifying a family member to paragraph, the facility efforts, consistent with practice, to determine executed an advance esident's health care this paragraph, "reast (1) examining the resident; (2) examining the resident in the posses (3) inquiring of any family member contamples and whether the resident directive and whether physician to whom the care; and	no enters a facility is atose or is unable to cility shall make reander paragraph (c) per or a person design as the person to the resident has beetly. The facility shall urticipate in treatment facility knows or hant has an effective a treatment planning. In the facility knows the remat they do not want treatment planning. In the prior to all urticipate in treatment must make reasonable medical records of the facility; and personal effects of medical records of the facility; and personal effects of the resident has a treatment planning. The personal effects of the facility; and personal effects of the resident has a treatment planning the personal effects of the facility; and personal effects of the facility; and personal effects of the resident has a treatment planning the physician to whome the personal effects of the resident normally the physician to whome the personal effects of the resident normally the physician to whome the personal effects of the resident normally the physician to whome the physician to whome the personal effects of the resident normally the physician to whome the physician to whome the personal effects of the resident normally the physician to whome the physician the physician to whome the physician th	asonable to notify ignated in contact in allow the at a family. After lowing a at able ical sto the rposes of ude: the the ct or ction dvance a / goes for the m, dvance ember or s a family				

PRINTED: 07/10/2013 FORM APPROVED

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER KITTSON MEMORIAL HEALTHCARE CENTER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH HALLOCK, MN 56728	STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			E CONSTRUCTION	(X3) DATE	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH			00221		B. WING		06/	7/2012
MITTSON MEMORIAL HEALTHCARE CENTER 1010 SOUTH BIRCH	NAME OF I		00321	CTDEET AD			00/2	27/2013
	NAME OF F	ROVIDER OR SUPPLIER				STATE, ZIF GODE		
	KITTSOI	N MEMORIAL HEALTI	HCARE CENTER			}		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOORS CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETE DATE
liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact by examining the personal effects of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency shall assist the facility in injumementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a resident the choice regarding her morning wake up time for 1	21830	liable to resident for the notification of the emergency contact family member was patient's privacy rig (c) In making reafamily member or of the facility shall attembers or a design examining the person and the medical reapossession of the facility a family memergency contact admission, the facility has been member or designate county social service agency that the rest the facility has been member or designate county social service and the member or designate of the facility in and notification and notification is not list damages on the graticipation of the or violated the patient of the patient	r damages on the grate family member or or the participation of improper or violated thts. Isonable efforts to not lesignated emergency or onal effects of the records of the resident acility. If the facility is ember or designated within 24 hours after ity shall notify the cocy or local law enforcident has been admin unable to notify a factled emergency contact agency and local law enforcements in implementing the able to the resident founds that the notific or emergency contact amily member was incoming the provided that the notific or emergency contact amily member was incoming the provided that the notific or emergency contact amily member was incoming the provided that the notific or emergency contact amily member was incoming the provided and the provide a resident is not met as evident is not met	of the d the otify a cy contact, y ontact by esident in the s unable or the unty cement tted and amily act. The aw illity in er or ty social t agency is or eation of ct or the improper of denced ocument sident the	21830			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		` ′	E CONSTRUCTION		E SURVEY PLETED
		00321		B. WING		06/	27/2013
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
				JTH BIRCH K, MN 56728			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE ' MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21830	Continued From page 21		21830				
	Findings include:						
	anxiety. The admiss 6/6/13, indicated the cognitive impairmen	d with osteoarthritis a sion Minimum Data e resident had mode nt. R78 required exte I mobility and transfe	Set dated erate ensive				
	was able to choose morning. R78 state	a.m. R78 was aske what time she woke d staff would get her would like to get up a	e up in the up at				
	back in bed with the her. At 7:09 am nur into the room and a up for breakfast. At R78 from the toilet	a.m. R78 was asleed privacy curtain pull sing assistant (NA)-isked R78 if she war 7:30 a.m. NA-A trarto the wheelchair with NA-A wheeled R7	ed around A went nted to get nsferred th a gait				
	(SSD)-A stated upo	p.m. social service on admission resider up anytime they wan vas not aware R78 v	nts were ited.				
	R78's room this a.n NA-A stated she as up and R78 stated she en NA-A stated she en because the night li had reported the re night. NA-A stated, nurses encourage to	stated when she went the resident was a ked R78 if she want she wanted to stay in a couraged R78 to get censed practical nursident did not sleep "We have a routine, us to get everybody ated, "I don't know went to the course of	asleep. ted to get n bed. tt up, rse (LPN) well at and the up for				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		, ,	E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		00321		B. WING		06/:	27/2013
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 00/-	
KITTSON	N MEMORIAL HEALTH	ICARE CENTER		JTH BIRCH K, MN 56728	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE ' MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21830	Continued From pa	ge 22		21830			
	would hurt to have I	her sleep in."					
	stated upon admiss what time they wou morning. RN-A stat	a.m. registered nursion residents were r ld like to get up in th ed the policy was rest st later if they wante	not asked e sidents				
	Residents are enco	ated QUALITY OF LIFE POLICY reads, ts are encouraged to make choices about of their life in the facility that are nt to them.					
	The DON or admini procedures related DON, or designee(s for all appropriate s centered care. The	THOD FOR CORRECT istrator could establito resident directed is) could provide an interfer on providing research, or designee(ach resident is persident is persident.	sh care. The n-service ident s) could				
	TIME PERIOD FOF (21) days.	R CORRECTION: T	wenty one				
21855	MN St. Statute 144. Residents of HC Fa		nts &	21855			
	residents shall have and privacy as it rel personal care progr consultation, exami confidential and sha Privacy shall be res bathing, and other a	nent privacy. Patients the right to respect ates to their medica ram. Case discussionation, and treatmentall be conducted discontected during toiletinactivities of personal or patient or residen	fulness I and on, nt are creetly. ng, hygiene,				

Minnesota Department of Health

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00204		B. WING		00/0	7/0010
		00321	0.000000 4.0		TATE TIP CORE	06/2	27/2013
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
KITTSON	N MEMORIAL HEALTH	HCARE CENTER		JTH BIRCH K, MN 56728	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21855	Continued From pa	ge 23		21855			
	assistance.						
	assistance.						
	by: Based on observati review, the facility for	ent is not met as ev on, interview and do ailed to ensure perso ined for 1 of 6 (R49) orning cares.	cument				
	Findings include:						
	Parkinson's disease Set (MDS) dated 3/ severe cognitive im	R49's diagnoses included Alzheimer's and Parkinson's disease. The quarterly Minimum Data Set (MDS) dated 3/26/13, indicated R49 had severe cognitive impairment and required extensive assistance with all activities of daily					
	•	ated 7/24/13, directed activities of daily livin					
	was observed to pla (BSC) next to R49's the bed onto the BS was observed awak privacy curtain betw 7:02 a.m. NA-E was pajama top, expose proceed to wash ar 7:08 a.m. NA-E was stand and hold onto NA-E was observed also dress R49's lot to have a conversar providing R49's mo R49's cares were c wheeled out of the	a.m. nursing assistance a bedside common bed and transfer R BC. R49's roommate we in bed. NA-E did reveen the two residents observed to remove R49's bare chest and dress R49's uppersobserved to assist to the bed rail. Once so the bed rail.	node 49 from e (R53) not pull the ts. At e R49's nd r body. At R49 to standing, care and observed NA-E was a.m. as ghout the				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		, ,	E CONSTRUCTION		E SURVEY PLETED
		00321		B. WING		06/	27/2013
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 00/	
	I MEMORIAL HEALTH	HCARE CENTER		JTH BIRCH K, MN 56728	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21855	Continued From pa	ige 24		21855			
	curtain between the two residents.						
		26/13, at 8:55 a.m. NA-E confirmed the cy curtain had not been closed during R49's nal cares.					
	-C verified it was th personal privacy du	0 p.m. registered nu e facility policy to pro iring cares. RN-C als should have been ut nal cares.	ovide so stated				
	policy dated 5/2011	M. Care (Early Morning Care) 11, directed the staff to "Screen nt for maximum privacy."					
	The Director of Nur could review and re and procedures reg privacy. The DON an in-service for all personal privacy wh resident. The DON	THOD FOR CORRECTION (DON) or designation as necessary the parding resident personal propriete staff on appropriate staff on a nile they cared for early or designee(s) couldent 's personal priving	nee(s) ne policies conal ld provide providing ich ld monitor				
	TIME PERIOD FOR days.	R CORRECTION: T	hirty (30)				
21980	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 3 Report Inerable Adults	ing -	21980			
	reporter who has revulnerable adult is lor who has knowled has sustained a physical reporter.	of report. (a) A mand eason to believe that being or has been m dge that a vulnerable ysical injury which is ed shall immediately	a altreated, adult not				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE		` '	E CONSTRUCTION		SURVEY PLETED
ANDELAN	OF CONNECTION	IDENTIFICATION NO	JWIDLIX.	A. BUILDING:		COM	LLILD
		00321		B. WING		06/2	27/2013
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 30/-	
				JTH BIRCH	,		
KITTSON	N MEMORIAL HEALTI	HCARE CENTER		K, MN 56728			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21980	Continued From pa	ige 25		21980			
	individual is a vulne the individual is adr reporter is not requ maltreatment of the to admission, unles		ecause mandated sted rred prior				
	another facility and believe the vulneral previous facility; or	as admitted to the fa the reporter has rea ble adult was maltrea knows or has reason	son to ated in the				
	that the individual is in section 626.5572 (b) A person not	s a vulnerable adult a 2, subdivision 21, cla required to report ur ection may voluntari	as defined use (4). nder the				
	as described above (c) Nothing in this known or suspected	e. s section requires a d maltreatment, if the	report of e reporter				
	been made to the o	on to know that a rep common entry point. s section shall preclure preporting to a law ent	ıde a				
	agency. (e) A mandated i	reporter who knows	or has				
	626.5572, subdivisi	nat an error under se ion 17, paragraph(c make a report under	;), clause				
	subdivision. If the i	reporter or a facility, an investigation by a	at any lead				
	the reported error v	ne or should determ vas not neglect acco ection 626.5572, sub	rding to				
	17, paragraph (c), of facility may provide	clause (5), the report to the common enti- agency information	er or ry point or				
	how the event mee 626.5572, subdivisi	ts the criteria under sion 17, paragraph (c)	section), clause				
		naking an initial disp					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			E CONSTRUCTION		E SURVEY PLETED
		00321		B. WING		06/:	27/2013
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	·	
KITTSOI	N MEMORIAL HEALTI	HCARE CENTER		JTH BIRCH K, MN 56728	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ΓΙΟΝ SHOULD BE ΤΗΕ APPROPRIATE	(X5) COMPLETE DATE
21980	Continued From pa	ige 26		21980			
	the report under su						
	by: Based on observati review, the facility f of unknown origin v to the appropriate S with State law for 1 reviewed. Findings include: R9's injury of unknoreported or investig R9's diagnoses includabetes mellitus ar significant change I dated 5/28/13, indice	ent is not met as eviction, interview and do ailed to ensure that a vere investigated and State agency in accordant of 1 resident (R9) in the state of 1 resident (R9) in a timely manually degeneration arth Minimum Data Set (Notated R9 had cognitivatived total assistancing.	cument all injuries d reported rdance cidents een ner. roke, iritis. The MDS) ve				
	and NA-G was obs morning cares. R9's was observed to be purple bruise by the NA-H stated the sw concern that she was eview of the Nurs 6/15/13, lacked do bruising of the second The Skin Observation indicated R9's 2nd	es Notes (NN) from cumentation related	ith left foot th a deep f the toe. vas a new 6/1/13 - to the /24/13, purple.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		` '	MULTIPLE CONSTRUCTION (X3) DATE S COMPL		
		00321		B. WING		06/2	27/2013
NAME OF F	ROVIDER OR SUPPLIER	•	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KITTSON	TISON MEMORIAL HEALTHCARE CENTER HALLOC			JTH BIRCH K, MN 56728	}		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES (ENCY)	ULD BE	(X5) COMPLETE DATE
21980	Continued From page 27			21980			
	updated on 6/24/13 toe as being bruise a tendency to kick a bed cradle (metal fi feet while in bed.) monitor R9's skin a The facility Incident include a report rela toe. On 6/26/13, at 11:5 -C verified she was swollen left, second have kicked the tab to how the bruise h she had reported th nursing (DON) and monitor the area. A the bruise was of ur report had not beer	OC) dated 12/25/12, indicated R9's left state. The POC indicate at things such as the rame that hold blank. The POC directed stand report changes. Reports for 6/2013, ated to R9's swollen aware of R9's bruised toe. RN-C stated Role legs but was not plad occurred. RN-C are bruise to the direct they both had concluditionally, RN-C conknown etiology, and completed and the peen investigated or	second ed R9 had table or a ets off of aff to did not bruised rse (RN) ed and 9 may positive as also stated tor of uded to infirmed incident cause of				
	On 6/26/13, at 1:00 p.m. the DON confirmed R9's red, swollen and bruised toe. The DON stated the facility was "quite sure" R9 had bumped his toe. The DON verified an incident report or investigation had not been completed. Additionally, the DON verified the injury of unknown source had not bee reported to the State agency as required.						
	doctors appointmen	a.m. RN-C stated R nt to evaluate the sec p.m. licensed practi	cond toe.				
		9's second toe was					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU					(X3) DATE SURVEY COMPLETED	
		00321		B. WING		06/:	27/2013	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE			
				JTH BIRCH C, MN 56728	3			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
21980	Continued From pa	ge 28		21980				
	was fractured and a begun an investigat	p.m. RN-C confirment this time, the facilition as to the cause of scheduled changes	ty had of the					
	The administrator, I designee(s) could r necessary the policithe internal process process of abuse of administrator, DON (s) could provide training on these policies are administrator, DON (s) could monitor to are being reported and the second sec	, social services or coassure all reports of	regarding gating the designee iate staff designee f abuse					

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