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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: R6V4

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245247**
2.STATE VENDOR OR MEDICAID NO.
(L2) **738745801**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 08/14/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **70** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective August 5, 2013, the facility is certified for 70 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 08/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/20/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/22/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 Leach

Colleen B. Leach, Program Specialist
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

MINNESOTA MDH DEPARTMENT OF HEALTH

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

Colleen Leach, Program Specialist
Licensing and Certification Program
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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245247	A. Building B. Wing	8/14/2013

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
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **08/05/2013**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **08/05/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **08/05/2013**
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **08/05/2013**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **08/05/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/05/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/05/2013**	ID Prefix **F0406** Reg. # **483.45(a)** LSC	Correction Completed **08/05/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/05/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/cbl	08/20/2013	28035	08/14/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/27/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245247	A. Building B. Wing **01 - MAIN BUILDING 01**	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
ID Prefix	Correction Completed **07/16/2013**	ID Prefix	Correction Completed **07/16/2013**	ID Prefix	Correction Completed **07/16/2013**
Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0033	
ID Prefix	Correction Completed **07/16/2013**	ID Prefix	Correction Completed **07/16/2013**	ID Prefix	Correction Completed **07/16/2013**
Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0066		Reg. # **NFPA 101** LSC K0076	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/cbl	08/20/2013	03006	08/06/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/26/2013			

MINNESOTA MDH DEPARTMENT OF HEALTH

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

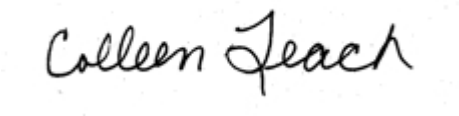
Dear Mr. Failing:

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
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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00321	A. Building B. Wing	8/14/2013

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 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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **08/05/2013**	ID Prefix **21000** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **08/05/2013**	ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **08/05/2013**
ID Prefix **21510** Reg. # **MN Rule 4658.1200 Subp.** LSC	Correction Completed **08/05/2013**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **08/05/2013**	ID Prefix **21830** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **08/05/2013**
ID Prefix **21855** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **08/05/2013**	ID Prefix **21980** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **08/05/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** LB/cbl	**Date:** 08/20/2013	**Signature of Surveyor:** 00321	**Date:** 08/14/2013
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/27/2013	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: R6V4

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245247**
2.STATE VENDOR OR MEDICAID NO.
(L2) **738745801**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/27/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **70** (L18)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
At the time of the Standard survey completed on June 27, 2013, the facility was not in compliance with Federal Certification Regulations. Please refer to the CMS 2567 along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Rebecca Haberle, HFE NEII — 07/29/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist — 08/22/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted
8/22/2013
ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

Remedies - 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;

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	06/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

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 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164		

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.

7-29-13 ok plw

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Richard J Tooley	CEO/Administrator	7/22/13

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

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F 164	Continued From page 1 The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained for 1 of 6 (R49) residents observed during morning cares. Findings include: 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 plan of care dated 7/24/13, directed staff to assist R49 with all activities of daily living. On 6/26/13, at 7:00 a.m. nursing assistant (NA)-E was observed to place a bedside commode (BSC) next to R49's bed and transfer R49 from the bed onto the BSC. R49's roommate (R53) was observed awake in bed. NA-E did not pull the	F 164	It is the policy of Kittson Memorial Healthcare Center that all resident's personal privacy is maintained. To assure compliance with this the staff that forgot to close the privacy curtain during survey was spoken to regarding the need to provide resident privacy at all times, the day the incident occurred. All of the resident's at KMHC have the potential to be affected if privacy is not provided. Staff will be instructed at a mandatory inservice on resident's right to privacy. 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 performed to ensure compliance. The results of the audits will be reviewed by the risk management team. Kim Anderson, DON responsible for compliance 8/5/13	

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F 164	Continued From page 2 privacy curtain between the two residents. At 7:02 a.m. NA-E was observed to remove R49's pajama top, expose R49's bare chest and proceed to wash and dress R49's upper body. At 7:08 a.m. NA-E was observed to assist R49 to stand and hold onto the bed rail. Once standing, NA-E was observed to provide perineal care and also dress R49's lower body. R53 was observed to have a conversation with NA-E while NA-E was providing R49's morning cares. At 7:20 a.m. R49's cares were completed and she was wheeled out of the double room. Throughout the observation, NA-E had not pulled the privacy curtain between the two residents. On 6/26/13, at 8:55 a.m. NA-E confirmed the privacy curtain had not been closed during R49's personal cares. On 6/26/13, at 12:10 p.m. registered nurse (RN) -C verified it was the facility policy to provide personal privacy during cares. RN-C also stated the privacy curtain should have been utilized during R49's personal cares. Review of the A.M. Care (Early Morning Care) policy dated 5/2011, directed the staff to "Screen and drape resident for maximum privacy."	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;	F 225		

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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 mon-itoring will be reviewed at facility Risk Management Meetings. SS and DON responsible for compliance	8/5/13

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F 225	Continued From page 4	F 225		

resident (R9, R4, R20) incidents reviewed.

Findings include:

R9's injury of unknown origin had not been reported or investigated 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.

Review of the Nurses Notes (NN) from 6/1/13 - 6/15/13, lacked documentation related to the bruising of the second 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."

The plan of care (POC) dated 12/25/12, and updated on 6/24/13, indicated R9's left second toe as being bruised. The POC indicated R9 had a tendency to kick at things such as the table or a bed cradle (metal frame that hold blankets off of feet while in bed.) The POC directed staff to monitor R9's skin and report changes.

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F 225	Continued From page 5	F 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.

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.

On 6/27/13, at 8:00 a.m. RN-C stated R9 had a doctors appointment 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.

On 6/27/13, at 1:43 p.m. RN-C confirmed the toe was fractured and at this time, the facility had begun an investigation as to the cause of the fracture. R9 had no scheduled changes in current treatment.

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F 225	Continued From page 6	F 225		

R4 was mistreating R20 and the facility failed to investigate and report the resident to resident altercations.

R4's diagnoses included low back pain, weakness, glaucoma and dementia. The MDS dated 4/10/13, indicated R4 had severe cognitive impairment.

R20's diagnoses included altered mental status, dementia, osteoarthritis and a stroke. The quarterly MDS dated 5/14/13, indicated R20 was moderately cognitively impaired.

The Nursing Assistant (NA) note dated 5/4/13, at 5:00 - 6:00 p.m. indicated R20 started spitting at R4.

The NA note dated 5/7/13, [untimed] indicated R20 was pushing and ramming R4 into the linen room door, pinching R4's arm and hand between the door and the wheelchair.

The NN dated 5/18/13, at 5:30 p.m. indicated R20 was found feeding R4 at the supper table. The note also indicated R4 was crying and saying, "No, I'm not hungry, I don't want it."

The NA note dated 5/18/13, at 6:00 p.m. indicated R20 was in the dining room trying to force feed R4 while R4 was crying and telling R20 no. The note further indicated when R4 said, "No, " R20 shoved a fork full of green beans in her mouth. The note indicated R20 was removed from the dining room and when R20 saw R4 she

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F 225	Continued From page 7	F 225		

had made a "beeline" right for her and tried to push her to her room.

The NA note dated 5/24/13, [untimed] indicated R20 wheeled herself to R4's table and attempted to feed her.

The NA note dated 5/29/13, [untimed] indicated R20 tried to feed R4. The note also indicated R20 focused on R4 throughout the day making R4 very uncomfortable.

The NN dated 6/9/13, at 9:30 a.m. indicated R20 had made R4 her concern, trying to force feed R4 and pushed R4 into doors and walls.

The NA note dated 6/11/13, [untimed] indicated during lunch R20 would not leave R4 alone. The note indicated R20 was trying to physically push R4 in her chair and also tried taking the brakes off of R4's chair. The note also indicated R4 had verbally stated she did not want any help. Additionally, R20 had attempted to massage R4's legs. The note indicated R4 had asked to leave the dining room.

The NA note dated 6/24/13, at 9:30 a.m. indicated R20 was attempting to push R4's wheelchair near the front desk.

R4's NN and NA notes from 3/12/13, to 6/26/13, lacked documentation of the interactions between R4 and R20.

R20's Resident Care Sheet indicated R20 should not be left alone with R4.

R4's Resident Care Sheet indicated R4 should

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F 225	Continued From page 8	F 225		

not be left alone with R20.

On 6/27/13, at 12:51 p.m. registered nurse (RN) -B verified she was aware of the ongoing incidents between R20 and R4, however didn't know if this would be something that would be reportable.

On 6/27/13, at 2:10 p.m. NA-B and NA-C both revealed that on several occasions they have witnessed R20 trying to force feed R4. NA-B stated R20 seems to target R4 for some reason and that R4 has told NA-B that it really bothers her.

On 6/27/13, at 2:20 p.m. NA-D stated she has witnessed R20 force feeding R4. NA-D also felt this was bothersome to R4. NA-A, NA-B, and NA-C all revealed this happens at least once week and that the charge nurses where aware of the behavior.

On 6/27/13, at 1:10 p.m. DON stated she was aware of the ongoing incidents between R20 and R4. She stated she would only report this as a resident to resident altercation if there was an injury, however, stated resident to resident altercations should be investigated.

On 6/27/13, at 2:50 p.m. administrator confirmed resident to resident altercations should be investigated and reported.

On 6/27/13, at 3:07 p.m. social worker designee (SSD)-A and SSD-B confirmed resident to resident altercations should be investigated and reported.

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F 225	Continued From page 9	F 225		

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 State 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.

Review of the reported abuse concerns reported in the past year, revealed the facility had notified the State Agency immediately of the concerns.

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F 225	Continued From page 10 On 6/26/13, at 1:50 p.m. the SSD-A and SSD-B were interviewed. They reported that over a year ago, they had been made aware of the immediate notification of the State Agency regarding any potential abuse concerns. They confirmed the facility had been notifying the State immediately, but they had not updated the policy to reflect the changes. They confirmed the policy still incorrectly directed the staff to report within 24 hours and the staff had not received education regarding the immediate notification. On 6/27/13, at 8:10 a.m. the facility administrator confirmed he was notified immediately of any allegations of abuse or maltreatment and the State Agency was also notified of the concerns. He verified neither the altercations between R4 and R20 along with R9's fractured toe had not been reported to the State Agency.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement policies and procedures regarding alleged violations of mistreatment, abuse or neglect, including injuries of unknown origin for 3 of 6 resident (R9, R4, R20) incidents reviewed.	F 226		

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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	

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Review of the reported abuse concerns reported in the past year, revealed the facility had notified the State Agency immediately of the concerns.

On 6/26/13, at 1:50 p.m. the social service designees (SSD)-A and SSD-B were interviewed. They reported that over a year ago, they had been made aware of the immediate notification of the State Agency regarding any potential abuse concerns. They confirmed the facility had been notifying the State immediately, but they had not updated the policy to reflect the changes. They confirmed the policy still incorrectly directed the staff to report within 24 hours and the staff had not received education regarding the immediate notification.

R9's injury of unknown origin had not been reported or investigated in a timely manner.

R9's diagnoses included depression, status post stroke, diabetes mellitus and degeneration arthritis. The significant change Minimum Data Set (MDS) dated 5/28/13, identified R9 with cognitive impairments and requiring total assistance with all activities of daily living.

On 6/26/13, at 8:10 a.m. nursing assistant (NA)-H and NA-G assisted R9 with morning cares. During the cares R9's left foot was observed. The second toe was red, swollen and had deep purple bruising by the nail and the base of the toe. NA-H stated she had worked the previous weekend and had not noted any concerns with the 2nd toe. She stated the swelling and bruising was a new concern.

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Review of the Nurses Notes (NN) from 6/1/13 -6/15/13 (most current notes) lacked documentation related to the bruising of the second toe.

The Skin Observation Charting dated 6/24/13, identified the 2nd toe as being swollen and purple. The cause of the bruise was noted as: "unknown how."

Review of the plan of care dated 12/25/12, included an update dated 6/24/13, identified the left second toe as being bruised. The plan of care explained R9 had a tendency to kick at things such as the table or a bed cradle (metal frame that hold blankets off of feet while in bed.) The plan directed the staff to monitor R9's skin and report changes.

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 stated she was aware of the left second toe being bruised and swollen. She stated R9 may have kicked the table legs but she was not positive as to how the toe had become bruised. She stated she had reported the bruise to the director of nursing (DON) and they had determined to monitor the area She 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.

On 6/26/13, at 1:00 p.m. the DON stated the facility was "quite sure" R9 had bumped his toe. She explained R9 had a history of kicking out

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during cares and did not find a report of R9's bruised toe concerning. The DON then observed R9's toe. The DON confirmed R9's toes was red, swollen and bruised. The DON attempted to interview R9. R9 was not able to explain what happened to the toe. The DON asked licensed practical nurse (LPN)- D when she had noticed the bruise. LPN-D reported it had been noticed on 6/24/13, and reported to the unit manager (RN-C). The DON confirmed the bruised toe had not been reported to the State Agency.

On 6/27/13, at 8:00 a.m. RN-C stated R9 had a doctors appointment 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.

On 6/27/13, at 1:43 p.m. RN-C confirmed the toe was fractured, the facility had begun an investigation as to the cause of the fracture and at this time, R9 had no scheduled changes in current treatment.

R4 had been mistreated by R20 and the incident was not investigated or reported to the State agency.

R4's diagnoses included low back pain, weakness, glaucoma and dementia. The MDS dated 4/10/13, identified R4 as being severely cognitively impaired.

R20's diagnoses included altered mental status, dementia, osteoarthritis and a cerebral vascular accident (stroke). The quarterly MDS dated

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5/14/13, identified R20 as being moderately cognitively impaired.

The facility's Vulnerable Adult (VA) policy dated 7/27/10, identifies possible incidents or allegations which need to be assessed to include any event to a patient such as bruising, emotional trauma, shoving, handling in a rough manner, verbal abuse and occurrence patterns and trends. The VA policy also identifies indications of maltreatment of a VA to include any event or circumstance which a reasonable person could consider as maltreatment. The VA policy directs staff to report all suspected maltreatment to their supervisor immediately. After reporting internally, there would be an investigation. The internal review team may consist of the administrator, director of nursing (DON), social services, supervisor and any other staff deemed appropriate. The investigation would consist of interviewing appropriate staff and patient involved in the incident; decide on a safety plan as needed; gather information on the perpetrator; document the description of the maltreatment and decide if the incident requires a report to the State agency.

Nursing assistant (NA) note dated 5/4/13, 5:00 - 6:00 p.m. indicated R20 started spitting at R4.

NA note dated 5/7/13, [untimed] revealed R20 was pushing R4, ramming her into the linen room door, pinching R4's arm and hand between the door and the wheelchair.

NN dated 5/18/13, at 5:30 p.m. indicated R20 was found feeding R4 at the supper table. R4 was crying and saying, " No, I'm not hungry, I

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don't want it. "

NA note dated 5/18/13, at 6:00 p.m. indicated R20 was in the dining room trying to force feed R4. R4 was crying and telling R20, "No." When R4 said no, R20 shoved a fork full of green beans in her mouth. R20 was removed from the dining room. When R20 saw R4 she made a "beeline" right for her and tried to push her to her room.

NA note dated 5/24/13, [untimed] indicated R20 wheeled herself to R4's table and attempted to feed her.

NA note dated 5/29/13, [untimed] indicated R20 tried to feed R4. R20 focuses on R4 throughout the day making R4 very uncomfortable.

NN dated 6/9/13, at 9:30 a.m. indicated R20 has made R4 her concern, trying to force feed R4 and pushes R4 into doors and walls.

NA note dated 6/11/13, [untimed] indicated during lunch R20 would not leave R4 alone. R20 was trying to physically push R4 in her chair and tried taking the brakes off of R4's chair. R4 verbally stated she did not want any help. R20 was attempting to massage R4's legs. R4 asked to leave the dining room.

NA note dated 6/24/13, at 9:30 a.m. indicated R 20 was attempting to push R4's wheelchair when she was by the front desk.

R4's NN and NA notes from 3/12/13, to 6/26/13, lacked documentation of the interactions between R4 and R20.

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R20's Resident Care Sheet indicated R20 should not be left alone with R4.

R4's Resident Care Sheet indicated R4 should not be left along with R20.

On 6/27/13, at 12:51 p.m. RN-B verified she was aware of the ongoing incidents between R20 and R4, however, did ' not know if this would be something that would be reportable.

On 6/27/13, at 2:10 p.m. NA-B and NA-C both revealed that on several occasions they have witnessed R20 trying to force feed R4. NA-B stated R20 seems to target R4 for some reason and that R4 has told NA-B that it really bothers her.

On 6/27/13, at 2:20 p.m. NA-D stated she has witnessed R20 force feeding R4. NA-D also felt this was bothersome to R4. NA-A, NA-B, and NA-C all revealed this happens at least once week and that the charge nurses where aware of the behavior.

On 6/27/13, at 1:10 p.m. DON stated she was aware of the ongoing incidents between R20 and R4. She stated she would only report this as a resident to resident altercation if there was an injury, however, stated resident to resident altercations should be investigated.

On 6/27/13, at 2:50 p.m. administrator confirmed resident to resident altercations should be investigated and reported.

On 6/27/13, at 3:07 p.m. SSD-A and SSD-B confirmed resident to resident altercations should

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F 226	Continued From page 18 be investigated and reported. On 6/27/13, at 8:10 a.m. the facility administrator confirmed he was notified immediately of any allegations of abuse or maltreatment and the State Agency was also notified of the concerns. He verified neither the altercations between R4 and R20 along with R9's fractured toe had not been reported to the State Agency	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation 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	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 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.	8/5/2013

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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 clearing the 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.

At 12:50 p.m. HK-A wheeled the bus cart out of the dining room, covered it and wheeled it out of the upper level unit. R39 continued to be sitting at her table drinking her liquids.

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F 241	Continued From page 20 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. On 6/27/13, at 12:53 p.m. HK-B entered the upper level dining room. Two residents were seated in the dining room eating their meals. HK-B used the bus cart as she wheeled the cart throughout the room scraping the dishes into the bucket and placing the dirty dishes into the appropriate containers. HK-B cleared the dishes around the dining room until she noticed the survey staff in the room. She then wheeled the bus cart to the side of the dining room and cleared the remaining tables by carrying the dirty dishes to the cart away for the residents who were still eating.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.	F 242		

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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 inter-viewable 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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F 242	Continued From page 22 R78's room this a.m. the resident was asleep. NA-A stated she asked R78 if she wanted to get up and R78 stated she wanted to stay in bed. NA-A stated she encouraged R78 to get up, because the night licensed practical nurse (LPN) had reported the resident did not sleep well at night. NA-A stated, "We have a routine, and the nurses encourage us to get everybody up for breakfast." NA-A stated, "I don't know why it would hurt to have her sleep in." On 6/27/13, at 9:15 a.m. registered nurse (RN)-A stated upon admission residents were not asked what time they would like to get up in the morning. RN-A stated the policy was residents could have breakfast later if they wanted to sleep in. The undated QUALITY OF LIFE POLICY reads, Residents are encouraged to make choices about aspects of their life in the facility that are significant to them.	F 242	SSD, LaDonna Truedson and DON Kim Anderson will be responsible for compliance. 8/5/13	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement wheelchair	F 323	It is the policy of KMHC to ensure that the resident's enviroment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents. This has the potential to affect all residents transported via wheelchair. To assure compliance OT screened the resident involved for proper w/c leg use. OT recommendations were added to the resident's care plan. A policy and procedure (continued)	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 23 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. 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 get caught on the floor five times. Three of the five times 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 seated in the wheelchair without leg rests. On 6/26/13, at 8:00 a.m. nursing assistant (NA)-K	F 323	was developed on the use of adaptive equipment on wheelchairs. Staff will be trained on the policy 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 monthly to ensure all residents are receiving appropriate care. These audits will be reviewed at our facility Risk Management Meetings. DON responsible for compliance.	8/5/13

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was observed wheeling R21 from her room to the dining room. R21 was observed wearing shoes with a rubber sole. R21's feet were observed to catch the floor twice. NA-K reminded R21 to hold her feet up. R21 stated she had difficulty holding her feet up.

On 6/26/13, at 11:19 a.m. NA-B verified R21 required staff assistance with wheelchair mobility to all destinations. NA-B stated R21 did not utilize leg rests.

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.

At 10:56 a.m. the occupational therapist (OT) verified leg rests were to be utilized for any resident who required staff assistance with wheelchair mobility. The OT stated her fear without using leg rests was a resident getting their foot caught on the floor which could cause an injury. The OT also stated if a resident did not use leg rests and was having difficulty holding their feet up during transportation she would expect staff to request a wheelchair leg rest screen in order to properly fit a resident with leg rests. Additionally, the OT stated she would expect a screening request the first time a residents foot got caught on the floor. The OT verified she had not received a leg rest screening request for R21.

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F 323	Continued From page 25 At 11:06 a.m. the OT was observed to retrieve R21's leg rests from R21's closet, wipe the dust off them, apply them to R21's wheelchair and adjust them for proper fit. At 12:54 p.m. registered nurse (RN)-A stated she did not believe R21 could safely hold her feet up during wheelchair transportation of great distance. RN-A also stated R21 was at risk for injury without the use of the leg rests. At 1:27 p.m. the director of nursing (DON) stated if a resident was unable to safely hold their feet up during wheelchair transportation, even just once, leg rests should be used. The DON verified the facility did not have a policy and procedure related to safe wheelchair transportation or the use of legs rests.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to distribute and serve food under sanitary conditions related to improper food handling of bread which had the potential to	F 371	It is the policy of KMHC to store, prepare and distribute food under sanitary conditions. This has the potential to affect all residents of KMHC. The Dietary Manager immediately wrote in her communication book on the proper way to handle bread when she was informed of the deficient practice and other staff were notified via memo. The Dietary Manager will educate her staff, the activity staff and nursing staff on serving food in a sanitary manner at a mandatory inservice. The staff meeting will be taped. Staff not able to attend will be provided with the written material (continued)	

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F 371	Continued From page 26 affect 67 residents residing in the facility. In addition, the facility failed to ensure the microwave were clean in the upper level kitchenette which had the potential to affect 24 residents residing on the upper level of the facility. Findings include: On 6/26/13, at 8:06 a.m. during the breakfast meal observation on the lower level, dietary aide (DA)-A was observed to butter 4 slices of toast with her hands and then carried the toast to the steam table. She then placed a half a piece of toast on a plate with a tong. At 8:10 a.m. DA-A stated she knew she could not 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	F 371	for the inservice and will view the presentation on the recorded DVD. Audits will be held on proper serving techniques. A policy and procedure has been developed on the cleaning of the facility microwaves and a daily cleaning schedule has been set up. A memo has been posted on the microwaves reminding staff to wipe up splatters in the microwave immediately when soiled. Staff will be educated on this 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 to ensure compliance. These audits will be reviewed at our facility Risk Management Meetings. DON and Dietary Manager responsible for compliance	8/5/2013

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cleaning of the microwave every Sunday. The manager stated she did not have a cleaning policy related to the microwave.

On 6/24/13, at 4:43 p.m. the evening meal was served in the upper level dining room for the 24 residents residing in the unit. The dietary staff member severed the main meal items from the steam table located in the kitchenette. The dietary staff handed the plates to the nursing and activity staff members who added condiment and bread to the plates. The nursing and activity staff wore gloves while dishing the meals. The following observations were noted:

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 she delivered the plate, she was observed to touch the table, the resident and her uniform with her gloved hands. She then returned to the kitchenette window and received a second plate of for another resident. AA-A was observed to use the same gloved hand to pick up a slice of bread for the second resident.
At 4:46 p.m. nursing assistant (NA)-N donned gloves and received a plate for the dietary staff. NA-N used her gloved hand to pick up the bread and delivered the plate to a resident. NA-N moved the residents drinking glasses, arranged the table items and served the plate to the resident. NA-N was not observed to change her gloves as she received the second plate of food, picked up the bread with her dirty gloves.

At 4:47 p.m. AA-B donned gloves and assisted a

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resident with applying a clothing protector, AA-B then walked to the kitchenette window, received a plate of food and used the same gloved hand to pick up bread for a resident and delivered it to a second resident.

At 4:47 p.m. AA-A returned to the kitchenette window, AA-A was not observed to change her gloves prior to picking up bread with her gloved hand and delivering the meal to a resident.

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 staff were observed to consistently use the fork to pick up the bread from the kitchenette window.

On 6/26/13, at 8:35 a.m. NA-H was observed to assist R9 to the dining room by pushing the wheelchair. At 8:40 a.m. NA-H was entered the upper level kitchenette to prepare breakfast for R9. NA-H used her bare unwashed hands to remove bread from a bag and place it in the toaster. At 8:41 a.m. NA-H opened the door to the kitchenette, carried a bowl of cereal to R9, returned to the kitchenette, used a key to open the door and removed the toast from the toaster. She used her unwashed bare hand to hold the toast as applied butter, opened the door and served it to R9. NA-H was not observed to wash

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F 371	Continued From page 29 her hand prior to directly touching R9's bread.	F 371		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: 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, and indicated R9 was to utilize a rock and go	F 406		

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F 406	Continued From page 30 wheelchair for mobility. 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. On 6/25/13, at 9:24 a.m. R9 was wheeled out of the dining room by nursing assistant (NA)-F. R9 was positioned in an upright position in the Rock and Go chair and R9's feet were dragging on the floor as the chair was being pushed. NA-F noticed that R9's feet were dragging on the floor so NA-F turned the chair around and pulled R9 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 On 6/26/13, at 8:37 a.m. R9 was wheeled from	F 406	It is the policy of KMHC that if specialized services rehabilitative services such as physical therapy, occupational therapy are required in resident's comprehensive plan of care, the facility must provide the required services. This has the potential to affect all residents of KMHC. The resident involved was evaluated for proper w/c positioning by OT and adjustments made. A policy will be developed related to w/c positioning and staff will be educated 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 to ensure all residents have the proper adaptive devices in place. These audits will be reviewed at facility Risk Management Meetings. DON responsible for compliance	8/5/2013

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his room to the dining room by NA-H. R9 was in a reclining position as he feet dangled in the air while being wheeled down the hallway.

On 6/26/13, at 11:30 am. R9 was sitting in the dining room in a reclined position. R9's feet were not observed to be able to touch the floor.

On 6/26/13, at 11:45 a.m. registered nurse (RN) -C stated R9's wheelchair had been removed and R9 had been placed in the Rock and Go wheelchair to enhance comfort and positioning. She stated R9 has been very happy with the chair and when he is positioned upright, R9's feet are able to touch the floor. She stated the occupational therapy department had been made aware of placing R9 in the Rock and Go but the facility had not requested an evaluation by the therapy department. RN-C was not aware of any concerns related to R9's current Rock and Go chair. RN-C stated the chair does have foot pedals to assist with positioning in the chair. 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

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F 406	Continued From page 32 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.	F 406	It is the policy of KMHC to handle, store, process and transport linens so as to prevent the spread of infection. This has	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	the potential to affect all residents of KMHC. Laundry immediately discontinued the laundering of the cushions and a memo was posted that they should be covered and thrown if heavily soiled. New 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 cushions. Staff will be educated on the policy 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 of the condition of w/c cushions will be done to ensure compliance. These audits will be reviewed at facility Risk Management	

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F 441	Continued From page 33 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow manufacturer's recommendations for the cleaning of foam wheelchair cushions for 4 of 4 (R49, R45, R44, R60) residents observed with soiled cushions. This had the potential to affect 25 residents on the upper and lower level. Findings include: During observations of the upper level dining room on 6/24/13, at 5:00 p.m. several of the residents were observed to be sitting on four inch thick foam wheelchair cushions. The cushions 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	F 441	Meetings. Housekeeping Supervisor, Pam Ingeman will be responsible for compliance	8/5/2013

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wheelchair.

On 6/25/13, at 2:31 p.m. R49 was observed sitting in her wheelchair in the dining room. The wheelchair was equipped with a four inch foam cushion. The cushion was observed to have stains along the front edges which were purple in color.

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.

R45's diagnoses included Alzheimer's dementia and diabetes. The significant change MDS dated 5/14/13, identified R45 with severe cognitive impairments and as being totally dependant upon staff for all activities of daily living. The plan of care dated 5/28/13, directed the staff to provide a pressure relief cushion on her wheelchair.

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.

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F 441	Continued From page 35	F 441		

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.

Review of the undated MediChoice Pressure Relief Cushion (manufacture instructions) stated: "Easy Care - Clean the cushion cover with a germicidal cleaning solution or soap and water. Do not use bleach or launder."

On 6/26/13, at 11:29 a.m. director of nursing (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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	06/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 36 On 6/27/13, at 11:02 a.m. DON confirmed the facility currently had 25 foam wheelchair cushions being used by residents.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/26/2013**

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

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K 000	INITIAL COMMENTS	K 000		

DC: 08.06.2013

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

EXIT: 06.27.2013

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

Or by email to:

RECEIVED
JUL 29 2013
MINNESOTA DEPARTMENT OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

POC ok
7-29-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Richard M Taylor — TITLE: CEO/Administrator — (X6) DATE: 7/22/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/26/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Kittson Memorial Hospital C & NC is made up of two buildings. The original building is north of and separated from, with a 2-hour fire barrier, the Kittson Memorial Hospital building. It is 1-story with a basement and was constructed in 1968. It was determined to be of Type II(000) construction and is now fully sprinkler protected and is called the upper level. In 1981 an addition was built to the north of the original building, is a 1-story building without a basement. It was determined to be of Type V (111) construction, is fully sprinkler protected and is separated with at least a 2-hour fire barrier from the original building and is called the Lower Level. The buildings are divided into 8 smoke zones. The facility is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke	K 000		

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	245247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/26/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 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 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core 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.	K 018	Lower level dining room doors and room 48 door were adjusted to insure proper latching. Monitoring of proper door closure will be conducted by Terry Anderson, Maintenance Manager 7/16/2013	

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	245247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/26/2013**

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K 018	Continued From page 3	K 018		

This STANDARD is not met as evidenced by:
Observations showed that three of fifty corridor doors tested did not comply with NFPA 101 "The Life Safety Code" 2000 Edition Section 19.3.6.3. If corridor doors do not positively latch a fire could spread beyond the room of origin and would negatively impact 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 and tests of corridor doors by surveyor 03006, revealed that
1) The lower dining room doors did not close completely and latch, and
2) The latch to room 48 was stuck in the door and did not hold the door tightly closed.

The Director of Maintenance verified these findings during the facility tour and during the exit conference.

K 029 SS=F — NFPA 101 LIFE SAFETY CODE STANDARD — K 029

One hour fire rated construction (with ¾ 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

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	245247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/26/2013**

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

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K 029	Continued From page 4 48 inches from the bottom of the door are permitted. 19.3.2.1 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 029	Storage Room door was adjusted to insure proper latching. Monitoring of proper door closure will be conducted by Terry Anderson, Maintenance Manager 7/16/2013	
K 033 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 033		

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K 033	Continued From page 5 This STANDARD is not met as evidenced by: Observations revealed that one of four stairway 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 033	Upper Level stairway door was adjusted to insure proper latching, Monitoring of proper latching will be conducted by Terry Anderson, Maintenance Manager 7/16/13	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 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	K 062		

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K 062	Continued From page 6 automatic fire sprinkler system could affect all residents, staff and visitors of the facility, if the sprinkler system fails to function properly in a fire emergency. Findings include: During the facility tour on June 26, 2013, between 10:35 am and 12:15 pm, observations by 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.	K 062	Escutcheon rings have been ordered to replace the ones missing. Rings will be installed upon receipt. Spare sprinkler head box has been attached to the wall and filled with two types and temperature heads. Monitoring of Escutcheon rings and sprinkler head box will be conducted by Terry Anderson, Maintenance Manager. 7/16/2013	
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (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	K 066	"No Smoking/Oxygen In Use" and "No Smoking Within 10 Feet Of This Area" signs have been ordered and will be installed upon receipt. Monitoring of signs will be conducted by Terry Anderson, Maintenance Manager 7/16/13	

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	245247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/26/2013**

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K 066	Continued From page 7 direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: An interview with the Director of Maintenance and observations revealed that the facility staff are not properly posting NO SMOKING Oxygen in Use, signs in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code" (LSC) 2000 edition, Section 19.7.4. This deficient practice could negatively affect all residents, staff and visitors of the facility by allowing a fire to occur. 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: 1) Rooms 106 and 120 had oxygen in use and no signs on the doors (No Smoking Oxygen In Use) nor are all of the major entrances into the facility are marked No Smoking Oxygen in Use, and 2) The outdoor smoking area is within 10 feet of	K 066		

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K 066	Continued From page 8 the emergency generator's fuel tank. The Director of Maintenance verified these findings during the facility tour and during the exit conference.	K 066		
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 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.	K 076	Full oxygen tanks were removed from Lower Level west storage room and placed in the east storage room. All oxygen tanks will be at least five feet from combustibles. Compliance will be monitored by Terry Anderson, Maintenance Manager. 7/16/13	

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K 076	Continued From page 9 The Director of Maintenance verified this finding during the facility tour and during the exit conference.	K 076		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00321	A. BUILDING: _____ B. WING _____	06/27/2013

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 6/24/13 - 6/27/13, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00321	A. BUILDING: _____ B. WING _____	06/27/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Certification Program; 705 5th St. N.W., Suite A, Bemidji, MN 56601-2933	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet;	2 915		

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2 915	Continued From page 2 (4) eat; and (5) use speech, language, or other functional communication 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. 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 get caught on the floor five times. Three of the five times R21's feet was observed to partially go under the wheelchair	2 915		

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2 915	Continued From page 3 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 seated in the wheelchair without leg rests. On 6/26/13, at 8:00 a.m. nursing assistant (NA)-K was observed wheeling R21 from her room to the dining room. R21 was observed wearing shoes with a rubber sole. R21's feet were observed to catch the floor twice. NA-K reminded R21 to hold her feet up. R21 stated she had difficulty holding her feet up. On 6/26/13, at 11:19 a.m. NA-B verified R21 required staff assistance with wheelchair mobility to all destinations. NA-B stated R21 did not utilize leg rests. 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. At 10:56 a.m. the occupational therapist (OT) verified leg rests were to be utilized for any resident who required staff assistance with wheelchair mobility. The OT stated her fear without using leg rests was a resident getting their foot caught on the floor which could cause an injury. The OT also stated if a resident did not use leg rests and was having difficulty holding their	2 915		

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2 915	Continued From page 4 feet up during transportation she would expect staff to request a wheelchair leg rest screen in order to properly fit a resident with leg rests. Additionally, the OT stated she would expect a screening request the first time a residents foot got caught on the floor. The OT verified she had not received a leg rest screening request for R21. At 11:06 a.m. the OT was observed to retrieve R21's leg rests from R21's closet, wipe the dust off them, apply them to R21's wheelchair and adjust them for proper fit. At 12:54 p.m. registered nurse (RN)-A stated she did not believe R21 could safely hold her feet up during wheelchair transportation of great distance. RN-A also stated R21 was at risk for injury without the use of the leg rests. At 1:27 p.m. the director of nursing (DON) stated if a resident was unable to safely hold their feet up during wheelchair transportation, even just once, leg rests should be used. The DON verified the facility did not have a policy and procedure related to safe wheelchair transportation or the use of legs rests. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with adaptive equipment on wheelchairs. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are utilizing the adaptive equipment properly and are receiving appropriate care.	2 915		

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2 915	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	2 915		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to distribute and serve food under sanitary conditions related to improper food handling of bread which had the potential to affect 67 residents residing in the facility. In addition, the facility failed to ensure the microwave were clean in the upper level kitchenette which had the potential to affect 24 residents residing on the upper level of the facility. Findings include: On 6/26/13, at 8:06 a.m. during the breakfast meal observation on the lower level, dietary aide (DA)-A was observed to butter 4 slices of toast with her hands and then carried the toast to the steam table. She then placed a half a piece of toast on a plate with a tong. At 8:10 a.m. DA-A stated she knew she could not	21000		

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21000	Continued From page 6 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. On 6/24/13, at 4:43 p.m. the evening meal was served in the upper level dining room for the 24 residents residing in the unit. The dietary staff member severed the main meal items from the steam table located in the kitchenette. The dietary staff handed the plates to the nursing and activity staff members who added condiment and bread to the plates. The nursing and activity staff wore gloves while dishing the meals. The following observations were noted: 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	21000		

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21000	Continued From page 7 she delivered the plate, she was observed to touch the table, the resident and her uniform with her gloved hands. She then returned to the kitchenette window and received a second plate of for another resident. AA-A was observed to use the same gloved hand to pick up a slice of bread for the second resident. At 4:46 p.m. nursing assistant (NA)-N donned gloves and received a plate for the dietary staff. NA-N used her gloved hand to pick up the bread and delivered the plate to a resident. NA-N moved the residents drinking glasses, arranged the table items and served the plate to the resident. NA-N was not observed to change her gloves as she received the second plate of food, picked up the bread with her dirty gloves. At 4:47 p.m. AA-B donned gloves and assisted a resident with applying a clothing protector, AA-B then walked to the kitchenette window, received a plate of food and used the same gloved hand to pick up bread for a resident and delivered it to a second resident. At 4:47 p.m. AA-A returned to the kitchenette window, AA-A was not observed to change her gloves prior to picking up bread with her gloved hand and delivering the meal to a resident. 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 staff were observed to	21000		

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21000	Continued From page 8 consistently use the fork to pick up the bread from the kitchenette window. On 6/26/13, at 8:35 a.m. NA-H was observed to assist R9 to the dining room by pushing the wheelchair. At 8:40 a.m. NA-H was entered the upper level kitchenette to prepare breakfast for R9. NA-H used her bare unwashed hands to remove bread from a bag and place it in the toaster. At 8:41 a.m. NA-H opened the door to the kitchenette, carried a bowl of cereal to R9, returned to the kitchenette, used a key to open the door and removed the toast from the toaster. She used her unwashed bare hand to hold the toast as applied butter, opened the door and served it to R9. NA-H was not observed to wash her hand prior to directly touching R9's bread. SUGGESTED METHOD OF CORRECTION: The Director of Dietary Services could develop a policy and procedure to ensure that food was served in a sanitary manner. Staff could receive training regarding hand washing and glove use to ensure knowledge of safe food handling while serving residents food. Monitoring could occur to ensure food was served in a safe and sanitary manner. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents;	21390		

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21390	Continued From page 9 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow manufacturer's recommendations for the cleaning of foam wheelchair cushions for 4 of 4 (R49, R45, R44, R60) residents observed with soiled cushions. This had the potential to affect 25 residents on the upper and lower level. Findings include: During observations of the upper level dining room on 6/24/13, at 5:00 p.m. several of the residents were observed to be sitting on four inch thick foam wheelchair cushions. The cushions	21390		

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21390	Continued From page 10 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. On 6/25/13, at 2:31 p.m. R49 was observed sitting in her wheelchair in the dining room. The wheelchair was equipped with a four inch foam cushion. The cushion was observed to have stains along the front edges which were purple in color. 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. R45's diagnoses included Alzheimer's dementia and diabetes. The significant change MDS dated 5/14/13, identified R45 with severe cognitive impairments and as being totally dependant upon staff for all activities of daily living. The plan of care dated 5/28/13, directed the staff to provide a	21390		

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21390	Continued From page 11 pressure relief cushion on her wheelchair. 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. Review of the undated MediChoice Pressure Relief Cushion (manufacture instructions) stated: "Easy Care - Clean the cushion cover with a germicidal cleaning solution or soap and water. Do not use bleach or launder."	21390		

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21390	Continued From page 12 On 6/26/13, at 11:29 a.m. director of nursing (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. On 6/27/13, at 11:02 a.m. DON confirmed the facility currently had 25 foam wheelchair cushions being used by residents. 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 Correction: Twenty one (21) days.	21390		
21510	MN Rule 4658.1200 Subp. 2 A.B. SpecializedRehabilitative Services; Provision Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must: A. provide the required services; or obtain the required services from an outside source according to part 4658.0075. This MN Requirement is not met as evidenced by:	21510		

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21510	Continued From page 13 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, and indicated R9 was to utilize a rock and go wheelchair for mobility. 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. On 6/25/13, at 9:24 a.m. R9 was wheeled out of the dining room by nursing assistant (NA)-F. R9 was positioned in an upright position in the Rock and Go chair and R9's feet were dragging on the floor as the chair was being pushed. NA-F noticed that R9's feet were dragging on the floor	21510		

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21510	Continued From page 14 so NA-F turned the chair around and pulled R9 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 On 6/26/13, at 8:37 a.m. R9 was wheeled from his room to the dining room by NA-H. R9 was in a reclining position as he feet dangled in the air while being wheeled down the hallway. On 6/26/13, at 11:30 am. R9 was sitting in the dining room in a reclined position. R9's feet were not observed to be able to touch the floor. On 6/26/13, at 11:45 a.m. registered nurse (RN) -C stated R9's wheelchair had been removed and R9 had been placed in the Rock and Go wheelchair to enhance comfort and positioning. She stated R9 has been very happy with the chair and when he is positioned upright, R9's feet are able to touch the floor. She stated the occupational therapy department had been made aware of placing R9 in the Rock and Go but the facility had not requested an evaluation by the therapy department. RN-C was not aware of any concerns related to R9's current Rock and Go chair. RN-C stated the chair does have foot pedals to assist with positioning in the chair.	21510		

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21510	Continued From page 15 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 CORRECTION: Twenty-One (21) days.	21510		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with	21805		

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21805	Continued From page 16 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: 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 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 clearing the	21805		

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21805	Continued From page 17 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. At 12:50 p.m. HK-A wheeled the bus cart out of the dining room, covered it and wheeled it out of the upper level unit. R39 continued to be sitting at her table drinking her liquids. 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. On 6/27/13, at 12:53 p.m. HK-B entered the upper level dining room. Two residents were seated in the dining room eating their meals. HK-B used the bus cart as she wheeled the cart	21805		

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21805	Continued From page 18 throughout the room scraping the dishes into the bucket and placing the dirty dishes into the appropriate containers. HK-B cleared the dishes around the dining room until she noticed the survey staff in the room. She then wheeled the bus cart to the side of the dining room and cleared the remaining tables by carrying the dirty dishes to the cart away for the residents who were still eating. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents are assisted in the dining room under dignified conditions. The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21805		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such	21830		

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21830	Continued From page 19 conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not	21830		

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21830	Continued From page 20 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 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 that assists a facility in implementing 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 of 3 (R78) residents reviewed with concerns regarding these choices.	21830		

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21830	Continued From page 21 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 R78's room this a.m. the resident was asleep. NA-A stated she asked R78 if she wanted to get up and R78 stated she wanted to stay in bed. NA-A stated she encouraged R78 to get up, because the night licensed practical nurse (LPN) had reported the resident did not sleep well at night. NA-A stated, "We have a routine, and the nurses encourage us to get everybody up for breakfast." NA-A stated, "I don't know why it	21830		

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21830	Continued From page 22 would hurt to have her sleep in." On 6/27/13, at 9:15 a.m. registered nurse (RN)-A stated upon admission residents were not asked what time they would like to get up in the morning. RN-A stated the policy was residents could have breakfast later if they wanted to sleep in. The undated QUALITY OF LIFE POLICY reads, Residents are encouraged to make choices about aspects of their life in the facility that are significant to them. SUGGESTED METHOD FOR CORRECTION: The DON or administrator could establish procedures related to resident directed care. The DON, or designee(s) could provide an in-service for all appropriate staff on providing resident centered care. The DON, or designee(s) could monitor to assure each resident 's personal choice. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21830		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or	21855		

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21855	Continued From page 23 assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained for 1 of 6 (R49) residents observed during morning cares. Findings include: 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 plan of care dated 7/24/13, directed staff to assist R49 with all activities of daily living. On 6/26/13, at 7:00 a.m. nursing assistant (NA)-E was observed to place a bedside commode (BSC) next to R49's bed and transfer R49 from the bed onto the BSC. R49's roommate (R53) was observed awake in bed. NA-E did not pull the privacy curtain between the two residents. At 7:02 a.m. NA-E was observed to remove R49's pajama top, expose R49's bare chest and proceed to wash and dress R49's upper body. At 7:08 a.m. NA-E was observed to assist R49 to stand and hold onto the bed rail. Once standing, NA-E was observed to provide perineal care and also dress R49's lower body. R53 was observed to have a conversation with NA-E while NA-E was providing R49's morning cares. At 7:20 a.m. R49's cares were completed and she was wheeled out of the double room. Throughout the observation, NA-E had not pulled the privacy	21855		

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21855	Continued From page 24 curtain between the two residents. On 6/26/13, at 8:55 a.m. NA-E confirmed the privacy curtain had not been closed during R49's personal cares. On 6/26/13, at 12:10 p.m. registered nurse (RN) -C verified it was the facility policy to provide personal privacy during cares. RN-C also stated the privacy curtain should have been utilized during R49's personal cares. Review of the A.M. Care (Early Morning Care) policy dated 5/2011, directed the staff to "Screen and drape resident for maximum privacy." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee(s) could review and revise as necessary the policies and procedures regarding resident personal privacy. The DON, or designee(s) could provide an in-service for all appropriate staff on providing personal privacy while they cared for each resident. The DON, or designee(s) could monitor to assure each resident 's personal privacy. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21855		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the	21980		

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21980	Continued From page 25 information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of	21980		

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21980	Continued From page 26 the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that all injuries of unknown origin were investigated and reported to the appropriate State agency in accordance with State law for 1 of 1 resident (R9) incidents reviewed. Findings include: R9's injury of unknown origin had not been reported or investigated 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. Review of the Nurses Notes (NN) from 6/1/13 - 6/15/13, lacked documentation related to the bruising of the second 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."	21980		

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21980	Continued From page 27 The plan of care (POC) dated 12/25/12, and updated on 6/24/13, indicated R9's left second toe as being bruised. The POC indicated R9 had a tendency to kick at things such as the table or a bed cradle (metal frame that hold blankets off of feet while in bed.) The POC directed staff to monitor R9's skin and report changes. 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. 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. On 6/27/13, at 8:00 a.m. RN-C stated R9 had a doctors appointment 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.	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00321	A. BUILDING: _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21980	Continued From page 28 On 6/27/13, at 1:43 p.m. RN-C confirmed the toe was fractured and at this time, the facility had begun an investigation as to the cause of the fracture. R9 had no scheduled changes in current treatment. SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported and investigated. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21980		