#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

	_	ARE/MEDICAL TO BE COMPI						ID: RZ7T Facility ID: 00321		
1. MEDICARE/MEDICAID PROVII (L1) 245247 2.STATE VENDOR OR MEDICAID (L2) 738745801		3. NAME AND AL (L3) <b>KITTSON M</b> (L4) <b>1010 SOUTI</b> (L5) <b>HALLOCK</b> ,	MEMORIAL H H BIRCH		ARE CENTER (L6) 5	66728	4. TYPE OF AC  1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint		
5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 7. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	60/2016 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	IPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY  09 ESRD  10 NF  11 ICF/IID  12 RHC	02 (L7) 13 PTIP 14 CORF 15 ASC 16 HOSPICE	22 CLIA	FISCAL YEAR E	8. Full Survey After Complaint  FISCAL YEAR ENDING DATE: (L35)  09/30		
13.Total Certified Beds  14. LTC CERTIFIED BED BREAKD 18 SNF 18/19 SNF 60 (L37) (L38)  16. STATE SURVEY AGENCY REN  See Attached Remarks  17. SURVEYOR SIGNATURE	60 (L18) 60 (L17) OWN 19 SNF (L39)	Compliance  X 1. A  B. Not in Comp Requirements  ICF  (L42)  ABLE SHOW LTC CA  Date:	nnce With equirements e Based On: cceptable POC liance with Progra and/or Applied V  IID  (L43)	am Waivers:  DATE):	2. Techr 3. 24 Ho 4. 7-Day 5. Life S * Code: A 15. FACILITY M 1861 (e) (1) or	our RN  y RN (Rural SN  gafety Code  A, 1  IEETS  1861 (j) (1):	7. Medica 8. Patient 9. Beds/R (L12) (L15)	of Services Limit al Director Room Size		
	RT II - TO RE			(L19)	hodeceweend <del>en</del> 1400	one to be a second or define	a compare service come a sen tome	- 02/27/2017	(L20	
19. DETERMINATION OF ELIGIBL  _X 1. Facility is Eligible to  2. Facility is not Eligible.	LITY Participate	20. COM	IPLIANCE WITH		21. 1. Sta 2. Ov	atement of Finar	ncial Solvency (HCFA	n-2572)		
22. ORIGINAL DATE  OF PARTICIPATION  07/01/1982  (L24)  25. LTC EXTENSION DATE:  (L27)	B. Rescind St	G DATE	4. LTC AGREEM ENDING DATE (L25) (L44) (L45) CARRIER NO.		26. TERMINAT  VOLUNTARY 01-Merger, Closu 02-Dissatisfaction 03-Risk of Involut 04-Other Reason to	re n W/ Reimbursentary Terminatio		ovider Status Change		
31. RO RECEIPT OF CMS-1539	(L28)	03001	OF APPROVAL	(L31)						
14. LTC CERTIFIED BED BREAKD  18 SNF 18/19 SNF 60 (L37) (L38)  16. STATE SURVEY AGENCY REN  See Attached Remarks  17. SURVEYOR SIGNATURE  Lisa Carey, HFE NEII  PA  19. DETERMINATION OF ELIGIBLE X 1. Facility is Eligible to 2. Facility is not Eligible  22. ORIGINAL DATE OF PARTICIPATION 07/01/1982 (L24)  25. LTC EXTENSION DATE:  (L27)	OWN  19 SNF  (L39)  MARKS (IF APPLICA  LITY  Participate le (L21)  23. LTC AGREEN  BEGINNING  (L41)  27. ALTERNATT  A. Suspension  B. Rescind St  29  (L28)	B. Not in Comp Requirements  ICF  (L42)  BLE SHOW LTC CA  Date:  0  COMPLETED I  20. COM RIGH  AMENT DATE  VE SANCTIONS of Admissions: aspension Date:  1. INTERMEDIARY/ 03001	Iliance with Progra and/or Applied V IID (I.43) INCELLATION I 2/06/2017 BY HCFA RE IPLIANCE WITH ITS ACT: 4. LTC AGREEM ENDING DAT (I.25) (I.44) (I.45) CCARRIER NO.	DATE):  CGIONAI H CIVIL  MENT TE  (L31)	* Code: A  * Code: A  15. FACILITY M  1861 (e) (1) or  18. STATE SURV  OFFICE OR  21. 1. State 2. Or  3. Both  26. TERMINAT VOLUNTARY  01-Merger, Closur  02-Dissatisfaction  03-Risk of Involur  04-Other Reason in	Safety Code  A, 1  IEETS  1861 (j) (1):  VEY AGENCY  SINGLE S'  atement of Finar wnership/Contro oth of the Above  TION ACTION:  00  re n W/ Reimburse ntary Terminatio	9. Beds/R (L12)  (L15)  APPROVAL  Inforcement Special Solvency (HCFA) Interest Disclosure  INVC 05-Fa ement 06-Fa n OTHI 07-Pr	Date:  Cialist 02/27/20  Y  (L30)  OLUNTARY  il to Meet Health/Safet; il to Meet Agreement  ER  ovider Status Change		

(L33)

DETERMINATION APPROVAL

(L32)

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00321

**C&T REMARKS - CMS 1539 FORM** 

STATE AGENCY REMARKS

CCN: 24 5247

On December 30, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 5, 2016, the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on November 4, 2016. We presumed, based on their plan of correction, that your facility had corrected these deficiencies as of December 13, 2016. We have determined, based on our visit, that the facility has corrected the deficiencies issued pursuant to our extended survey, completed on November 4, 2016, as of December 13,

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 13, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies recommended in our letter of November 19, 2016:

- Civil Money penalty for deficiency cited at F226, be imposed. (42 CFR 488.430 through 488.444)
- •Mandatory denial of payment for new Medicare and Medicaid admissions effective February 4, 2017, be rescinded. (42 CFR 488.417 (b))

However, as we notified you in our letter of November 19, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii) (I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 4, 2016 as a result of the extended survey which identified substandard quality of care.

Refer to the CMS 2567b forms for the results of the revisits.

Effective December 13, 2016, the facility is certified for 60 skilled nursing facility beds.



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 24 5247

March 15, 2017

Ms. Cindy Urbaniak, Administrator Kittson Memorial Healthcare Center 1010 South Birch Hallock, Minnesota 56728

Dear Ms. Urbaniak:

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 December 13, 2016 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 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.

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

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

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



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 6, 2017

Ms. Cindy Urbaniak, Administrator Kittson Memorial Healthcare Center 1010 South Birch Hallock, Minnesota 56728

RE: Project Number S5247028

Dear Ms. Urbaniak:

On November 19, 2016, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective November 28, 2016. (42 CFR 488.422)

On November 19, 2016, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F226. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 4, 2017. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on November 4, 2016. At the time of the November 4, 2016 extended survey conditions in the facility constituted Substandard Quality of Care (SQC) to resident health and safety. The most serious deficiency was found 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 December 30, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 5, 2016, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on November 4, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 13, 2016. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on November 4, 2016, as of December 13, 2016.

Kittson Memorial Healthcare Center February 6, 2017 Page 2

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 13, 2016.

However, as we notified you in our letter of November 19, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 4, 2016 as a result of the extended survey which identified substandard quality of care.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies recommended in our letter of November 19, 2016:

- Civil Money penalty for deficiency cited at F226, remain in effect. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 4, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

#### POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION  A. Building			DATE OF REV	ISIT
	B. Wing	,	Y2	12/ <b>29</b> /2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
KITTSON MEMORIAL HEALTH	ICARE 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).

ITE Y4		<b>DATE</b> Y5	ITEM Y4			<b>DATE</b> Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.10(b)(5) - ( 483.10(b)(1)	10), Completed		483.13( - (4)	c)(1)(ii)-(iii), (c)(2)	Completed	Reg. #	483.13(c)		Completed
LSC		11/29/2016	LSC			12/09/2016	LSC			12/09/2016
ID Prefix	F0241	Correction	ID Prefix	F0282		Correction	ID Prefix	F0312		Correction
Reg. #	483.15(a)	Completed	Reg. #	483.20(	k)(3)(ii)	Completed	Reg. #	483.25(a)(3)		Completed
LSC		12/09/2016	LSC			12/13/2016	LSC			12/09/2016
ID Prefix	F0356	Correction	ID Prefix	F0406		Correction	ID Prefix	F0465		Correction
Reg. #	483.30(e)	Completed	Reg. #	483.45(	a)	Completed	Reg. #	483.70(h)		Completed
LSC		12/01/2016	LSC			12/09/2016	LSC			12/09/2016
ID Prefix		Correction	ID Prefix	-		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg.#			Completed
LSC			LSC				LSC			
REVIEWI STATE A		REVIEWED BY (INITIALS) LB/mm	<b>DATE</b> 02/06/20		SIGNATURE OF	SURVEYOR 34985			<b>DATE</b> 12/29	9/2016
REVIEWI CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW 11/4/201		Y COMPLETED ON			ANY UNCORRECTED DEFICIENCIE					s 🗆 NO

		POST-C	CERTI	FICA	FION RE	EVISIT F	REPOR	RT		
	ER / SUPPLIER / ICATION NUMBE				1				DATE (	OF REVISIT
245247		Y1 B. Wing						Y2	12/5/2	016 <sub>Y3</sub>
NAME O	F FACILITY				STRE	ET ADDRESS, C	CITY, STATE	, ZIP CODE		
KITTSO	N MEMORIAL H	IEALTHCARE CENTE	R			SOUTH BIRCH				
					HALLO	OCK, MN 56728				
program correcte provision	n, to show those od and the date s	by a qualified State so deficiencies previously such corrective action e identification prefix o	y reported was accom	on the CM plished.	IS-2567, State Each deficien	ement of Defici cy should be fu	encies and ally identifie	Plan of Corrected using either the	ion, tha ne regula	t have been ation or LSC
ITE	М	DATE	ITEM	l		DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101		Completed	Reg. #	NFPA 101		Completed
LSC	K0211	11/29/2016	LSC	K0321		11/29/2016	LSC	K0712		11/29/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			-	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			-	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC	-		LSC			-	LSC	-		
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			=	LSC			
REVIEW STATE A		REVIEWED BY (INITIALS) TL/mm	<b>DATE</b> 02/06/2	017 <b>S</b> I	GNATURE OF	SURVEYOR 36536			<b>DATE</b> 12/08	/2016

Form CMS - 2567B (09/92) EF (11/06)

FOLLOWUP TO SURVEY COMPLETED ON

**REVIEWED BY** 

(INITIALS)

DATE

**REVIEWED BY** 

CMS RO

11/2/2016

Page 1 of 1

TITLE

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

**EVENT ID:** 

RZ7T22

☐ YES ☐ NO

DATE



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 6, 2017

Ms. Cindy Urbaniak, Administrator Kittson Memorial Healthcare Center 1010 South Birch Hallock, Minnesota 56728

Re: Reinspection Results - Project Number S5247028

Dear Ms. Urbaniak:

On December 29, 2016 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 November 4, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

#### POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION  A. Building			DATE OF REV	ISIT
	B. Wing	,	Y2	12/ <b>29</b> /2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
KITTSON MEMORIAL HEALTH	ICARE 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).

ITE Y4		<b>DATE</b> Y5	ITEM Y4			<b>DATE</b> Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.10(b)(5) - ( 483.10(b)(1)	10), Completed		483.13( - (4)	c)(1)(ii)-(iii), (c)(2)	Completed	Reg. #	483.13(c)		Completed
LSC		11/29/2016	LSC			12/09/2016	LSC			12/09/2016
ID Prefix	F0241	Correction	ID Prefix	F0282		Correction	ID Prefix	F0312		Correction
Reg. #	483.15(a)	Completed	Reg. #	483.20(	k)(3)(ii)	Completed	Reg. #	483.25(a)(3)		Completed
LSC		12/09/2016	LSC			12/13/2016	LSC			12/09/2016
ID Prefix	F0356	Correction	ID Prefix	F0406		Correction	ID Prefix	F0465		Correction
Reg. #	483.30(e)	Completed	Reg. #	483.45(	a)	Completed	Reg. #	483.70(h)		Completed
LSC		12/01/2016	LSC			12/09/2016	LSC			12/09/2016
ID Prefix		Correction	ID Prefix	-		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg.#			Completed
LSC			LSC				LSC			
REVIEWI STATE A		REVIEWED BY (INITIALS) LB/mm	<b>DATE</b> 02/06/20		SIGNATURE OF	SURVEYOR 34985			<b>DATE</b> 12/29	9/2016
REVIEWI CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW 11/4/201		Y COMPLETED ON			ANY UNCORRECTED DEFICIENCIE					s 🗆 NO

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: RZ7T Facility ID: 00321

	IAKI I-	TO BE COMIT	LEIED DI	IIIE SIAI	IE SURVET AGENCI	racinty ID. 00321
MEDICARE/MEDICAID PROVID     (L1) 245247	DER NO.	3. NAME AND AI (L3) <b>KITTSON N</b>			ARE CENTER	4. TYPE OF ACTION: <u>2 (</u> L8)  1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID	NO.	(L4) 1010 SOUT	H BIRCH			3. Termination 4. CHOW
(L2) <b>738745801</b>		(L5) HALLOCK,	, MN		(L6) <b>56728</b>	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	7. On-Site Visit 9. Other 8. Full Survey After Complaint
(L9)	4/2016 (7.2.1)	01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	, I
	<b>14/2016</b> (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
ACCREDITATION STATUS:     Unaccredited 1 TJC	(L10)		07 X-Ray 08 OPT/SP	11 ICF/IID		09/30
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OP 1/SP	12 RHC	16 HOSPICE	07/30
11LTC PERIOD OF CERTIFICATIO	ON	10.THE FACILITY	Y IS CERTIFIED	AS:		
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requirements:
To (b):		~	equirements		2. Technical Personnel	6. Scope of Services Limit
		1	e Based On:		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	<b>60</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	· —
13.Total Certified Beds	<b>60</b> (L17)	X B. Not in Con	npliance with Pro	gram	5. Life Safety Code	9. Beds/Room
		Requirements	and/or Applied	Waivers:	* Code: <b>B*</b>	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
60						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Christina Martinson, I	HFE NEII	1	12/13/2016	(L19)	Mark Meath	, Enforcement Specialist 12/19/2016 (L20)
PA	ART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBI	LITY		MPLIANCE WIT	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
X 1. Facility is Eligible to	Participate	Rigi	III3ACI.		3. Both of the Above	
2. Facility is not Eligible						<del></del>
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUNTARY
07/01/1982					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	· ·
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)			(L44)			00-Active
(L27)	B. Rescind St	uspension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL	L DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

Facility ID: 00321

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

**C&T REMARKS - CMS 1539 FORM** 

STATE AGENCY REMARKS

CCN: 24 5247

An extended survey was completed at this facility on November 4, 2016, by the Departments of Health and Public Safety. Conditions in the facility at the time of the extended survey constituted Substandard Quality of Care (SQC) to resident health or safety. The most serious deficiencies in the facility at the time of the extended survey to be widespread deficiencies that constitute no actual harm with ptential for more than minimal harm that was not immediate jeopardy (Level F). Under September 1, 2016 CMS Policy requires a facility not be given an opportunity to correct before remedies will be imposed when deficiencies of SQC are identified on the current survey. The facility meets this criteria, therefore this Department imposed the Category 1 remedy of State monitoring effective November 28, 2016.

In addition, we recommeded to the CMS Region V office that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F226. (42 CFR 488.430 through 488.444)
- Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 4, 2016. (42 CFR 488.417 (b))

The facility is subject to a two year loss of NATCEP, beginning November 4, 2016, as a result of the extended survey that identified SQC.

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

SQC atF226



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered November 19, 2016

Ms. Cindy Urbaniak, Administrator Kittson Memorial Healthcare Center 1010 South Birch Hallock, Minnesota 56728

RE: Project Number S5247028

Dear Ms. Urbaniak:

On November 4, 2016, an extended 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. Conditions in the facility at the time of the November 4, 2016 extended survey constituted Substandard Quality of Care (SQC) to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

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

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

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

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

#### **DEPARTMENT CONTACT**

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us

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

#### NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016 CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of Substandard Quality of Care (SQC) that are not immediate jeopardy are identified on the current survey. A whereby significant corrections were required was issued pursuant to a survey completed on . The current survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective November 28, 2016. (42 CFR 488.422)

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

• Civil money penalty for the deficiency cited at F226. (42 CFR 488.430 through 488.444)

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 4, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

#### SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Kittson Memorial Healthcare Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 4, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

#### **APPEAL RIGHTS**

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

You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <a href="https://dab.efile.hhs.gov">https://dab.efile.hhs.gov</a> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

#### Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include electronic acknowledgement signature of provider and date.

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

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

### FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 4, 2017 (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 May 4, 2017 (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 Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

> Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

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

#### Sincerely,

### Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 12/13/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245247	B. WING			11/	04/2016
	PROVIDER OR SUPPLIER	HCARE CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH BIRCH IALLOCK, MN 56728	•	
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	as your allegation of Department's acceenrolled in ePOC, yat the bottom of the form. Your electron be used as verificate.  Upon receipt of an on-site revisit of your validate that substates.	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.  acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with					
F 156 SS=C	Minnesota Departn Substandard Quali F226 related to fac implement polices of resident property residents from harn allegations of abus 483.10(b)(5) - (10) RIGHTS, RULES,	y was conducted by the nent of Health on 11/4/16. ty of Care was identified at ility failure to develop and that prohibit misappropriation y, and the protection of m during investigation of e, neglect or mistreatment.  483.10(b)(1) NOTICE OF SERVICES, CHARGES	F 1	156			11/30/16
I ABORATOP)	and in writing in a lunderstands of his regulations governing responsibilities dur facility must also protice (if any) of the §1919(e)(6) of the made prior to or up resident's stay. Resident's stay.	form the resident both orally anguage that the resident or her rights and all rules and ing resident conduct and ing the stay in the facility. The rovide the resident with the e State developed under Act. Such notification must be son admission and during the eceipt of such information, and	NATURE		TITLE		(X6) DATE

Electronically Signed 11/29/2016

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) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
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F 156	writing.  The facility must intentitled to Medicaid of admission to the resident becomes ditems and services facility services und which the resident other items and services and for which the resident other items and services the amount of charinform each resident inform each resident inform each resident items and service (i)(A) and (B) of this the time of admist the time of admist the resident's stay, facility and of charginal including any charge under Medicare or the facility must full legal rights which in A description of the funds, under parage A description of the for establishing eligit the right to request	form each resident who is a benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing der the State plan and for may not be charged; those rvices that the facility offers esident may be charged, and ges for those services; and in when changes are made to ces specified in paragraphs (5) is section.  form each resident before, or esion, and periodically during of services available in the ges for those services, ges for services not covered by the facility's per diem rate.  rnish a written description of includes: In manner of protecting personal raph (c) of this section;  requirements and procedures gibility for Medicaid, including an assessment under section	F 15					
	non-exempt resour institutionalization a spouse an equitabl cannot be consider	rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which red available for payment the institutionalized spouse's						

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F 156	medical care in his down to Medicaid ed A posting of names numbers of all pert groups such as the agency, the State I ombudsman progradvocacy network, unit; and a stateme complaint with the agency concerning misappropriation of facility, and non-codirectives requirem.  The facility must in name, specialty, and physician responsi.  The facility must provide a facil	or her process of spending eligibility levels.  s, addresses, and telephone inent State client advocacy estate survey and certification icensure office, the State am, the protection and and the Medicaid fraud control ent that the resident may file a State survey and certification resident abuse, neglect, and fresident property in the mpliance with the advance	F 1	56		
	by: Based on observa review, the facility to current nursing hou March 2016, was p	NT is not met as evidenced tion, interview and document failed to ensure the most me Bill of Rights, revised in posted and used by the facility. tial to affect all 56 residents ity.		It is the policy of KMHC the residents shall be told that rights for their protection defined throughout their stay or contreatment and maintenance Failing to post the most curbome Bill of rights has the	of their legal uring and urse of e in the facility. rrent nursing	

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F 156	Findings include:  During the initial to observation reveals the facility was date.  On 11/3/16, at 10:3 designee (SSD)-A Bill of Rights was nand stated she was and would work on Rights posted. SSI "Your Rights" dates combined Federal given to each resid facility.  On 11/4/16, at 8:30 observed the Bill of and verified it was most current, revis  A facility policy on Frequested, however 483.13(c)(1)(ii)-(iii) INVESTIGATE/RE ALLEGATIONS/INITIALLE	ur, on 10/31/16, at 5:30 p.m., ed the Bill of Rights posted in ed 10/05.  30 a.m., social service confirmed the facility's posted of the most current version. It is responsible for the posting getting the most current Bill of D-A stated the booklet titled, if 1/16, which covered the and State Bill of Rights was ent, when admitted to the in a.m., the director of nursing if Rights posted in the facility an outdated version and the ed copy was needed.  Resident Rights was er, no policy was received.	F 1	affect all residents, staff and members. Updated Bill of Righave been posted. KMHC spolicy has been updated and receive education on the policompliance, our Social Servi Consultant will do QA checks monthly visits. The results wito the Risk Management Cortheir review and corrective as needed. S.S.D. responsibility continued compliance. Comp 11/29/16	ghts posters Bill of rights staff will cy. To ensure ces at her Il be brought mmittee for ctions taken le for	12/1/16

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F 225	other facility staff or licensing author licensing author licensing author licensing author licensing mistreat including injuries or misappropriation immediately to the to other officials in through established State survey and licensing licensin	to the State nurse aide registry rities.  ensure that all alleged violations ment, neglect, or abuse, of unknown source and of resident property are reported a administrator of the facility and a accordance with State law ed procedures (including to the certification agency).  have evidence that all alleged roughly investigated, and must otential abuse while the	F2	225				
	by: Based on interviet facility failed to immisappropriation (R36) who reported not reported to the failed to immediate investigate allegarmissing property (R53, R9) who rep	ENT is not met as evidenced aw and document review, the mediately report an allegation of of property for 1 of 5 residents and missing money which was a State agency. The facility also rely report and/or thoroughly tions of misappropriation of for 4 of 5 residents (R27, R39, orted missing property. The difference of the property to be valued at		It is the policy of KMHC that mandated reporter that has believe that a vulnerable add has been mistreated, or who knowledge that a vulnerable sustained a physical injury we reasonably explained and/or misappropriation of property immediately report the informadministrator of the facility a	reason to ult is being or has adult has which is not r, shall mation to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 225	· ·	therefore did not report to the	F 2	225	residents of KMHC are vulnerable a and all have the potential to be affe KMHC s VA policy has been update the portion that states loss amounts \$20 value will be reported has been removed and the wording changed of property or monetary amounts.	cted. ted and s over n to loss Our	
	R36's undated admission record indicated R36's diagnoses included dementia without behavior disturbance.  R36's annual Minimum Data Set (MDS) dated 7/12/16, indicated R36 had no cognitive impairment or memory problems and R36 could effectively verbalize needs and understand verbal communication needs adequately.				policy also now states that staff suspected to be involved with a VA incident shall be sent home pending the results of an investigation for resident safety. If a crime has been committed,it will be reported to law enforcement. To prevent further such occurrence, all staff will be re-educated or the need to report suspected abuse/neglect and misappropriation of property immediately to KMHC□s administrator and MDH at a mandatory in-service 12/05/16. A log will be kept of		
	On 11/1/16, at 10:59 a.m. R36 stated approximately six weeks ago she had money missing (20.00 dollars in the form of two 10 dollar bills) from her room which was stored in her second dresser drawer, in a wallet which was in a purse. R36 stated at the time of the discovery of the missing money, she reported it to a nursing assistant, however, could not remember the name of the nursing assistant. R36 stated she kept the money in a wallet in her purse and put the purse in the second drawer of her dresser.				all reported missing items and the I be monitored by the SSD and DON appropriate implementation of KMFVA policy. The results of these audi be brought to the Risk Managemer Committee monthly for their review corrective actions taken as needed and Administrator responsible for compliance Completion date 12/09.	for lC□s ts will it and . DON	
	(NA)-G stated she any missing mone	04 p.m. nursing assistant was not aware of R36 having y. NA-G stated if a resident noney she would immediately rge nurse.					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
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F 225	was not aware of R NA-H stated that if money she would in charge nurse. On 11/2/16, 12:43 p (LPN)-D stated she	2:32 p.m. NA-H stated she 36 having any missing money. a resident reported missing mmediately report it to the co.m. licensed practical nurse was the charge nurse and	F 22	5				
	stated there were n reported R36 had r and if a resident or	d for over 3 years. LPN-D to nursing assistants that had nissing money from her wallet, NA had reported missing immediately report it to the (DON).						
	(RN)-A stated R36 RN-A had not heard RN-A stated the factitems very seriously money was turned services. RN-A state were reported to the	7 p.m. registered nurse was a reliable reporter and d R36 was missing money. cility staff took any missing y, and any amount of missing into the DON or social ted all missing money or items e DON and social worker. could report any amount of ssing.						
	was interviewed via had given R36 thre aware the money w herself had not rep- facility because she	p.m. R36's family member a telephone and confirmed she e twenty dollars bills and was vas missing. She stated she orted the missing money to the e had not looked all over R36's the money was missing or not.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 225	The Vulnerable Add 12/15-11/2/16, were incident reports for	age 7 ult (VA) reports from e reviewed as well as the the same time period and t R36 was missing money.	F 2	25			
	able to report incidentistory of making under accusations or report not received a report DON confirmed the reported the missing reported to the characteristic and the investigated as the investigated all and the reported to the characteristic and the reported to the reported to the reported to the reported to the characteristic and the reported to the reported	s p.m. the DON stated R36 was ents accurately and had no up stories or making false orts. The DON stated she had ort of R36 missing money. The enursing assistant R36 mg money to should have urge nurse so it could have and reported. The DON stated I missing items and missing only reported those incidents 20 dollars or over.					
	R27 had moderate	OS dated 9/20/16, indicated cognitive impairment. The direct R27 had no symptoms of vioral symptoms.					
	the social service of 6/1/16, indicated R that he had behind incident report furth was refunded his \$	ncident Report completed by designee (SSD) and dated 27 reported missing \$10 bill his calendar in his room. The ner indicated on 6/11/16, R27 10 as it was not found. The ported to the State agency.					
	designee (SSD) co stated R27's missii	30 a.m. the social service infirmed the allegation and ing money was not called into ind should have been and a full					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245247	B. WING			11/0	04/2016
	PROVIDER OR SUPPLIER	ICARE CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 010 South Birch Iallock, MN 56728	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	On 11/3/16, at 1:45 administrator confir reported to the Stat DON indicated they policy which stated resident's property meaning greater that R39's quarterly MD R39 had moderated A Missing Item Incidindicated R39 was were last seen in R did not know how low missing. Notification sent to the upper an housekeeping, laundepartments and the conclusion of the mindicated R39 had a dispensed stamps. son she could not of the stamps were gothe stamps were lost	p.m. the DON and med the incident was not e agency as required. The were following the facility they would report theft of of any significant amount	F 2	25			
	her a book of stamp allegation was not r	R39's son stated he would get os verses a roll of stamps. The reported to the State agency estigation was not completed.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245247	B. WING			11/04/2016		
	PROVIDER OR SUPPLIER	HCARE CENTER		1010	EET ADDRESS, CITY, STATE, ZIP CODE 0 South Birch LLOCK, MN 56728	<u>,</u>	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 225	R53's quarterly MD R53 had severely in A Missing Item Inci indicated R53 was last seen 11/17/15. the watch was not 11/18/15. R53's roo of the missing watch lower level mainten activities, dietary de administrator. The 11/18/15, indicated watch for her, as w of missing property agency, as required was not completed	S dated 10/4/16, indicated	F2	225				
	A Missing Item Inci indicated R9 was n seen the day prior of a search of R9's ro Notification of the nupper and lower level housekeeping, laur departments and the conclusion dated 7 had went to laundry deemed non fixable missing property were seen as a search of R9's root as a search of R9's roo	mum Data Set (MDS) dated severely impaired cognition.  dent Report dated 7/8/16, nissing a watch which was last on 7/7/16. The report indicated from was conducted. In the well maintenance, andry, activities, dietary the administrator. The SSD's /11/16, indicated R9's watch y, had been washed and e. Family was notified. The as not immediately reported to R9's medical record lacked any						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL <sup>*</sup> A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245247	B. WING			11/0	04/2016
	PROVIDER OR SUPPLIER	HCARE CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH BIRCH ALLOCK, MN 56728	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 225	Continued From pa	age 10	F 2	25			
	missing stamps wh & R9's missing wat were not called into have been. The SS implemented the \$ amount. However, may be just as imp \$20.00 amount. Th should be reporting by an investigation stated the facility w	o p.m. the SSD verified R39's sich valued at \$50.00, and R53 ches each valued at \$10.00, the State agency and should 5D stated the facility had 520.00 reportable monetary agreed a lesser amount/value ortant to a resident as a e SSD stated the facility any missing money followed which was lacking. The SSD ould be revising their Abuse sappropriation of resident					
	(DON) and administry for R39, R53 and R State agency as rethey were following they would report the state of	p.m. the director of nursing strator confirmed the incidents 89 were not reported to the quired. The DON indicated the facility policy which stated neft of resident's property of punt meaning greater than \$20.					
	awareness of missing resident's room and have been left at. If daily function wait of replacement. If lost (ie: clothing, jewelry found in the time spand/or administrate.	Policy, undated, indicated upon ing personal items, search dother possible areas it may flost item affects residents one week before initiating item is other than those listed y, etc.) wait one month. If not pans listed, refer to DON or for decision as to facility rement and/or replacement.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
		245247	B. WING _		11/	04/2016
	PROVIDER OR SUPPLIER	ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH HALLOCK, MN 56728	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
F 225 F 226 SS=F	Vulnerable Adults P 7/13/16, and 8/23/1 trained on abuse ar exploitation at the ti directed staff to rep neglect, financial ex immediately. The pr of maltreatment of a "Theft of patient's p amount of money m (\$20.00)." The polic suspected maltreat anyone shall be rep administrator and o State agency, the ir interview appropriat safety was needed, information on susp document the desc Following the intern administrator would days as to the resul review team determ external report, they Adult Abuse Report 483.13(c) DEVELO ABUSE/NEGLECT The facility must de policies and proced mistreatment, negle	ting Maltreatment of Policy and Procedure revised 6, indicated all staff were and neglect, including financial me of hire and annually and ort incidents of abuse, exploitation to the administrator policy also identified indicators a Vulnerable Adult included roperty. Any significant meaning over twenty dollars by further indicated incidents of ment of a vulnerable adult by ported immediately to the ance a report was made to the atternal review team would be staff and resident, decide if gather appropriate pected perpetrator and ription of the maltreatment. In all investigation, the libe notified within five working lits of the investigation. If the nined the incident required any would notify the Minnesota ing Center.  P/IMPLMENT, ETC POLICIES	F 22			12/1/16
	This REQUIREMEN	NT is not met as evidenced				

PRINTED: 12/13/2016 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  KITTSON MEMORIAL HEALTHCARE CENTER  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1010 SOUTH BIRCH	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
KITTSON MEMORIAL HEALTHCARE CENTER			245247	B. WING			11/0	4/2016
HALLOCK, MN 56728					10	010 SOUTH BIRCH		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	PRÉFIX	(EACH DEFICIENC)	EFICIENCY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
Based on interview and document review, the facility failed to implement their policy for immediate reporting of misappropriation of property for 1 of 5 residents (R36) who reported missing \$20 dollars. The facility also failed to immediately report allegations of misappropriation of property for 4 of 5 residents (R27, R39, R53, R9) who reported missing property. The facility determined the property to be valued at less than \$20 therefore did not report to the State agency, as required. The facility abuse prohibition policy lacked the appropriate definition and reporting requirements regarding misappropriation of resident property financial exploitation. In addition, the facility failed to develop and implement policies addressing resident protection during investigation of allegations of abuse/neglect/mistreatment. This had the potential to affect all 58 residents who resided in the facility. The facility also failed to implement their policy related to prescreening of new employees for 2 of 5 employees (EE-B, EE-A) whose records were reviewed and lacked reference checks.  The facility's Reporting Maltreatment of Vulnerable Adults Policy and Procedure revised 7/13/16, and 8/23/16, indicated all staff were trained on abuse and neglect, including financial exploitation at the time of hire and annually and directed staff to report incidents of abuse, neglect, financial exploitation to the administrator of mimediately. The policy also identified indicators of mattreatment of a Vulnerable Adult in view that safe in the same and reglect, including financial exploitation of a vulnerable adult thas sustained a physical injury which is not reasonably explained and/or misappropriation of property, shall immediately report the information to the administrator and the portion that states loss amounts over \$20 value will be reported has been removed and the working loss of property or monetary amounts added. Our policy also now states that staff suspected to be involved with a VA incident shall be sent home pending the res	F 226	Based on interview facility failed to imp immediate reporting property for 1 of 5 missing \$20 dollars immediately report of property for 4 of R9) who reported in determined the prospect of the facility. The fallacked the appropring requirements regar resident property faddition, the facility implement policies during investigation abuse/neglect/mist potential to affect at the facility. The fact their policy related employees for 2 of whose records were reference checks.  Findings include:  The facility's Report Vulnerable Adults F7/13/16, and 8/23/11 trained on abuse at exploitation at the trained on abuse at exploitation at the trained in a directed staff to repring lect, financial eximmediately. The property of the propert	nterview and document review, the d to implement their policy for reporting of misappropriation of 1 of 5 residents (R36) who reported 0 dollars. The facility also failed to y report allegations of misappropriation for 4 of 5 residents (R27, R39, R53, ported missing property. The facility the property to be valued at less than re did not report to the State agency, The facility abuse prohibition policy appropriate definition and reporting ts regarding misappropriation of operty/ financial exploitation. In a facility failed to develop and policies addressing resident protection stigation of allegations of ect/mistreatment. This had the affect all 58 residents who resided in The facility also failed to implement related to prescreening of new for 2 of 5 employees (EE-B, EE-A) ands were reviewed and lacked hecks.  Clude:  S Reporting Maltreatment of Adults Policy and Procedure revised d 8/23/16, indicated all staff were abuse and neglect, including financial at the time of hire and annually and aff to report incidents of abuse, ancial exploitation to the administrator y. The policy also identified indicators	F 2	2226	mandated reporter has reason to bel that a vulnerable adult is being or has been mistreated, or who has knowled that a vulnerable adult has sustained physical injury which is not reasonable explained and/or misappropriation of property, shall immediately report the information to the administrator of the facility and MDH. All residents of KMI are vulnerable adults and all have the potential to be affected. KMHC S VA policy has been updated and the port that states loss amounts over \$20 va will be reported has been removed at the wording loss of property or mone amounts added. Our policy also now states that staff suspected to be invowith a VA incident shall be sent home pending the results of an investigation ensure resident safety. If a crime has been committed, it will be reported to enforcement. To prevent further such occurrence, all staff will be re-educated the need to report suspected abuse/neglect and misappropriation of property immediately to KMHC sadministrator and MDH at a mandate in-service 12/05/16. A log will be kept all reported missing items and the log be monitored by the SSD and DON frappropriate implementation of KMHC services actions taken as needed. If and Administrator responsible for	lieve s dge d a oly f e e e IHC e A tion alue and etary / olved e on to s o law h of g will for C□s s will and DON	

"Theft of patient's property. Any significant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245247	B. WING			11/0	4/2016
	ROVIDER OR SUPPLIER  MEMORIAL HEALTH	ICARE CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH BIRCH ALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	(\$20.00)." The policy suspected maltreat anyone shall be repadministrator and of State agency, the irrinterview appropriation on suspected maltreat anyone shall be repadministrator and of State agency, the irrinterview appropriation on suspected maltreadministrator would days as to the result review team determented the required composition would protect the reand how they would employee involved.  On 11/2/16, at 11:40 employee involved suspended until the The DON verified the address the issue the DON confirmed the missing items if valued on 11/2/16, at 10:40 designee (SSD) coupolicy lacked the rehow the facility would vulnerable adult involved.	heaning over twenty dollars by further indicated incidents of ment of a vulnerable adult by corted immediately to the name a report was made to the atternal review team would the staff and resident, decide if	F 2	2226	applicants. Reference checks obtain attempted to be obtained will be documented on this form. The form turned into the Human Resources Manager. The HR manager will be responsible for monitoring compliant with the reference checks. All manawill be educated by HR on the use form. Completion date 12/09/16	n will be nce agers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245247	B. WING _		11	/04/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1010 SOUTH BIRCH HALLOCK, MN 56728			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 226	The Missing Item Fawareness of miss resident's room an have been left at. I daily function wait replacement. If los (ie: clothing, jewelr found in the time s and/or administrate liability and reimbut R36's undated administrate liability and reimbut R36's annual Minir 7/12/16, indicated impairment or men effectively verbalize communication needs approximately six missing \$20.00 dol bills) from her room second dresser drapurse. R36 stated the missing money assistant, however name of the nursin kept the money in the purse in the second 11/2/16, at 12:00 dol 11/2/16, at	Policy, undated, indicated upon ing personal items, search dother possible areas it may flost item affects residents one week before initiating titem is other than those listed y, etc.) wait one month. If not pans listed, refer to DON or for decision as to facility rement and/or replacement.  Inission record indicated R36's didementia without behavior  mum Data Set (MDS) dated R36 had no cognitive nory problems and R36 could be needs and understand verbal eds adequately.	F 2:	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245247	B. WING		11	/04/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1010 SOUTH BIRCH HALLOCK, MN 56728			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 226	any missing money reported missing n report it to the chai	y. NA-G stated if a resident noney she would immediately rge nurse.	F 2	26			
	was not aware of F NA-H stated that if	12:32 p.m. NA-H stated she R36 having any missing money. a resident reported missing mmediately report it to the					
	(LPN)-D stated she had been employe stated there were reported R36 had and if a resident or	p.m. licensed practical nurse was the charge nurse and d for over 3 years. LPN-D no nursing assistants that had missing money from her wallet, NA had reported missing immediately report it to the (DON).					
	(RN)-A stated R36 RN-A had not hear RN-A stated the fa items very seriousl money was turned services. RN-A sta were reported to the	47 p.m. registered nurse was a reliable reporter and rd R36 was missing money. cility staff took any missing ly, and any amount of missing into the DON or social ted all missing money or items ne DON and social worker. Yould report any amount of issing.					
	was interviewed vis had given R36 thre aware the money v	B p.m. R36's family member a telephone and confirmed she be twenty dollars bills and was was missing. She stated she ported the missing money to the					

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245247	B. WING _		11	/04/2016	
	PROVIDER OR SUPPLIER	HCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 1010 SOUTH BIRCH HALLOCK, MN 56728			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (E	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 226	facility because she room to truly see if  The Vulnerable Add 12/15-11/2/16, wer incident reports for there was no report.  On 11/2/16, at 1:03 able to report incide history of making accusations or report received a report. DON confirmed the reported the missing reported to the characteristic and the confirmed to the characteristic and the reported to the reported to the characteristic and the reported to the reported to the characteristic and the reported to the repo	e had not looked all over R36's the money was missing or not.  ult (VA) reports from e reviewed as well as the the same time period and t R36 was missing money.  8 p.m. the DON stated R36 was ents accurately and had no up stories or making false orts. The DON stated she had ort of R36 missing money. The e nursing assistant R36 mg money to should have arge nurse so it could have and reported. The DON stated I missing items and missing only reported those incidents	F 22				
	assistant (NA) and neglect, including fimplemented as with the social service of 6/1/16, indicated R	missing money to a nursing the facilities policy on abuse, inancial exploitation was not ritten.  OS dated 9/20/16, indicated cognitive impairment. The d R27 had no symptoms of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245247	B. WING		11/04/2016		
NAME OF PROVIDER OR SUPPLIER  KITTSON MEMORIAL HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	ON SHOULD BE COMPLETION DATE  DATE		
F 226	incident report furt was refunded his	age 17 ther indicated on 6/11/16, R27 \$10 as it was not found. The eported to the State agency.	F 22	26			
	the allegation and was not called into have been and a f	:30 a.m., the SSD confirmed stated R27's missing money of the State agency and should full investigation and R27's medical record was					
	administrator conf reported to the Sta DON indicated the policy which stated	5 p.m. the DON and irmed the incident was not ate agency as required. The ey were following the facility d they would report theft of of any significant amount han \$20.					
		DS dated 10/11/16, indicated ely impaired cognition.					
	indicated R39 was were last seen in I did not know how missing. Notification sent to the upper a housekeeping, lau departments and to conclusion of the indicated R39 had dispensed stamps son she could not	cident Report dated 5/23/16, is missing a roll of stamps which R39's drawer, in her room. R39 long the stamps had been on of the missing stamps was and lower level maintenance, andry, activities, dietary the administrator. The SSD's missing stamps dated 5/23/16, a machine that weighed and is. R39 had complained to her open it and when he opened it gone. R39's son did not know if					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED	
		245247	B. WING _		11	/04/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH HALLOCK, MN 56728			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 226	the stamps were loalso indicated R39 incident happened her a book of stamallegation was not and a thorough inverse R53's quarterly MER53 had severely indicated R53 was last seen 11/17/15 the watch was not 11/18/15. R53's roof the missing wat lower level maintenactivities, dietary dadministrator. The 11/18/15, indicated watch for her, as wof missing property agency, as require was not completed any documentation R9's quarterly MDS	ost, used or gone. The report 's son did not know when the . R39's son stated he would get aps verses a roll of stamps. The reported to the State agency estigation was not completed.  OS dated 10/4/16, indicated impaired cognition.  Ident Report dated 11/18/15, indicated impaired a watch which was an Anursing assistant reported seen during R53's bath on one was searched. Notification in the was sent to the upper and in ance, housekeeping, laundry, epartments and the SSD's conclusion dated, I, "Family brought in another was not expensive." The report was not reported to the State in and a thorough investigation I. R53's medical record lacked in regarding the missing watch.	F 22	26			
	indicated R9 was r seen the day prior a search of R9's r	ident Report dated 7/8/16, missing a watch which was last on 7/7/16. The report indicated oom was conducted. missing watch was sent to the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		E SURVEY PLETED
		245247	B. WING			11/0	04/2016
	PROVIDER OR SUPPLIER	ICARE CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH BIRCH ALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	housekeeping, laur departments and the conclusion dated 7/ had went to laundry deemed non fixable missing property was the State agency. Fi	ge 19 adry, activities, dietary be administrator. The SSD's all/16, indicated R9's watch by, had been washed and be. Family was notified. The bas not immediately reported to be reduced any arding the missing watch.	F 2	26			
	missing stamps wh & R9's missing wat were not reported to have been. The SS implemented the \$2 amount. However, a may be just as imposphene \$20.00 amount. The should be reporting by an investigation stated the facility were stated to the state of the s	p.m. the SSD verified R39's ich valued at \$50.00, and R53 ches each valued at \$10.00, of the State agency and should D stated the facility had 20.00 reportable monetary agreed a lesser amount/value ortant to a resident as a e SSD stated the facility any missing money followed which was lacking. The SSD ould be revising their Abuse sappropriation of resident					
	R53 and R9 were n agency as required were following the f staff to report theft	p.m. the DON and med the incidents for R39, ot reported to the State . The DON indicated they acility policy which directed of resident's property of any meaning greater than \$20.					
	REFERENCE CHE	CKS					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED	
		245247	B. WING _		11	/04/2016	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH HALLOCK, MN 56728				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 226	On 11/3/16, at 9:00 reviewed with the M (HRM) and the following in EE-B's employee reference checks that the stated it was the remanager to complete. A was hired 8/working in the dietemployee record is completion of reference on 11/3/16, at 9:35	a.m. employee records were numan resource manager owing was revealed:  was hired 8/23/16, and was not the activities department. Record lacked documentation of being completed. The HRM responsibility of the department rete the reference checks.  30/16, and was currently ary department. EE-A's acked documentation of the	F 2:	26			
	employee's should documented accor Adding, she would would be followed documented in the The facility policy h	a.m. the DON verified new have references checked and ding to the facility policy. assume the three references through on and would be employee files.					
	The facility Reporti	on all new employees.  Ing Maltreatment of Vulnerable Procedure, revised 7/13/16 & the facility would attempt to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245247	B. WING _		11/	04/2016
	PROVIDER OR SUPPLIER	HCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH HALLOCK, MN 56728	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CONTRACTOR OF THE APPROPRIED	D BE	(X5) COMPLETION DATE
F 226 F 241 SS=D	obtain information references and the documented in the 483.15(a) DIGNITY	from previous employers with findings would be	F 22			12/1/16
33-0	The facility must pr manner and in an e enhances each res	romote care for residents in a environment that maintains or sident's dignity and respect in is or her individuality.				
	by: Based on observa review, the facility the dining experience to	NT is not met as evidenced tion, interview and document failed to provide a dignified for 3 of 3 residents (R24, R41, vait for their meal while erved.		It is the policy of KMHC that their residents have the right to be trea courtesy and respect for their individual by employees providing services in health care facility. For residents FR41, and R 26 that were a not prodignified dining services during su	ted with viduality n our R24, ovided	
	10/4/16, indicated I impairment and recone person with ear 10/11/16, directed assistance as need and reminders.  R41's quarterly ME R41 had severe corequired limited assessing. R41's care	nimum Data Set (MDS) dated R24 had severe cognitive quired limited assistance of ating. R24's care plan dated staff to provide set up and ded for meals and provide cues and provide cues are good of the company of the		-involved staff were educated as a the concern was shared and correwere made. All of KMHC residents the potential to be affected. To obtain maintain compliance, A Dining Windles Dignity Policy has been developed includes serving table by table during noon and evening meals. Educated be provided for all involved staff be Dietary Technician at a mandatory meeting December 5th regarding Dining with Dignity Policy. Randor will be performed of dignified dining experience. Corrective action will during these audits as needed to dignity. The results will be brought monthly x 3 then quarterly to the Format was shared and corrective action will be performed to the format will be brought monthly x 3 then quarterly to the Format was shared and corrective action will be brought monthly x 3 then quarterly to the Format was shared and corrective action will be brought monthly x 3 then quarterly to the Format was shared and corrective action will be brought monthly x 3 then quarterly to the Format was shared and corrective action will be brought monthly x 3 then quarterly to the Format was shared and corrective action will be brought monthly x 3 then quarterly to the Format was shared and corrective action will be brought monthly x 3 then quarterly to the Format was shared and corrective action will be brought monthly x 3 then quarterly to the Format was shared and corrective action will be provided to the c	soon as ections s have tain and th d that ring the on will y our r staff the new n audits ng be taken ensure t	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245247	B. WING		11/	04/2016
	PROVIDER OR SUPPLIER	ICARE CENTER	STREET ADDRESS, CITY, STATE, ZIP ( 1010 SOUTH BIRCH HALLOCK, MN 56728		CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 241	R26 had severe corequired extensive eating. R26's care staff to provide set and to assist with formal of the breakfast meals are recliner to a wheeled with R23, R24 and breakfast and also and R74 were obscindependentlyat 7:50 a.m. R26 via wheelchair and Nursing assistant (aid (AA)-C were obresidents seated at dining roomat 8:10 a.m. R24 minutes after R23 seated next to R74 toward R74's food. R41at 8:14 a.m. R41 minutes after R23 seated a.m. R26 a	S dated 10/18/16, indicated gnitive impairment and assistance of one person with plan dated 10/25/16, directed up and assistance for meals reding as warranted.  Owing was observed during R24, and R74 were observed the dining room. R41 was next to the table. Was transferred from the chair and seated up to the table R74. R23 was served R74, shortly thereafter. R23 erved to eat their meals was brought to the dining room seated at the same table. NA)-I, NA-J, NA-K and activity served distributing meals to three other tables in the was served. R41, who was was observed to reach A staff member redirected was served breakfast, 28 was served. was served breakfast, 26 was brought to the table where	F 24	Management Committee and corrective actions tak Completion date 12/09/16	en as needed.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		245247	B. WING _	· · · · · · · · · · · · · · · · · · ·	11	/04/2016
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F 241	On 11/3/16, the bree-at 7:54 a.m. R24, seated at a table in were served breaks served residents at served. at 8:04 a.m. R74 table and R23 wasat 8:10 a.m. R74at 8:13 a.m. NA-0 and sat down to as after other resident served.  On 11/3/16, at 11:3 (LPN)-C stated the for the dining room wherever it worked was usually for pedeat. LPN-C and AA fed and stated she staff member was a constant of the stated R41 required assistance normally would not everyone else had R24, R41 and R26 confirmed resident table without their rand should be servent.	R2 and R41 were observed the dining room. R24 and R2 fast. Staff proceeded to adjoining tables. R41 was not and R23 were brought to the	F 24			

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F 241	(DON) indicated st individuals seated	ne would expect all the at the same table to be served and not have to wait for their	F 24	41		
F 282 SS=D	should interact with enhance his or her and promote reside in dining. 483.20(k)(3)(ii) SE PERSONS/PER C The services provi- must be provided by	ty of Life policy indicated staff in the residents in ways that it self-esteem and self-worth ent independence and dignity RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in each resident's written plan of	F 2	32		12/13/16
	by: Based on observareview, the facility with oral hygiene a 1 of 3 residents (R with oral hygiene.  Findings include:  R53's care plan reres as to receive minimum. The care	NT is not met as evidenced ation, interview and document failed to provide assistance s directed by the care plan for 53) who required assistance viewed 10/18/2016, indicated e oral hygiene twice daily, at a e plan instructed the nursing t as needed especially when implete oral cares.		It is the Policy of KMHC that a comprehensive plan of care be personnel involved in the care of resident. In relation to R53, who provided oral care during survey staffs involved were educated of importance of oral care and in fet the care plan. Staff ensured that resident received oral care that residents of the facility have the to be affected if they are not procare or cares according to their Compliance will be monitored we sign-off sheet has been develop CNA to initial after the oral care done in accordance with care plants.	of the owas not owas	

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F 282	nursing assistants on their person, in lower dentures an refuse oral cares.'  On 11/1/16, at 9:3 stated he had con and whether or no hygiene/care.  On 11/02/16, at 8: the bathroom on the distriction of the bed. At that timputting her robe of be getting a bath a NA-A left R53's roreceived oral hygicand had also slept mouth. R53 then a wheeled walker do and then to the direction of the direction	ent Care Sheet which the (NA's) referred to and carried dicated R53 had upper and d directed staff: "Do not let her of the care with R53's oral hygiene at R53 was receiving oral and R53 was observed in the toilet. R53 voided, nursing out a new pull up on R53, and R53 ambulated back to the NA-A assisted R53 with and stated R53 was going to after she finished her breakfast. The come with the remarks of the care with her dentures in her ambulated with her front the care with the care with the nand stated R53 was going to after she finished her breakfast. The care with her dentures in her ambulated with her front the care with her dentures in her ambulated with her front bown the hall to the nurse's desking room.  35 p.m. NA-B/bath aide digiven R53 a bath after R53 and only provided bathing, not a confirmed she had not oral hygiene during the	F 28	ensure compliance, observed be done on various shifts of care plan and providing additional care will continue monthly a throughout the entire year of the audit if noncompliant. The audits of care provided with the care plan will be reperiodically by the DON and nursing home subcommitted. The initial oral care audit would the importance of following. The oral care policy will be include the risks of not recoral care and all staff will be care plan implementation a importance of oral care at a in-service 12/05/16. The reaudits will be brought to the Management Committee months then quarterly for a corrective actions taken as Completion date 12/09/16.	of following the equate oral and randomly by nursing and taken the day ce is found. It is a coordance eviewed in accordance eviewed dependent of the care plan are to include the care plan. The care plan are educated on and the armandatory is sults of these exists in onthly x three their review and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IG	X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER	ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1010 SOUTH BIRCH  HALLOCK, MN 56728	
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F 282	should be complete on the care plan.	age 26 ect and stated oral hygiene ed two times a day as directed General Resident Care Plan	F 28	32	
F 312 SS=D	Documentation Gu oral hygiene would with who was responsible and instruction would be addresse 483.25(a)(3) ADL COEPENDENT RESTATES	idelines, dated 10/11, indicated be identified on the care plan onsible for completing oral ctions unique to the resident d on the resident's care plan. CARE PROVIDED FOR	F 31	2	11/30/16
	by: Based on observative review, the facility for with oral cares for required assistance and did not receive	NT is not met as evidenced tion, interview and document ailed to provide assistance 1 of 3 residents (R53) who a from staff for oral hygiene the assistance.		It is the policy of KMHC that adequate and proper care is provided for oral of and that assistance is provided as nowith oral hygiene to keep the mouth, or dentures clean and that measures be taken to prevent dry cracked lips. relation to R53 who was not provided.	care eeded teeth s will In d oral
	10/4/16, indicated Inhypertension, had sand used a walker	nimum Data Set (MDS) dated R53's diagnoses included severe cognitive impairment to ambulate with. The MDS ired limited assistance of one		care during survey, the staffs involve were educated on the importance of care and in following the care plan. It ensured that R53received oral care day. All residents of the facility have potential to be affected if they are no provided oral care according to their plan. An oral care compliance sign or	oral t was that the t care

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F 312	was to receive oral minimum. The care assistants to assist R53 refused to con.  The current Reside nursing assistants on their person, inclower dentures and refuse oral cares."  On 11/1/16, at 9:30 stated he was cond and questioned who cares.  On 11/02/16, at 8:3 the bathroom on the assistant (NA)-A purplied transfer be her bed. At that time putting her robe on be getting a bath at NA-A left R53's rocoffered or provided received oral hygie and that she had simouth. R53 ambulations.	ygiene.  ted 10/18/16, indicated R53 hygiene twice daily, at a e plan instructed the nursing as needed especially when	F 312	sheet has been developed for the initial after the oral care has been accordance with care plan. Nursi check for completeness of this for and PM shifts. KMHC oral care pube updated to include importance care and all staff will be educated policy. Staff will also be educated oral changes elderly experience importance of adequate oral care Ostrosky D.D.S. To ensure compromentally and random audits will define throughout the entire year of oral dry, cracked lips by nursing and locorrective action taken the day of if noncompliance is found. The rethe QA will be brought to the Risk Management Committee monthly quarterly for their review and corractions taken as needed. Results audits will also be shared with the care staff at monthly staff meetin Completion date 12/09/16	n done in ng will orm AM olicy will of oral don the lon the land the eard the care and DON with the audit esults of cortive sof edirect	
	On 11/02/16, at 1:3	35 p.m. NA-B/bath aide				

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F 312		ge 28 given R53 a bath after provided bathing, not oral	F 3	12		
	provided R53 with a providing morning of -At 1:45 p.m. regist would expect R53 t provided morning chygiene should be directed on the care	ered nurse (RN)-A stated she o receive oral hygiene when ares and confirmed oral completed two times a day as e plan. RN-A stated FM-A had rn regarding R53's oral				
	On 11/3/16, at 8:30 (DON) verified NA-hygiene to R53 in the as directed by the control of the facility's Oral Hindicated oral hygie	a.m. the director of nursing A should have provided oral ne morning before breakfast				
	INFORMATION  The facility must po a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per shape.		F 3	56		12/1/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245247	B. WING			11/0	4/2016
	PROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE D10 SOUTH BIRCH ALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	vocational nurses - Certified nurses - Certified nurses o Resident census The facility must perspecified above of each shift. Date o Clear and reada of line a prominent presidents and visit The facility must, make nurse staffing review at a costandard. The facility must restaffing data for a required by State	(as defined under State law). see aides. s. cost the nurse staffing data in a daily basis at the beginning a must be posted as follows: lble format.	F3	356			
	by: Based on interviet facility failed to en posting included the for 20 of the 30 date and 19 of the 30 delevel. This had the living in the facility Findings include:  Review of facility's	ew and document review, the sure the daily nurse staff he resident census, as required ays reviewed for the lower level lays reviewed for the upper e potential to affect all residents of the daily nursing staff postings ent census was not included on			It is the policy of KMHC to post information that includes the facility current date, total number and actual hours worked of staff directly responsor resident care and resident censural to affect all residents living in the facility. To ensurand the compliance, all nurses were educated mandatory nurses meeting November 10th, 2016 on KMHC's policy on state posting sheets. All nurses were given copy of KMHC's policy regarding posting sheets and were also given the meeting minutes. Audits of the staff posting sheepan daily on 11/05/16. If informating missing the nurse responsible will be	al nsible us. sure ed at a per off en a peting sheets on is	

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	PROVIDER OR SUPPLIER	ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1010 SOUTH BIRCH HALLOCK, MN 56728	•	
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F 406	lacked resident cen 8-11th, 13th, 15th, and 31st and also coupper level staff polacked the resident 9th-13th, 15th, 18th also November 1st  On 11/4/16, at 11:3 (DON) confirmed the was required to refliverified this was mismentioned postings nurse was responsing. The DON of the aforemention missing resident cethe sheets were retected to the sheets were retected in the missing resident cethe sheets were retected in the missing Facility policy dated misunderstood and filled in the missing Facility policy dated posting of nursing sthe resident census 483.45(a) PROVIDINGEHAB SERVICES If specialized rehabinot limited to, physipathology, occupation health rehabilitative and mental retardates resident's comprehensions.	sting sheets for October is us on the 4th, 5th, 7th, 16th, 18th, 19th, 21st -25th, on November 1st and 2nd. Desting sheets for October census on the 4th-7th, 1, 22nd-25th, 27th, 28th and and 2nd.  1 a.m. the director of nursing ne daily nurse staffing posting ect the resident census and sing from the above is. The DON stated the night is ble to complete the daily was asked to provide copies ned staffing sheets with the insus information, however, urned to the surveyor with the filled in. The DON stated, the to make the copies instead of making copies information.  1 6/14, indicated the dialing staffing report was to include at the start of each shift. E/OBTAIN SPECIALIZED	F 35	educated. Results of the au brought to the Risk Manage monthly x 3 months then queview and any needed action DON responsible for completion date 12/01/16	ement Meeting uarterly for ions taken.	11/30/16

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION  NG		E SURVEY PLETED
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F 406	This REQUIREMI by: Based on observ review, the facility comprehensive as intellectual disabil 1 resident (R74) v disability who was	\$483.75(h) of this part) from a dized rehabilitative services.  ENT is not met as evidenced ation, interview and document failed to complete a seessment and provide needed ity rehabilitative services for 1 of with a diagnosis of intellectual a not receiving services to	F 4	It is the policy of KMHC to p comprehensive assessment intellectual disability rehabilit for their residents. Provision rehabilitation for developmer residents has the potential to	and needed ative services of ntally disabled affect 1	
	Additionally, R74	n related to communication. was placed in a locked special dentified needs requiring a		resident. R74has been asses appropriate placement on the Memory Unit as he is at risk wandering, has made attempand he requires a wander gu To ensure that R74, who has intellectual disability, receive specialized rehabilitation ser referral was made to OT 11/	e secured for to elope eard bracelet. an s the required vices a 10/16 which	
	prior to that R74 at home, R74 rec	I to the facility on 8/18/16, and lived at home with family. While eived intellectual disability and services provided by a day AC).		employs a COTA who has be and has experience working person s with intellectual dis COTA working with this resid certification on Development from Minot State University.  experience as a Programmir working with REM. A list of se	with sability. The lents has a al Disorders She also has ng Specialist	
	Review of R74's a (MDS) dated 8/30 admitted from the speech that was sunderstanding of	rission Record indicated R74 f Down's syndrome.  admission Minimum Data Set 1/16, indicated R74 was community and had unclear sometimes understood. R74's verbal content was sometimes MDS indicated R74 had no		working with REM. A list of s activities has been given to the Department to incorporate in resident's activity plan of care monitoring will be done by the Director as to the level of this participation in these as well activities this resident participation will be reviewed monthly by the Also ADL goals have been secont activities and results are being	he Activity the e and e Activity s resident 's as other pates in . This he COTA. et up by the	

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		245247	B. WING			11/0	04/2016
NAME OF	PROVIDER OR SUPPLIE	R		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
VITTOO	IMEMODIAL HEAL	TUCADE CENTED		10	10 SOUTH BIRCH		
KILISUI	N MEMORIAL HEAL	INCARE CENTER		H	ALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDE DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 406	inappropriate beh focusing attention assistance of one ambulation, dress and toilet use. R7 include an assess needs related to complete the complete	avior symptoms except difficulty a. R74 required physical be person for transfers, sing, personal hygiene, eating, 4's medical record did not be ment of R74's strengths and communication.  Admission Screening and (PASRR) for persons with be sability (DD) or related 8/24/16, indicated R74 had DD, and health care needs requiring vices. Review of the Level II be section, Need for Active Illowing was identified by a check This person's medical and be are so severe that, in the CMRP [qualified mental be signal], the person cannot from active treatment." The DD proved by DHS (Department of	F4	406	staff in relation to dressing and communication. The resident will be assessed for ability to feed self to determine if this might be the 3rd at ADL dependence for which measure goals could be developed and a plimplemented. The COTA has proveducation specific to this resident incorporated family input. A policy developed for providing specializes services and on the evaluation of residents for appropriateness of placement on the Memory Care Urstaff will be educated on these poland on working with the developmed disabled population. COTA, SSD at DON responsible for compliance. The results of these measures will be at the Resident's primary physicial review and corrective actions take needed. Completion date 12/09/16	area of ireable an ided and has will be d icies entally and The prought in for in as	
	breakfast, seated served cold cerea	d on 11/2/16, at 8:28 a.m. eating at a table alone. R74 was al, a banana, and a piece of as noted R74 used the fork to					

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245247	B. WING			11/0	04/2016
	PROVIDER OR SUPPLIER	ICARE CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH BIRCH ALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 406	interviewed during in R74 was very shy a words. However, it what R74 was sayin not clear and was whad learned all of R she could commun NA-K stated R74 hat the facility unattend lived in the locked to there were more ac participate in on the did not have any sp	Nursing assistant (NA)-K was this observation and stated and could sometimes verbalize was difficult to understanding because the speech was very very soft. NA-K stated she rather than the state of the facility, except that extivities offered that R74 could be locked unit. NA-K stated R74 pecialized programs to as much independence and	F	406			
	time to eat and nee R74 generally follow and liked interacting was not sure why R because she had n leave the facility. No any specialized pro as much independe possible.  Further review of R there was no assess	NA-L stated R74 took a long ded prompting. NA-L stated wed the staff around all day g with them. NA-L stated she R74 required a locked unit ever known R74 to attempt to A-L stated R74 did not have grams to maintain or achieve ence and self-determination as					
	indicated the need Additionally, the cal identified R74 had soccasional whisper	for a locked unit for R74. re plan dated 8/23/16, speech that was limited to s. However, the care plan had stion for the sign language R74					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY PLETED
		245247	B. WING			11/(	04/2016
	PROVIDER OR SUPPLIER			10	REET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH BIRCH ALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES :Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 406	(SSD)-A stated she specialized rehabil for individuals who was not aware of a training in the field services. SSD-A siplaced on a locked they were afraid R facility. SSD-A con attempted to elope admission, and an locked dementia u placement had not (DON) stated she assessed to determine the determine the sure what assessment who were admitted DON stated they how the county case mana specialized habilitation services who were admitted to the county case mana specialized habilitation services and the specialized habilitation services are who were admitted book as a specialized habilitation services and the specialized habilitation services are with the facility of	P a.m. social service designee e was not aware of any litation requirements for caring had DD. SSD-A stated she any staff at the facility who had of DD to provide R74 care and tated the only reason R74 was dementia unit was because 74 would try and elope from the firmed R74 had never from the facility since assessment to determine if a nit was an appropriate to been completed.  15 a.m. the director of nursing was not aware if R74 was mine what specialized ces needed. The DON was not nent was required for residents downth diagnoses of DD. The final never consulted with the ger to determine R74's action needs.  ity's policy for admission to the field was reviewed and identified lid be made by the nursing staff, M.D. to determine the final placement on the locked unit.	F 4	106			
F 465	483.70(h)		F 4	65			11/30/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245247	B. WING _		11/0	04/2016
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP COL 1010 SOUTH BIRCH HALLOCK, MN 56728		
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	SAFE/FUNCTION E ENVIRON The facility must p sanitary, and com	orovide a safe, functional, fortable environment for	F 46	65		
	by: Based on observ review, the facility services related to ensure safe and s resident room doo rm49-1, rm49-2, r were observed so of repair; and faile dining room floori potential injuries of	ation, interview and document failed to provide maintenance or ongoing repairs in order to sanitary environment for 6 of 14 ors (rm) (rm41, rm46, rm47, rm45) on the second floor which ratched and marred and in need and to ensure the second flooring was maintained to prevent due to ripped, raised flooring in 1		It is the policy of KMHC that the plant, including walls, furnishing ceilings, systems and equipment in a continuous state of good operation with regard to the hocomfort, safety and wellbeing according to a written routine maintenance and repair programments the potential to affect all rather scratched and marred kind identified during survey will be temporary patching has been	ngs, floors, ent be kept repair and ealth, of residents ram. This esidents. ck plates e painted. A performed	
	of the second floor maintenance direct the door rm41, rm rm45 doors were marred. MD-A state maintenance plant actual door scrape system in place to marred kick pane there were two are room flooring app	0:19 a.m. an environmental tour or was completed with ctor (MD)-A. The kick panels on 146, rm47, rm49-1, rm49-2, and observed scratched and ted he had a preventative of or all of the room scrapes and es and chips, but did not have a paint/repair the scratched and als of the doors. Additionally, eas on the second floor dining roximately six inches by six inches and lifted creating a		for the ripped lifted area in the Level dining room floor. We a investigating more permanent have these ripped areas perm removed either by replacing the sections or replacing the entir maintenance program of walk and completing a general buil inspection 2 times a month wi implemented to ensure the far good repair to make it a safe clean, homelike environment, taken will be reported to the a All staff will be educated on the importance of maintaining a senvironment by reporting dam promptly at a mandatory in-se	re t options to nanently ne damaged e flooring. A ting around ding ill be cility is in Actions dministrator. ne afe naged items	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245247	B. WING			11/0	04/2016
	PROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE 010 SOUTH BIRCH IALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	potential tripping h maintenance depa ripped/raised floor prior and had start finished the repair areas of flooring.	age 36 azard. MD-A stated the artment was notified of the ing approximately two weeks ed the repair, but had not by tacking down the ripped  facility repairs was requested	F 4	465	12/05/16. This monitoring will be reby the Administrator and will be shathe monthly Management Risk Management Meetings for their revand corrective actions taken as necessorsibility for compliance will be Maintenance Manager, DON and Administrator. Completion date 12/	riew eded. e the	

PRINTED: 12/05/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION - Main Building 01		E SURVEY PLETED		
		245247	B. WING		11/0	02/2016		
	PROVIDER OR SUPPLIER	HCARE CENTER	101	STREET ADDRESS, CITY, STATE, ZIP CODE  1010 SOUTH BIRCH  HALLOCK, MN 56728				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
K 000	INITIAL COMMEN	тѕ	K 000					
	FIRE SAFETY							
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TO	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.						
i	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.							
	Minnesota Departr Fire Marshal Divisi Kittson Memorial I- not in substantial or requirements for p Medicare/Medicaio 483.70(a), Life Saf of National Fire Pro Standard 101, Life , (LSC), Chapter 1	I at 42 CFR, Subpart ety from Fire, the 2012 edition otection Association (NFPA)						
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	OR THE FIRE SAFETY		EPO(				
	Health Care Fire In State Fire Marshal 445 Minnesota Str St. Paul, MN 5510	Division eet, Suite 145						

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.

**Electronically Signed** 

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

TITLE

(X6) DATE

11/29/2016

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION 11 - MAIN BUILDING 01		SURVEY PLETED
		245247	B, WING		=	11/0	2/2016
	ROVIDER OR SUPPLIER	ICARE CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH BIRCH ALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO  1. A description of to correct the deficit  2. The actual, or properties of the correct the deficit of the correct the deficit of the correct of the correc	tate.mn.us  RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION:  what has been, or will be, done ency.  oposed, completion date.  r title of the person rection and monitoring to ence of the deficiency  rial Healthcare Center is made.  The original building is north om, with a 2-hour fire barrier, al Hospital building. It is ment and was constructed in ermined to be of Type II(000) now fully sprinkler protected oper level. In 1981 a 1-story basement was built to the north ing that was determined to be		0000			
	accordance and ha	as a fire alarm system with the corridor system and in all					
		apacity of 70 beds and had a time of the survey.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '			TE SURVEY MPLETED
		245247	B. WING			/02/2016
	PROVIDER OR SUPPLIER	HCARE CENTER		10	REET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH BIRCH ALLOCK, MN 56728	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From pa	ige 2	K	000		
K 211 SS=E	NOT MET as evidented NFPA 101 Means of Egress - Aisles, passageware exit locations, and with Chapter 7, and continuously maint full use in case of early 18.2.1, 19.2.1, 7.1. This STANDARD Based on observation facility failed to prothe corridor from rethe Life Safety Cocsection 19.2.2 & 7. could affect the exit residents and an uland visitors.	General General ys, corridors, exit discharges, accesses are in accordance of the means of egress is ained free of all obstructions to emergency, unless modified by 18/19.2.11.	K	2211	It is the policy Of KMHC to provide unobstructed access to the corridor from resident rooms. This has the potential to affect all residents and staff. Door closures have been ordered for each bathroom door in the upper level and will be installed as soon as they arrive. Maintenance Manager responsible for compliance. Maintenance will report to the administrator when the project has been completed. Completion date 12/19/16	ie
K 321 SS=E	revealed all resider care wing were unathe door when the open position.  This deficient condition Director of Mainter NFPA 101 Hazardous Areas - 2012 EXISTING	ous Areas - Enclosure	κ	321		11/29/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245247	B. WING			11/0	2/2016
	PROVIDER OR SUPPLIER	HCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  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)  SUMMARY STATEMENT OF DEFICIENCY  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)				(X5) COMPLETION DATE		
K 321	fire rated doors) or system in accordar approved automati option is used, the other spaces by sn doors in accordance self-closing or autohave nonrated or fithat do not exceed the door.  Describe the floor system in accordance in accordance self-closing or autohave nonrated or fithat do not exceed the door.	age 3 resistance rating (with 3/4-hour an automatic fire extinguishing nce with 8.7.1. When the crime extinguishing system areas shall be separated from noke resisting partitions and rewith 8.4. Doors shall be smatic-closing and permitted to eld-applied protective plates 48 inches from the bottom of and zone locations of nat are deficient in REMARKS.  Automatic Sprinkler	K	321			
	Seperation N/ a. Boiler and Fuel- b. Laundries (large c. Repair, Maintena d. Soiled Linen Roi e. Trash Collection (exceeding 64 galla f. Combustible Sto (over 50 square feag. Laboratories (if of Hazard - see K322 This STANDARD Based on observa facility to maintain accordance with the (NFPA 101) section condition could allo corridor making it of and efficient exiting an undetermined a	A Fired Heater Rooms r than 100 square feet) ance, and Paint Shops oms (exceeding 64 gallons) Rooms ons) rage Rooms/Spaces et) classified as Severe			It is the policy of KMHC that hazar areas are protected by a fire barrie automatic fire extinguishing system has the potential to affect all KMHC residents, visitors and staff. A door closure has been ordered for the ostorage room on the second level as be installed as soon as it arrives. Maintenance Manager responsible compliance. Maintenance will report	r or n. This C xygen and will	
	Findings include: On the facility tour	between 7:30am to 11:00am			compliance. Maintenance will repo the administrator when the project been completed. Completion date		

		A MEDICAID SERVICES		_			0000-000
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION O1 - MAIN BUILDING 01		SURVEY
		245247	B. WING			11/0	2/2016
	PROVIDER OR SUPPLIER	HCARE CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE D10 SOUTH BIRCH ALLOCK, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
K 321	on 11-2-2016 observeealed the oxyge admin office on the self closer.	ryations and staff interview n storage room, north of the second level did not have a	K	321	12/19/16		
K 712 SS=F	Director of Mainten NFPA 101 Fire Drills Fire Drills Fire drills include the signal and simulation conditions. Fire drill times under varying on each shift. The sand is aware that droutine. Responsible conducting drills is persons who are quality where drills are confuncted in the conducting drills are confuncted in the conducting drills are confuncted in the confunction of the confunction	ance. Is  the transmission of a fire alarm on of emergency fire alarm on the stablished alarm of the stablished alarm on the stablished alarm on the stablished alarm of the stablished alarm on the stablished alarm on the stablished alarm on the stablished alarm on the stablished alarm of the stablished alarm on the stablis	K.	712	It is the policy of KMHC to hold fire drat least quarterly on all shifts. This hat the potential to affect all KMHC's residents, staff and visitors. A schedul has been devised indicating which shidue to have a fire dril1. The schedule be signed off when the drills have bee completed. Drill dates and times will be reviewed monthly by the Risk Management Committee. Maintenance manager responsible for compliance. Completion date 12/19/16	le ift is will en ee	11/29/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01		(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245247	B, WING		11/	02/2016	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZII 1010 SOUTH BIRCH HALLOCK, MN 56728	PCODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
K 712	Continued From p the past 12 month 1) 2nd shift 1st qtr 2) 2nd shift 3rd qtr 3) 3rd shift 4th qtr This deficient condition of Mainte	os. of 2016 or of 2016 or of 2015 dition was confirmed by the	K 7	712			



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered November 19, 2016

Ms. Cindy Urbaniak, Administrator Kittson Memorial Healthcare Center 1010 South Birch Hallock, Minnesota 56728

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5247028

Dear Ms. Urbaniak:

The above facility was surveyed on October 31, 2016 through November 4, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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

Kittson Memorial Healthcare Center November 19, 2016 Page 2

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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 Lyla Burkman at: (218) 308-2104 or email: lyla.burkman@state.mn.us.

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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 12/13/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 00321 11/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*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

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.

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.

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:**

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

Minnesota Department of Health

STATE FORM

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

11/29/16

(X6) DATE

Electronically Signed

TITLE

PRINTED: 12/23/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00321 11/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*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

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herein are not corrected, a fine for each violation not corrected shall be assessed in accordance

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.

that was violated during the initial inspection was

### **INITIAL COMMENTS:**

corrected.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

**Electronically Signed** 

11/29/16

PRINTED: 12/23/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00321 11/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Continued From page 1 2 000 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 31, November 1, 2, 3, and 4, 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using

6899

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 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

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00321	B. WING		11/0	4/2016
_	PROVIDER OR SUPPLIER	ICARE CENTER 1010 SOU	DRESS, CITY, S ITH BIRCH K, MN 56728	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA  THERE IS NO REC PLAN OF CORREC		2 000			
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the	2 565			11/30/16
	by: Based on observati review, the facility fa with oral hygiene as	ent is not met as evidenced on, interview and document ailed to provide assistance is directed by the care plan for is 3) who required assistance		Corrected		
	Findings include:					
	R53 was to receive minimum. The care	iewed 10/18/2016, indicated oral hygiene twice daily, at a plan instructed the nursing as needed especially when uplete oral cares.				
	The current Reside	nt Care Sheet which the				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
				7.1. 20122.110.1			
		00321		B. WING		11/0	4/2016
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
KITTSON	I MEMORIAL HEALTH	ICARE CENTER		ITH BIRCH K, MN 56728	<b>I</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 3		2 565			
	nursing assistants (NA's) referred to and carried on their person, indicated R53 had upper and lower dentures and directed staff: "Do not let her refuse oral cares."						
	On 11/1/16, at 9:30 a.m. family member (FM)-A stated he had concerns with R53's oral hygiene and whether or not R53 was receiving oral hygiene/care.						
	On 11/02/16, at 8:30 a.m. R53 was observed in the bathroom on the toilet. R53 voided, nursing assistant (NA)-A put a new pull up on R53, applied transfer belt and R53 ambulated back to her bed. At that time NA-A assisted R53 with putting her robe on and stated R53 was going to be getting a bath after she finished her breakfast. NA-A left R53's room. When asked if she had received oral hygiene, R53 stated she had not and had also slept with her dentures in her mouth. R53 then ambulated with her front wheeled walker down the hall to the nurse's desk and then to the dining room.						
	confirmed she had	5 p.m. NA-B/bath aide given R53 a bath after and only provided bath	r R53				
		confirmed she had no oral hygiene during the g cares.					
	-At 1:45 p.m. registered nurse (RN)-A verified the care plan was correct and stated oral hygiene should be completed two times a day as directed on the care plan.						

Minnesota Department of Health

STATE FORM RZ7T11 If continuation sheet 4 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00321	B. WING		11/0	04/2016
	PROVIDER OR SUPPLIER	HCARE CENTER 1010 SOU	DRESS, CITY, I ITH BIRCH K, MN 56728	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	The facility policy, (Documentation Guoral hygiene would with who was responsed by the second between the director of nurse could review or reveducation for staff implementation. The director of the second for staff implementation.	General Resident Care Plan idelines, dated 10/11, indicated be identified on the care plan onsible for completing oral ctions unique to the resident d on the resident's care plan.  THOD OF CORRECTION: sing (DON) and/or designee ise policies and provide regarding care plan he Quality Assessment and committee could do random impliance.	2 565			
2 855	Proper Nursing Ca Subp. 2. Criteria f proper care. The a adequate and prop E. Assistance as n keep the mouth, te Measures must be lips This MN Requirem by: Based on observat review, the facility f	or determining adequate and criteria for determining	2 855	Corrected		11/30/16

Minnesota Department of Health

STATE FORM RZ7T11 If continuation sheet 5 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00321	B. WING		11/0	04/2016
	PROVIDER OR SUPPLIER  N MEMORIAL HEALTH	ICARE CENTER 1010 SOL	DRESS, CITY, S JTH BIRCH K, MN 56728	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 855		from staff for oral hygiene	2 855			
	Findings include:					
	10/4/16, indicated F hypertension, had s and used a walker	imum Data Set (MDS) dated R53's diagnoses included severe cognitive impairment to ambulate with. The MDS red limited assistance of one giene.				
	was to receive oral minimum. The care	ed 10/18/16, indicated R53 hygiene twice daily, at a plan instructed the nursing as needed especially when aplete oral cares.				
	nursing assistants ( on their person, ind	nt Care Sheet which the (NA's) referred to and carried icated R53 had upper and directed staff: "Do not let her				
	stated he was conc	a.m. family member (FM)-A erned with R53's oral hygiene ether R53 was receiving oral				
	the bathroom on the assistant (NA)-A pu applied transfer bel	0 a.m. R53 was observed in e toilet. R53 voided, nursing t a new pull up on R53, t and R53 ambulated back to e NA-A assisted R53 with				

Minnesota Department of Health

STATE FORM RZ7T11 If continuation sheet 6 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

B. WING

11/04/2016

		00321				11/04/2016
				TATE, ZIP CODE		
KITTSON	N MEMORIAL HEALTH	ICARE CENTER		ITH BIRCH K, MN 56728		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE	
2 855	Continued From page 6  putting her robe on and stated R53 was going to be getting a bath after she finished her breakfast.  NA-A left R53's room. Oral cares had not been offered or provided. When asked if she had			2 855		
	received oral hygiene, R53 stated she had not and that she had slept with her dentures in her mouth. R53 ambulated with her front wheeled walker down the hall to the dining room.					
	On 11/02/16, at 1:35 p.m. NA-B/bath aide confirmed she had given R53 a bath after breakfast and only provided bathing, not oral cares.					
	-At 1:40 p.m. NA-A provided R53 with a providing morning of	any oral hygiene wh				
	-At 1:45 p.m. regist would expect R53 t provided morning c hygiene should be d directed on the care addressed a conce hygiene at R53's las	o receive oral hygie ares and confirmed completed two time e plan. RN-A stated rn regarding R53's	ene when d oral es a day as FM-A had oral			
	On 11/3/16, at 8:30 a.m. the director of nursing (DON) verified NA-A should have provided oral hygiene to R53 in the morning before breakfast as directed by the care plan.					
	The facility's Oral H indicated oral hygie daily.					
	SUGGESTED MET The director of nursepartment of Health					

Minnesota Department of Health

STATE FORM RZ7T11 If continuation sheet 7 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00321		B. WING		11/04/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KITTSON	N MEMORIAL HEALTH	ICARE CENTER	JTH BIRCH <, MN 56728	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 855	Continued From page 7 direct care staff regarding expectations for oral hygiene. The director of nursing or designee could develop auditing systems to monitor for ongoing compliance.		2 855			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					
21426	MN St. Statute 144A Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426			11/30/16
	maintain a comprehinfection control procurrent tuberculosis issued by the United Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volument to the shall provide regarding implement.	e provider must establish and nensive tuberculosis ogram according to the most is infection control guidelines d States Centers for Disease ation (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of extechnical assistance intation of the guidelines.				
	by:	ent is not met as evidenced and document review, the		Corrected		

Minnesota Department of Health

STATE FORM RZ7T11 If continuation sheet 8 of 47

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1) F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00321	B. WING		44/	04/0016
NAME OF	PROVIDER OR SUPPLIER	•		STATE, ZIP CODE	11/0	04/2016
	N MEMORIAL HEALTH	HCARE CENTER 1010 SO	UTH BIRCH			
(X4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	K, MN 56728	PROVIDER'S PLAN OF CO	ARRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETE DATE
21426	Continued From pa	age 8	21426			
	of the two step tube would include the ir the test was comple	ure consistent documentation erculin skin test (TST) which nduration and interpretation of eted for 4 of 5 residents (R27, viewed who lacked the ation.				
	Findings include:					
	R27's Resident Imr R27 received the firmedical record lack induration and inter Medication Adminis received the 2nd st TST was read on 3	to the facility on 3/11/16. munization Record indicated rst step TST on 3/11/16. The ked documentation of both the retation of the test. The stration History indicated R27 rep TST on 3/25/16, and the 1/28/16, however, the record ion of both the induration and e test.				
	R74's Medication A R74 was administe 8/18/16, and the TS results were identification was not Administration Histor TST was administe 9/4/16 with results in	to the facility on 8/18/16. Idministration History indicated ared the first step TST on ST was read on 8/21/16. The fied as negative, however the documented. The Medication ory indicated the second step ared on 9/1/16, and read on identified as negative. ation was not documented.				
	R71's Medication A R71 was administe 6/30/16, and the TS	to the facility on 6/30/16. Idministration History indicated red the first step TST on ST was read on 7/3/16. The fied as negative, however, the				

Minnesota Department of Health

STATE FORM RZ7T11 If continuation sheet 9 of 47

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00321	B. WING		11/04/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	_	
KITTSON	N MEMORIAL HEALTH	ICARE CENTER	TH BIRCH (, MN 56728			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	induration was not of Administration History TST was administe 7/21/16 with results However, the induration R58 was admitted the R58's Resident Imprevious facility indifferst step TST on 4/recorded as 0 milling TST was read and was not recorded. 4/30/16 and read of	documented. The Medication ory indicated the second step red on 7/18/16, and read on identified as negative. ation was not documented.  To the facility on 5/19/16. munization Record from the icated R58 had received the 8/16. The induration was neters (mm), but the date the the interpretation of the TST The second TST was given on 15/2/16. The induration was but the interpretation of the	21426			
	On 11/3/16 at approximately 10:00 a.m. registered nurse (RN)-C verified there was no documentation of the results of R27's step 1 or 2 TST.					
	confirmed R27's TS documented in the should have include	a.m. the director of nursing a.m. the director of nursing T results should have been record and the TST results ad interpretation and induration as directed by the facility				
	documentation of the time, number of mile interpretation of necessignature of the number of the numb	culosis policy indicated ne TST would include the date, limeters of induration and gative or positive and the se performing the test and of the nurse reading the				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00321	B. WING		11/0	4/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•		
KITTSON	I MEMORIAL HEALTH	ICARE CENTER	TH BIRCH K, MN 56728	}			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21426	Continued From pa	ge 10	21426				
	director of nursing (review policies and components of the monitoring program educated on the TE Mantoux process.	THOD OF CORRECTION: The DON) and/or designee could procedures related to the infection control and TB in Facility staff could be in regulations and the two steps a monitoring system to impliance.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one-					
21510	MN Rule 4658.1200 SpecializedRehabili	Subp. 2 A.B. itative Services; Provision	21510			11/30/16	
	rehabilitative service resident's comprehenursing home must A. provide the requirements	uired services; or obtain the om an outside source					
	by: Based on observati review, the facility fa comprehensive ass intellectual disability 1 resident (R74) wit disability who was r	ent is not met as evidenced on, interview and document ailed to complete a lessment and provide needed of rehabilitative services for 1 of the a diagnosis of intellectual not receiving services to related to communication.		Corrected			
	Findings include:						

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00321	B. WING		11/0	4/2016
NAME OF	PROVIDER OR SUPPLIER		DDECC CITY (	STATE, ZIP CODE	11/0	4/2010
		1010 SOU	TH BIRCH	STATE, ZIF GODE		
KITTSON	N MEMORIAL HEALTH	ICARE CENTER	K, MN 56728	ı		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21510	Continued From pa	ge 11	21510			
	prior to that R74 liv at home, R74 receirehabilitative care a activity center (DAC					
	The undated Admis had a diagnosis of	sion Record indicated R74 Down's syndrome.				
	(MDS) dated 8/30/1 admitted from the conspect that was so understanding of very understood. The Minappropriate behave focusing attention. It is assistance of one pambulation, dressinand toilet use. R74'	ng, personal hygiene, eating, s medical record did not nent of R74's strengths and				
	Resident Review (F developmental disa conditions dated 8/2 and had medical ar nursing home servi PASRR screening s Treatment, the follo mark indicating: "The	Imission Screening and PASRR) for persons with ability (DD) or related 24/16, indicated R74 had DD, and health care needs requiring ces. Review of the Level II section, Need for Active awing was identified by a check his person's medical and are so severe that, in the MRP [qualified mental]				

Minnesota Department of Health

STATE FORM RZ7T11 If continuation sheet 12 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00321	B. WING		11/0	4/201 <i>6</i>
NAME OF I	PROVIDER OR SUPPLIER	<u>I</u>		STATE, ZIP CODE	11/0	4/2016
		1010 SOU	TH BIRCH	TATE, ZII OODE		
KILISON	I MEMORIAL HEALTH	HALLOCK	K, MN 56728			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21510	Continued From pa	ge 12	21510			
	expect to benefit from	ional], the person cannot om active treatment." The DD roved by DHS (Department of n 10/13/16.				
	unit for persons wit 9:30 a.m. to 11:00 a follow staff around observed to redired different resident ro observed to wande at 10:44 a.m. and the	living on a locked special care h dementia. On 11/1/16, from a.m. R74 was observed to the unit and staff was at R74 from following them into soms to provide care. R74 was a r into another resident's room he resident told R74 he did not om and needed to leave.				
	breakfast, seated a served cold cereal, banana cake. It was eat the cold cereal. interviewed during the R74 was very shy a words. However, it what R74 was sayin not clear and was whad learned all of Participate in the locked uthere were more account participate in on the did not have any specific participate.	on 11/2/16, at 8:28 a.m. eating t a table alone. R74 was a banana, and a piece of s noted R74 used the fork to Nursing assistant (NA)-K was this observation and stated and could sometimes verbalize was difficult to understanding because the speech was very very soft. NA-K stated she transport of the facility, except that stivities offered that R74 could be locked unit. NA-K stated R74 pecialized programs to as much independence and as possible.				
	time to eat and nee	NA-L stated R74 took a long ded prompting. NA-L stated wed the staff around all day				

6899

Minnesota Department of Health STATE FORM

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6899

Further review of R74's medical record revealed there was no assessment completed which indicated the need for a locked unit for R74. Additionally, the care plan dated 8/23/16, identified R74 had speech that was limited to occasional whispers. However, the care plan had not included instruction for the sign language R74 used.

any specialized programs to maintain or achieve as much independence and self-determination as

On 11/3/16, at 8:39 a.m. social service designee (SSD)-A stated she was not aware of any specialized rehabilitation requirements for caring for individuals who had DD. SSD-A stated she was not aware of any staff at the facility who had training in the field of DD to provide R74 care and services. SSD-A stated the only reason R74 was placed on a locked dementia unit was because they were afraid R74 would try and elope from the facility. SSD-A confirmed R74 had never attempted to elope from the facility since admission, and an assessment to determine if a locked dementia unit was an appropriate placement had not been completed.

On 11/3/16, at 10:15 a.m. the director of nursing (DON) stated she was not aware if R74 was assessed to determine what specialized rehabilitation services needed. The DON was not sure what assessment was required for residents

Minnesota Department of Health STATE FORM

possible.

Minnesota Department of Health

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		00321	B. WING		11/0	4/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
KITTSON	I MEMORIAL HEALTH	HCARE CENTER	TH BIRCH (, MN 56728	F			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21510	Continued From page 14		21510				
	DON stated they ha	with diagnoses of DD. The ad never consulted with the ger to determine R74's tion needs.					
	locked unit (undate an evaluation would social services, or N	ty's policy for admission to the d) was reviewed and identified d be made by the nursing staff, M.D. to determine the placement on the locked unit.					
	A policy for specialized services for the DD was requested but not provided.						
	The administrator, scould develop and in procedure related to disabilities and treat staff. Then developensure ongoing control or the staff.	ETHOD FOR CORRECTION: social worker or designee implement policies and o residents with intellectual tment needs and educate o monitoring systems to impliance and report the lity Assurance Committee.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one					
21685	MN Rule 4658.1419 Housekeeping, Ope	5 Subp. 2 Plant eration, & Maintenance	21685			11/30/16	
	including walls, floo	plant. The physical plant, ors, ceilings, all furnishings, oment must be kept in a					

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00321	B. WING		11/0	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
KITTSON	N MEMORIAL HEALTH	ICARE CENTER	ITH BIRCH K, MN 56728	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21685	continuous state of with regard to the h well-being of the re	ge 15 good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.	21685			
	by: Based on observation review, the facility for services related to densure safe and same resident room doors rm49-1, rm49-2, rmwere observed scratof repair and failed dining room flooring	on, interview and document ailed to provide maintenance ongoing repairs in order to nitary environment for 6 of 14 s (rm) (rm41, rm46, rm47, 45) on the second floor which atched and marred and in need to ensure the second floor y was maintained to prevent e to ripped, raised flooring in 1 observed.		Corrected		
	Findings include:					
	of the second floor maintenance direct the door rm41, rm4 rm45 doors were of marred. MD-A state maintenance plan factual door scrapes system in place to parred kick panels there were two area room flooring approinches observed rip potential tripping hamaintenance depar	19 a.m. an environmental tour was completed with or (MD)-A. The kick panels on 6, rm47, rm49-1, rm49-2, and oserved scratched and of the had a preventative or all of the room scrapes and and chips, but did not have a paint/repair the scratched and of the doors. Additionally, also on the second floor dining eximately six inches by six uped and lifted creating a lizard. MD-A stated the timent was notified of the ang approximately two weeks				

Minnesota Department of Health

STATE FORM RZ7T11 If continuation sheet 16 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	E SURVEY MPLETED	
		00321	B. WING		11/0	4/2016
	PROVIDER OR SUPPLIER	1010 SOU	DRESS, CITY, S TH BIRCH K, MN 56728	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
21685	prior and had starte	ge 16 ed the repair, but had not by tacking down the ripped	21685			
	A policy related to fa and not provided.	acilty repairs was requested				
	The director of nurs develop a maintena facility was in good clean, homelike end designee could edu the program, and co	HOD OF CORRECTION: sing (DON) or designee could ance program to ensure the repair to maintain a safe, vironment. The DON or locate all appropriate staff on ould develop monitoring ongoing compliance.				
	TIME PERIOD FOR Twenty-One (21) Da					
21755	MN Rule 4658.2000 Criteria	Subp. 3 Secured Units;	21755			11/30/16
	A resident may be a secured unit only if comprehensive res by part 4658.0400 i a more secure envi physician's written a secured unit. A res a secured unit if the assessment and pla 4658.0400 and 465	r assignment to secured unit. assigned to placement in a the results of a ident assessment as required ndicate that resident requires ronment and there is a order for placement in a ident may choose to reside in a comprehensive resident an of care as required by parts 8.0405 determine that ured unit is appropriate for that				

Minnesota Department of Health

PRINTED: 12/23/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ B. WING 00321 11/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21755 Continued From page 17 21755 This MN Requirement is not met as evidenced Based on observation, interview and document Corrected review, the facility failed to complete a comprehensive assessment prior to assigning a resident with intellectual disabilities placement on a secured dementia unit for 1 of 1 (R74) resident observed to reside on a secured unit without an assesment to determine need for such placement. Findings include: R74's medical record indicated R74 was admitted to the facility on 8/18/16, and prior to that R74 lived at home with family. While at home, R74 received intellectual disability rehabilitative care and services provided by a day activity center (DAC). Review of R74's medical record, the undated Admission Record indicated R74 had a diagnosis of Down's syndrome, convulsions, psoriatic

Minnesota Department of Health

arthritis, cardiac murmur, and hypothyroidism.

Review of R74's admission Minimum Data Set (MDS) dated 8/30/16, indicated R74 was admitted from the community and had unclear speech that was sometimes understood. R74's understanding of verbal content was sometimes understood. The MDS indicated R74 had no inappropriate behavior symptoms except difficulty

focusing attention. R74 required physical

STATE FORM 6899 RZ7T11 If continuation sheet 18 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	ICARE CENTER 1010 SOU	DRESS, CITY, S ITH BIRCH K, MN 56728	STATE, ZIP CODE		
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21755	assistance of one p ambulation, dressin and toilet use. R74' include an assessm needs related to co The level II PASRR developmental disa	erson for transfers, ig, personal hygiene, eating, is medical record did not nent of R74's strengths and mmunication.  for persons with bility (DD) or related	21755			
	conditions dated 8/2 and had medical ar nursing home service PASRR screening some service Treatment the followed for the commark indicating: "The health care needs a judgment of the QN retardation professive expect to benefit from screening was appropriately for the command of the command o	24/16, indicated R74 had DD, and health care needs requiring ces. Review of the level II section Need for Active wing was identified by a check his person's medical and are so severe that, in the MRP (qualified mental onal), the person cannot or active treatment." The DD roved by DHS (Department of a 10/13/16. However, this of identified what health care of which precluded him from the treatment, and did not resident's current status thensive assessment.				
	unit for persons with 9:30 a.m. to 11:00 a follow staff around to observed to redirect different resident roobserved to wander at 10:44 a.m. and the belong in the bedroom R74 was observed	living on a locked special care of dementia. On 11/1/16, from a.m. R74 was observed to the unit and staff was to R74 from following them into oms to provide care. R74 was r into another resident's room the resident told R74 he didn't om and needed to leave.  On 11/2/16, at 8:28 a.m. eating to a table alone. R74 was				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

		00321		B. WING	<del></del>	11/04/2016
	PROVIDER OR SUPPLIER	IOADE OFNITED		DRESS, CITY, S	STATE, ZIP CODE	
KILISON	I MEMORIAL HEALTI	HCARE CENTER	HALLOCK	K, MN 56728		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENC Y MUST BE PRECEDED E SC IDENTIFYING INFOR	CIES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
21755	Continued From pa	ige 19		21755		
	served cold cereal, banana cake. It was eat the cold cereal, interviewed during R74 was very shy a words. However, it's R74 was saying be clear and was very had learned all of F she could commun NA-K stated R74 has the facility unattend lived in the locked of there were more acceparticipate in on the did not have any specific maintain or achieved self-determination as	s noted R74 used to Nursing assistant this observation and and could sometimes difficult to understause the speech wery soft. NA-K stauth R74's sign language icate with R74 effect and never attempted led, and did not known it of the facility, extinctions of the facility as much independent of the facility and the facility as much independent of the facility as much independent o	the fork to (NA)-K was d stated es verbalize stand what was not ated she e and felt ctively. If to leave ow why R74 xcept that R74 could stated R74 sto			
	On 11/2/16, at 9:22 time to eat and nee R74 generally follow and liked interacting was not sure why F because she had n leave the facility. Not any specialized pro as much independent possible.  Further review of R there was no assessindicated the need Additionally, the call identified R74 had seed the seed R74 had seed the seed R74 had seed	eded prompting. NA-wed the staff aroun g with them. NA-L staff aroun rever known R74 to A-L stated R74 did grams to maintain ence and self-determent completed version for a locked unit for re plan dated 8/23/speech that was ling wedther the staff and self-determent completed versions.	d-L stated d all day stated she ed unit attempt to not have or achieve mination as d revealed which r R74.			
	occasional whisper included instruction used.					
iviinnesota Di	epartment of Health					

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21755	Continued From pa	ge 20	21755			
	(SSD)-A stated she specialized rehabilit for individuals who was not aware of ar training in the field of services. SSD-A state placed on a locked they were afraid R7 facility. SSD-A configuratempted to elope admission, and an area.	a.m. social service designee was not aware of any ration requirements for caring had DD. SSD-A stated she my staff at the facility who had of DD to provide R74 care and ated the only reason R74 was dementia unit was because 4 would try and elope from the from the facility since assessment to determine if a it was an appropriate been completed.				
	(DON) stated she wassessed to determ rehabilitation services sure what assessm who were admitted DON stated they has county case manages specialized habilitate.  Review of the facilitation locked unit (undated an evaluation would social services, or Note that the services is the services of the services of the services.)	ies policy for admission to the d) was reviewed and identified I be made by the nursing staff, M.D. to determine the				
		placement on the locked unit. ed services for the DD was rovided.				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

AND DIAN OF CODDECTION IDENTIFICATION NI IMPED:		E CONSTRUCTION	(X3) DATE COMP	SURVEY			
		00321		B. WING	<del></del>	11/0	4/2016
	PROVIDER OR SUPPLIER	ICARE CENTER 10	010 SOU	DRESS, CITY, S TH BIRCH (, MN 56728	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21755	A SUGGESTED MITHE administrator, so could develop and in procedure related to prior to admission to staff. Then developensure ongoing confindings to the Qual TIME PERIOD FOR (21) days.	ETHOD FOR CORRECT social worker or designate in the policies and assessment of reside to the locked unit and economic monitoring systems to inpliance and report the ity Assurance Committed ity Assurance Towns and R CORRECTION: Twen	ee I nts ducate ee.	21755			11/00/10
21800	Subd. 4. Informa residents shall, at a are legal rights for stay at the facility of treatment and main that these are described written statement or responsibilities set case of patients ad as defined in section statement shall also person 16 years old provided in section shall list the names individuals and organ advocacy and legal residential program accommodations slicommunication impospeak a language of	tion about rights. Patied mission, be told that their protection during the resident in the communities in an accompany of the applicable rights a forth in this section. In mitted to residential properties of a secribe the right of a for older to request releases and telephone number anizations that provide services for patients in	here cheir de of nity and ng nd the grams ease as and s of with o	21800			11/30/16

6899

Minnesota Department of Health STATE FORM

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Minnesota Department of Health

facility.

and would work on getting the most current Bill of Rights posted. SSD-A stated the booklet titled, "Your Rights" dated 1/16, which covered the combined Federal and State Bill of Rights was given to each resident, when admitted to the

On 11/4/16, at 8:30 a.m., the director of nursing observed the Bill of Rights posted in the facility and verified it was an outdated version and the

Minnesota Department of Health

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	KITTSON MEMORIAL HEALTHCARE CENTER 1010 SC HALLO			STATE, ZIP CODE		
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21800	•	ge 23 ed copy was needed.	21800			
	A facility policy on F requested, however	Resident Rights was r no policy was received.				
	director of nursing ( develop, review, an procedures to ensu current resident bill system to ensure th	HOD OF CORRECTION: The DON) or designee could d/or revise policies and re residents receive the of rights, and develop a ne current resident bill of rights sidents, family, and staff				
	TIME PERIOD FOF (21) Days	R CORRECTION: Twenty-one				
21805	MN St. Statute 144. Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			11/30/16
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observati review, the facility fa dining experience fo	ent is not met as evidenced on, interview and document ailed to provide a dignified or 3 of 3 residents (R24, R41, rait for their meal while erved.		Corrected		

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

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21805	Continued From pa Findings include:	ge 24	21805			
	10/4/16, indicated F impairment and req one person with eat 10/11/16, directed s	imum Data Set (MDS) dated R24 had severe cognitive uired limited assistance of ting. R24's care plan dated staff to provide set up and ed for meals and provide cues				
	R41 had severe coorequired limited assetting. R41's Care	S dated 9/13/16, indicated gnitive impairment and sistance of one person with Plan dated 11/1/16, directed up and assist as needed for all				
	R26 had severe con required extensive eating. R26's care staff to provide set	S dated 10/18/16, indicated gnitive impairment and assistance of one person with plan dated 10/25/16, directed up and assistance for meals eeding as warranted.				
	On 11/1/16, the folk the breakfast meal:	owing was observed during				
	seated at a table in seated in a reclinerat 7:46 a.m. R41 v recliner to a wheeld with R23, R24 and breakfast and also and R74 were obseindependentlyat 7:50 a.m. R26 v	R24, and R74 were observed the dining room. R41 was next to the table.  was transferred from the hair and seated up to the table R74. R23 was served R74, shortly thereafter. R23 erved to eat their meals  was brought to the dining room seated at the same table.				

Minnesota Department of Health

STATE FORM RZ7T11 If continuation sheet 25 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUP	PLIER			DRESS, CITY, S JTH BIRCH	STATE, ZIP CODE			
KITTSON MEMORIAL H	ALTI	HCARE CENTER		K, MN 56728	3			
PRÉFIX (EACH DEFI	CIENC	ATEMENT OF DEFICIENCY Y MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
aid (AA)-C we residents sear dining roomat 8:10 a.m. minutes after seated next to toward R74's R41at 8:14 a.m. minutes after rat 8:16 a.m. minutes after tablemate's harmonia to the served at a tawere served be served reside servedat 8:04 a.m. table and R23 rat 8:10 a.m. rat 8:13 a.m. and sat down after other resiserved.  On 11/3/16, at (LPN)-C state for the dining wherever it we was usually for eat. LPN-C ar	ant (re obtained at the coom of the coom o	NA)-I, NA-J, NA-K served distributing three other tables was served breakf was served. R41, was observed to A staff member rewas served breakf	meals to in the sast, 24 who was reach edirected sast, 28 sast, 26 table where observed:  observed: observed R24 and R2 ded to R41 was not ught to the sast breakfast minutes been actical nurse rrangement d residents e big table ssistance to onfirmed	21805		• • •		

Minnesota Department of Health

STATE FORM RZ7T11 If continuation sheet 26 of 47

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Minnesota Department of Health STATE FORM

days.

dining expereience. The quality assessment and assurance committee could perform random

TIME PERIOD FOR CORRECTION: Twenty (21)

audits to ensure compliance.

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agency.

known or suspected maltreatment, if the reporter knows or has reason to know that a report has

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement

(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

been made to the common entry point.

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Minnesota Department of Health

Findings include:

disturbance.

R36's undated admission record indicated R36's diagnoses included dementia without behavior

R36's annual Minimum Data Set (MDS) dated 7/12/16, indicated R36 had no cognitive

impairment or memory problems and R36 could

PRINTED: 12/23/2016

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00321 11/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21980 Continued From page 29 21980

On 11/1/16, at 10:59 a.m. R36 stated approximately six weeks ago she had money missing (20.00 dollars in the form of two 10 dollar bills) from her room which was stored in her second dresser drawer, in a wallet which was in a purse. R36 stated at the time of the discovery of the missing money, she reported it to a nursing assistant, however, could not remember the name of the nursing assistant. R36 stated she kept the money in a wallet in her purse and put the purse in the second drawer of her dresser.

effectively verbalize needs and understand verbal

communication needs adequately.

On 11/2/16, at 12:04 p.m. nursing assistant (NA)-G stated she was not aware of R36 having any missing money. NA-G stated if a resident reported missing money she would immediately report it to the charge nurse.

On 11/2/2016, at 12:32 p.m. NA-H stated she was not aware of R36 having any missing money. NA-H stated that if a resident reported missing money she would immediately report it to the charge nurse.

On 11/2/16, 12:43 p.m. licensed practical nurse (LPN)-D stated she was the charge nurse and had been employed for over 3 years. LPN-D stated there were no nursing assistants that had reported R36 had missing money from her wallet, and if a resident or NA had reported missing money, she would immediately report it to the director of nursing (DON).

Minnesota Department of Health STATE FORM

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				7.1. 20.22.1.10.1				
		00321		B. WING		11/0	4/2016	
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
KITTSON	MEMORIAL HEALTH	ICARE CENTER		ITH BIRCH (, MN 56728	<b>.</b>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21980	Continued From pa	ge 30		21980				
	(RN)-A stated R36 RN-A had not heard RN-A stated the fact items very seriously money was turned services. RN-A stat were reported to the	7 p.m. registered nurse was a reliable reporter and R36 was missing moneility staff took any missing, and any amount of minto the DON or social and all missing money one DON and social worked build report any amount ssing.	and ney. ing issing r items er.					
	On 11/2/16, at 1:23 p.m. R36's family member was interviewed via telephone and confirmed she had given R36 three twenty dollars bills and was aware the money was missing. She stated she herself had not reported the missing money to the facility because she had not looked all over R36's room to truly see if the money was missing or not.							
	12/15-11/2/16, were incident reports for	ult (VA) reports from e reviewed as well as th the same time period a t R36 was missing mon	nd					
	able to report incide history of making up accusations or report not received a report DON confirmed the reported the missin reported to the characteristic and been investigated at she investigated all	p.m. the DON stated Rents accurately and had p stories or making falsorts. The DON stated short of R36 missing mone a nursing assistant R36 g money to should have rge nurse so it could have and reported. The DON missing items and missing reported those incide 20 dollars or over.	no e ne had ey. The e ve stated sing					

Minnesota Department of Health

STATE FORM RZ7T11 If continuation sheet 31 of 47

PRINTED: 12/23/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00321 11/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21980 Continued From page 31 21980 R27's guarterly MDS dated 9/20/16, indicated R27 had moderate cognitive impairment. The MDS also indicated R27 had no symptoms of psychosis or behavioral symptoms. The Missing Item Incident Report completed by the social service designee (SSD) and dated 6/1/16, indicated R27 reported missing \$10 bill that he had behind his calendar in his room. The

6899

On 11/3/16, at 10:30 a.m. the social service designee (SSD) confirmed the allegation and stated R27's missing money was not called into the State agency and should have been and a full investigation and documentation in R27's medical record was lacking.

incident report further indicated on 6/11/16, R27 was refunded his \$10 as it was not found. The incident was not reported to the State agency.

On 11/3/16, at 1:45 p.m. the DON and administrator confirmed the incident was not reported to the State agency as required. The DON indicated they were following the facility policy which stated they would report theft of resident's property of any significant amount meaning greater than \$20.

R39's quarterly MDS dated 10/11/16, indicated R39 had moderately impaired cognition.

A Missing Item Incident report dated 5/23/16, indicated R39 was missing a roll of stamps which

PRINTED: 12/23/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ B. WING 00321 11/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21980 Continued From page 32 21980 were last seen in R39's drawer, in her room. R39 did not know how long the stamps had been missing. Notification of the missing stamps was sent to the upper and lower level maintenance. housekeeping, laundry, activities, dietary departments and the administrator. The SSD's conclusion of the missing stamps dated 5/23/16, indicated R39 had a machine that weighed and dispensed stamps. R39 had complained to her

6899

R53's quarterly MDS dated 10/4/16, indicated R53 had severely impaired cognition.

son she could not open it and when he opened it the stamps were gone. R39's son did not know if the stamps were lost, used or gone. The report also indicated R39's son did not know when the incident happened. R39's son stated he would get her a book of stamps verses a roll of stamps. The allegation was not reported to the State agency and a thorough investigation was not completed.

A Missing Item Incident Report dated 11/18/15, indicated R53 was missing a watch which was last seen 11/17/15. A nursing assistant reported the watch was not seen during R53's bath on 11/18/15. R53's room was searched. Notification of the missing watch was sent to the upper and lower level maintenance, housekeeping, laundry, activities, dietary departments and the administrator. The SSD's conclusion dated. 11/18/15, indicated, "Family brought in another watch for her, as was not expensive." The report of missing property was not reported to the State agency, as required and a thorough investigation was not completed. R53's medical record lacked any documentation regarding the missing watch.

Minnesota Department of Health STATE FORM

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			B. WING	R WING		
		00321	b. WING		11/0	4/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KITTSON	N MEMORIAL HEALTH	HCARE CENTER	JTH BIRCH K, MN 56728	}		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21980	Continued From pa	age 33	21980			
		mum Data Set (MDS) dated severely impaired cognition.				
	indicated R9 was m seen the day prior of a search of R9's ro Notification of the n upper and lower lev housekeeping, laur departments and th conclusion dated 7, had went to laundry deemed non fixable missing property we the State agency. F	dent Report dated 7/8/16, nissing a watch which was last on 7/7/16. The report indicated from was conducted. nissing watch was sent to the vel maintenance, ndry, activities, dietary ne administrator. The SSD's /11/16, indicated R9's watch y, had been washed and e. Family was notified. The as not immediately reported to R9's medical record lacked any arding the missing watch.				
	missing stamps wh & R9's missing wat were not called into have been. The SS implemented the \$ amount. However, may be just as imposed \$20.00 amount. The should be reporting by an investigation stated the facility w	D p.m. the SSD verified R39's sich valued at \$50.00, and R53 ches each valued at \$10.00, of the State agency and should ED stated the facility had E20.00 reportable monetary agreed a lesser amount/value ortant to a resident as a e SSD stated the facility grany missing money followed which was lacking. The SSD ould be revising their Abuse sappropriation of resident				
	(DON) and adminis	p.m. the director of nursing strator confirmed the incidents as were not reported to the				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 34 of 47 RZ7T11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00321	B. WING		11/0	4/2016
	PROVIDER OR SUPPLIER	ICARE CENTER 1010 SOL	DRESS, CITY, S JTH BIRCH K, MN 56728	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21980	State agency as received were following they would report the any significant amount of the Missing Item P awareness of missing resident's room and have been left at. If daily function wait or replacement. If lost (ie: clothing, jewelry found in the time spand/or administrate liability and reimbur of the facility's Report Vulnerable Adults P 7/13/16, and 8/23/1 trained on abuse are exploitation at the tidirected staff to repuned to replace the financial eximmediately. The pof maltreatment of a "Theft of patient's pamount of money in (\$20.00)." The policious pected maltreat anyone shall be reported.	quired. The DON indicated the facility policy which stated aff of resident's property of unt meaning greater than \$20.  olicy, undated, indicated uponing personal items, search dother possible areas it may lost item affects residents one week before initiating item is other than those listed of, etc.) wait one month. If not boars listed, refer to DON or for decision as to facility sement and/or replacement.  Iting Maltreatment of colicy and Procedure revised 6, indicated all staff were and neglect, including financial me of hire and annually and ort incidents of abuse, exploitation to the administrator colicy also identified indicators a Vulnerable Adult included roperty. Any significant neaning over twenty dollars by further indicated incidents of ment of a vulnerable adult by worted immediately to the	21980	DEFICIENCY)		
	State agency, the ir interview appropriate safety was needed, information on suspersured to the description of the interview	nce a report was made to the aternal review team would te staff and resident, decide if gather appropriate pected perpetrator and ription of the maltreatment. al investigation, the				

Minnesota Department of Health

STATE FORM 6899 RZ7T11 If continuation sheet 35 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED	
		00321	B. WING		11/0	04/2016
	PROVIDER OR SUPPLIER	HCARE CENTER 1010 SO	DDRESS, CITY, S UTH BIRCH K, MN 56728	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21980	days as to the result review team determexternal report, they Adult Abuse Report SUGGESTED MET. The administrator of need to immediately abuse/neglect to the agency/common erfacility's policy. The	Its of the investigation. If the nined the incident required any would notify the Minnesotating Center.  THOD OF CORRECTION: could in-service all staff on the y reporting suspected e designated state ntry point according to the e director of nurses' could	21980			
22000	requirement.  TIME PERIOD FOR (21) days.	oorts for implementation of this R CORRECTION: Twenty One				11/30/16
	Reporting - Maltrea Subd. 14. Abuse facility, except hom personal care atten establish and enfor prevention plan. The assessment of the environment, and it factors which may ea and a statement of to minimize the risk comply with any rule promulgated by the (b) Each facility, agency and person	prevention plans. (a) Each e health agencies and idant services providers, shall ce an ongoing written abuse ne plan shall contain an physical plant, its s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	
		00321	B. WING	····	11/0	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KITTSON	N MEMORIAL HEALTH	HCARE CENTER	TH BIRCH (, MN 56728	<b>;</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
22000	residing there or retained the plan shall contrassessment of: (1) abuse by other indivulnerable adults; (other vulnerable adspecific measures the risk of abuse to the adults. For the purterm "abuse" include (c) If the facility, and personal care at knows that the vulnation violent crime or an toward others, the inplan must detail the minimize the risk the reasonably be experimentally and persons unsupervised. Under a vulnerable adult misconduct or physical information from the facility's ongoing vulnerable adult.	each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing lults; and (3) statements of the to be taken to minimize the t person and other vulnerable poses of this paragraph, the les self-abuse.  except home health agencies attendant services providers, rerable adult has committed a act of physical aggression individual abuse prevention is measures to be taken to eat the vulnerable adult might exted to pose to visitors to the coutside the facility, if the left his section, a facility knows lt's history of criminal sical aggression if it receives on a law enforcement in a medical record prepared by other health care provider, or grassessments of the	22000			
	by: Based on interview facility failed to imp immediate reporting	and document review, the lement their policy for g of misappropriation of esidents (R36) who reported		Corrected		

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 37 of 47 RZ7T11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00321	B. WING		11/0	4/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KITTSON	N MEMORIAL HEALTH	HCARE CENTER	TH BIRCH (, MN 56728			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	immediately report of property for 4 of R9) who reported in determined the pro \$20 therefore did in as required. The fallacked the appropri requirements regar resident property/ fi addition, the facility implement policies during investigation abuse/neglect/mist potential to affect a the facility. The facility repolicy related employees for 2 of	s. The facility also failed to allegations of misappropriation 5 residents (R27, R39, R53, nissing property. The facility perty to be valued at less than ot report to the State agency, cility abuse prohibition policy rate definition and reporting ding misappropriation of inancial exploitation. In a failed to develop and addressing resident protection	22000			
	Findings include:					
	Vulnerable Adults F 7/13/16, and 8/23/1 trained on abuse are exploitation at the tidirected staff to repneglect, financial eximmediately. The pof maltreatment of "Theft of patient's pamount of money n (\$20.00)." The policisuspected maltreat anyone shall be rep	ting Maltreatment of Policy and Procedure revised 6, indicated all staff were and neglect, including financial ime of hire and annually and port incidents of abuse, exploitation to the administrator policy also identified indicators a Vulnerable Adult included property. Any significant meaning over twenty dollars by further indicated incidents of a ment of a vulnerable adult by ported immediately to the once a report was made to the				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 38 of 47 RZ7T11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTR IDENTIFICATION NUMBER:  A. BUILDING:	COMPLETED
00321 B. WING	11/04/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP	CODE
KITTSON MEMORIAL HEALTHCARE CENTER  1010 SOUTH BIRCH HALLOCK, MN 56728	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BY BY FULL PREFIX (EACH DEFICIENCY MUST BY BY FULL PREFIX (EACH DEFICIENCY MUST BY	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE
State agency, the internal review team would interview appropriate staff and resident, decide if safety was needed, gather appropriate information on suspected perpetrator and document the description of the maltreatment. Following the internal investigation, the administrator would be notified within five working days as to the results of the investigation. If the review team determined the incident required an external report, they would notify the Minnesota Adult Abuse Reporting Center. The policy lacked the required component related to how the facility would protect the resident during an investigation and how they would handle/manage the employee involved in a maltreatment allegation.  On 11/2/16, at 11:40 a.m. the DON stated an employee involved in an investigation would be suspended until the investigation was completed. The DON verified the facility policy did not address the issue thoroughly. At 12:10 p.m. the DON confirmed the policy directed staff to report missing items if valued over \$20.00 dollars.  On 11/2/16, at 10:45 a.m. the social service designee (SSD) confirmed the facility's abuse policy lacked the required component related to how the facility would protect a resident during an vulnerable adult investigation and how they would deal with and manage the employee involved in the allegation.  The Missing Item Policy, undated, indicated upon awareness of missing personal items, search resident's room and other possible areas it may have been left at. If lost item affects residents	

Minnesota Department of Health

STATE FORM RZ7T11 If continuation sheet 39 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING		4440	
		00321	B. WING		11/0	4/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KITTSON	N MEMORIAL HEALTH	HCARE CENTER	ITH BIRCH (, MN 56728			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
22000	found in the time spand/or administrated liability and reimburk.  R36's undated administrated diagnoses included disturbance.  R36's annual Minim 7/12/16, indicated Fimpairment or memerated fimpairment or memerated for the missing \$20.00 dol bills) from her room second dresser drapurse. R36 stated at the missing money assistant, however, name of the nursing kept the money in a	y, etc.) wait one month. If not cans listed, refer to DON or for decision as to facility rement and/or replacement.  Inission record indicated R36's dementia without behavior  Thum Data Set (MDS) dated R36 had no cognitive mory problems and R36 could be needs and understand verbal eds adequately.	22000	DEFICIENCY)		
	(NA)-G stated she any missing money	4 p.m. nursing assistant was not aware of R36 having v. NA-G stated if a resident coney she would immediately ge nurse.				
		2:32 p.m. NA-H stated she 36 having any missing money.				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION (DENTIFICATION NUMBER: COMPLETED

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		00321	B. WING		11/0	4/2016
	PROVIDER OR SUPPLIER  N MEMORIAL HEALTH	1010 SO	DDRESS, CITY, S UTH BIRCH K, MN 56728	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	NA-H stated that if	ge 40 a resident reported missing nmediately report it to the	22000			
	(LPN)-D stated she had been employed stated there were n reported R36 had n and if a resident or	o.m. licensed practical nurse was the charge nurse and for over 3 years. LPN-D o nursing assistants that had nissing money from her wallet, NA had reported missing mmediately report it to the (DON).				
	(RN)-A stated R36 or RN-A had not heard RN-A stated the factitems very seriously money was turned is services. RN-A state were reported to the	7 p.m. registered nurse was a reliable reporter and d R36 was missing money. Ellity staff took any missing y, and any amount of missing into the DON or social ed all missing money or items a DON and social worker. Ellity bulld report any amount of ssing.				
	was interviewed via had given R36 three aware the money w herself had not repo facility because she	p.m. R36's family member telephone and confirmed she te twenty dollars bills and was as missing. She stated she orted the missing money to the had not looked all over R36's the money was missing or not				
	incident reports for	ult (VA) reports from e reviewed as well as the the same time period and : R36 was missing money.				

Minnesota Department of Health

STATE FORM RZ7T11 If continuation sheet 41 of 47

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY
		00321	B. WING		11/0	04/2016
	PROVIDER OR SUPPLIER	1010 SOU	DRESS, CITY, S TH BIRCH (, MN 56728	STATE, ZIP CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETE DATE
22000	able to report incide history of making up accusations or report not received a report poor confirmed the reported the missing reported to the characteristic been investigated all money, however, out that had a value of R36 had reported in assistant (NA) and	p.m. the DON stated R36 was ents accurately and had no p stories or making false orts. The DON stated she had rt of R36 missing money. The nursing assistant R36 g money to should have rge nurse so it could have and reported. The DON stated missing items and missing nly reported those incidents 20 dollars or over. In issing money to a nursing the facilities policy on abuse, nancial exploitation was not	22000			
	R27 had moderate MDS also indicated psychosis or behave.  The Missing Item In the social service d 6/1/16, indicated R2 that he had behind	S dated 9/20/16, indicated cognitive impairment. The IR27 had no symptoms of ioral symptoms.  ncident Report completed by esignee (SSD) and dated 27 reported missing \$10 bill his calendar in his room. The ter indicated on 6/11/16, R27				
	On 11/3/16, at 10:3 the allegation and s	10 as it was not found. The corted to the State agency.  30 a.m., the SSD confirmed stated R27's missing money the State agency and should Il investigation and				

Minnesota Department of Health

STATE FORM RZ7T11 If continuation sheet 42 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		00321	B. WING		11/0	4/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
KITTSON	KITTSON MEMORIAL HEALTHCARE CENTER  1010 SOUTH BIRCH							
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	K, MN 56728	PROVIDER'S PLAN OF CORRECTION		(X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE		
22000	Continued From pa	ge 42	22000					
	documentation in R lacking.	27's medical record was						
	reported to the Stat DON indicated they policy which stated	med the incident was not e agency as required. The were following the facility they would report theft of of any significant amount						
		S dated 10/11/16, indicated y impaired cognition.						
	indicated R39 was were last seen in R did not know how lo missing. Notification sent to the upper an housekeeping, laun departments and the conclusion of the mindicated R39 had a dispensed stamps. son she could not of the stamps were lost also indicated R39's incident happened. her a book of stampallegation was not reside the stamps were not resident happened.	dent Report dated 5/23/16, missing a roll of stamps which 39's drawer, in her room. R39 ong the stamps had been of the missing stamps was not lower level maintenance, adry, activities, dietary readministrator. The SSD's dissing stamps dated 5/23/16, a machine that weighed and R39 had complained to her open it and when he opened it one. R39's son did not know if st, used or gone. The report is son did not know when the R39's son stated he would get be verses a roll of stamps. The reported to the State agency restigation was not completed.						
	R53's quarterly MD R53 had severely in	S dated 10/4/16, indicated mpaired cognition.						

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING:

(X3) DATE SURVEY COMPLETED

		00321	В	s. WING		11/04/2016
	PROVIDER OR SUPPLIER	ICARE CENTER 10	10 SOUTH		STATE, ZIP CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETE
22000	indicated R53 was a last seen 11/17/15. the watch was not s 11/18/15. R53's roo of the missing watch lower level mainten activities, dietary de administrator. The S 11/18/15, indicated, watch for her, as was	dent Report dated 11/18/missing a watch which w A nursing assistant reposeen during R53's bath om was searched. Notifich was sent to the upper ance, housekeeping, lau	/15, /as prited on ation and undry, her eport	22000		
	agency, as required was not completed any documentation	d and a thorough investig R53's medical record la regarding the missing w dated 8/23/16, indicated	gation acked ratch.			
Ainnesota D	indicated R9 was m seen the day prior of a search of R9's ro Notification of the m upper and lower lev housekeeping, laund departments and th conclusion dated 7/ had went to laundry deemed non fixable missing property was the State agency. F	dent Report dated 7/8/16 hissing a watch which watch 7/7/16. The report indom was conducted. hissing watch was sent to rel maintenance, adry, activities, dietary are administrator. The SS 11/16, indicated R9's way, had been washed and a Family was notified. The same not immediately report 19's medical record lacked arding the missing watch	s last icated of the D's atch he ted to ed any			

6899

Minnesota Department of Health STATE FORM

PRINTED: 12/23/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00321 11/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 22000 Continued From page 44 22000 On 11/3/16, at 1:30 p.m. the SSD verified R39's missing stamps which valued at \$50.00, and R53 & R9's missing watches each valued at \$10.00. were not reported to the State agency and should have been. The SSD stated the facility had implemented the \$20.00 reportable monetary amount. However, agreed a lesser amount/value may be just as important to a resident as a \$20.00 amount. The SSD stated the facility should be reporting any missing money followed by an investigation which was lacking. The SSD stated the facility would be revising their Abuse policy regarding misappropriation of resident property. On 11/3/16, at 1:45 p.m. the DON and administrator confirmed the incidents for R39. R53 and R9 were not reported to the State agency as required. The DON indicated they were following the facility policy which directed staff to report theft of resident's property of any significant amount meaning greater than \$20. REFERENCE CHECKS On 11/3/16, at 9:00 a.m. employee records were reviewed with the human resource manager (HRM) and the following was revealed:

6899

Minnesota Department of Health STATE FORM

-Employee (EE)-B was hired 8/23/16, and was currently working in the activities department. EE-B's employee record lacked documentation of reference checks being completed. The HRM stated it was the responsibility of the department manager to complete the reference checks.

PRINTED: 12/23/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00321 11/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 22000 Continued From page 45 22000 -EE-A was hired 8/30/16, and was currently working in the dietary department. EE-A's employee record lacked documentation of the completion of reference checks. On 11/3/16, at 9:35 a.m. the HRM stated at least one reference check should be completed on new hires. On 11/3/16, at 9:50 a.m. the DON verified new employee's should have references checked and documented according to the facility policy. Adding, she would assume the three references would be followed through on and would be documented in the employee files. The facility policy handbook for new employees dated 2014, indicated the facility would conducts reference checks on all new employees. The facility Reporting Maltreatment of Vulnerable Adults Policy and Procedure, revised 7/13/16 & 8/23/16, indicated the facility would attempt to

Minnesota Department of Health

obtain information from previous employers with

SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the

need to immediately reporting suspected abuse/neglect to the designated state agency/common entry point according to the facility's policy. The director of nurses' could monitor incident reports for implementation of this

references and the findings would be documented in the employee's file.

PRINTED: 12/23/2016 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_\_\_ B. WING \_ 00321 11/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH BIRCH KITTSON MEMORIAL HEALTHCARE CENTER HALLOCK, MN 56728 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE DATE (X4) ID PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 22000 22000 Continued From page 46 requirement. TIME PERIOD FOR CORRECTION: Twenty One (21) days.

Minnesota Department of Health