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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RZ7T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00321

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/30/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A, 1** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lisa Carey, HFE NEII 02/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/27/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/23/2016
(L33)

DETERMINATION APPROVAL

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, 2016.

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.

MDH
Minnesota Department of Health

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 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

Minnesota Department of Health

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.

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245247 Y1	A. Building B. Wing Y2	12/29/2016 Y3

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

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0156	Correction	ID Prefix	F0225	Correction	ID Prefix	F0226	Correction
Reg. #	483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. #	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	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		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	LB/mm	02/06/2017	34985	12/29/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 11/4/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245247	A. Building 01 - MAIN BUILDING 01 B. Wing	12/5/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0211	Correction Completed 11/29/2016	ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 11/29/2016	ID Prefix Reg. # NFPA 101 LSC K0712	Correction Completed 11/29/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	**REVIEWED BY (INITIALS)** TL/mm	**DATE** 02/06/2017	**SIGNATURE OF SURVEYOR** 36536	**DATE** 12/08/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 11/2/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**			

Minnesota Department of Health

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245247 Y1	A. Building B. Wing Y2	12/29/2016 Y3

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

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0156	Correction	ID Prefix	F0225	Correction	ID Prefix	F0226	Correction
Reg. #	483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. #	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	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		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	LB/mm	02/06/2017	34985	12/29/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 11/4/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RZ7T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00321

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

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

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

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/04/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NEII 12/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5247

An extended survey was completd 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 addtion, 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

Minnesota Department of Health

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:

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

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

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

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

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 https://dab.efile.hhs.gov 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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted by the Minnesota Department of Health on 11/4/16. Substandard Quality of Care was identified at F226 related to facility failure to develop and implement polices that prohibit misappropriation of resident property, and the protection of residents from harm during investigation of allegations of abuse, neglect or mistreatment.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and	F 156		11/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/04/2016

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F 156	Continued From page 1	F 156		

any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

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F 156	Continued From page 2 medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most current nursing home Bill of Rights, revised in March 2016, was posted and used by the facility. This had the potential to affect all 56 residents residing in the facility.	F 156	It is the policy of KMHC that on admission residents shall be told that of their legal rights for their protection during and throughout their stay or course of treatment and maintenance in the facility. Failing to post the most current nursing home Bill of rights has the potential to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 3 Findings include: During the initial tour, on 10/31/16, at 5:30 p.m., observation revealed the Bill of Rights posted in the facility was dated 10/05. On 11/3/16, at 10:30 a.m., social service designee (SSD)-A confirmed the facility's posted Bill of Rights was not the most current version. and stated she was responsible for the posting 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 facility. 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 most current, revised copy was needed. A facility policy on Resident Rights was requested, however, no policy was received.	F 156	affect all residents, staff and family members. Updated Bill of Rights posters have been posted. KMHC□s Bill of rights policy has been updated and staff will receive education on the policy. To ensure compliance, our Social Services Consultant will do QA checks at her monthly visits. The results will be brought to the Risk Management Committee for their review and corrective actions taken as needed. S.S.D. responsible for continued compliance. Completion date 11/29/16	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F 225		12/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 4 other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an allegation of misappropriation of property for 1 of 5 residents (R36) who reported missing money which was not reported to the State agency. The facility also failed to immediately report and/or thoroughly investigate allegations of misappropriation of missing property for 4 of 5 residents (R27, R39, R53, R9) who reported missing property. The facility determined the property to be valued at	F 225	It is the policy of KMHC that when a mandated reporter that has reason to believe that a vulnerable adult is being or has been mistreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained and/or misappropriation of property, shall immediately report the information to the administrator of the facility and MDH. All	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 5 less than $20 and therefore did not report to the State agency, as required. Findings include: 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. 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. 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.	F 225	residents of KMHC are vulnerable adults and all have the potential to be affected. KMHC□s VA policy has been updated and the portion that states loss amounts over $20 value will be reported has been removed and the wording changed to loss of property or monetary amounts. Our 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 on 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 all reported missing items and the log will be monitored by the SSD and DON for appropriate implementation of KMHC□s VA policy. The results of these audits will be brought to the Risk Management Committee monthly for their review and corrective actions taken as needed. DON and Administrator responsible for compliance Completion date 12/09/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 6 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). On 11/2/16, at 12:47 p.m. registered nurse (RN)-A stated R36 was a reliable reporter and RN-A had not heard R36 was missing money. RN-A stated the facility staff took any missing items very seriously, and any amount of missing money was turned into the DON or social services. RN-A stated all missing money or items were reported to the DON and social worker. RN-A stated she would report any amount of money that was missing. 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.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/04/2016

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KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

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F 225	Continued From page 7	F 225		

The Vulnerable Adult (VA) reports from 12/15-11/2/16, were reviewed as well as the incident reports for the same time period and there was no report R36 was missing money.

On 11/2/16, at 1:03 p.m. the DON stated R36 was able to report incidents accurately and had no history of making up stories or making false accusations or reports. The DON stated she had not received a report of R36 missing money. The DON confirmed the nursing assistant R36 reported the missing money to should have reported to the charge nurse so it could have been investigated and reported. The DON stated she investigated all missing items and missing money, however, only reported those incidents that had a value of 20 dollars or over.

R27's quarterly 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 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 8 investigation and documentation in R27's medical record was lacking. 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 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 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.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/04/2016

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F 225	Continued From page 9	F 225		

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

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.

R9's quarterly Minimum Data Set (MDS) dated 8/23/16, indicated severely impaired cognition.

A Missing Item Incident Report dated 7/8/16, indicated R9 was missing a watch which was last seen the day prior on 7/7/16. The report indicated a search of R9's room was conducted. 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 7/11/16, indicated R9's watch had went to laundry, had been washed and deemed non fixable. Family was notified. The missing property was not immediately reported to the State agency. R9's medical record lacked any documentation regarding the missing watch.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/04/2016

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

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F 225	Continued From page 10 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 called into 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 director of nursing (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 stated they would report theft of resident's property of any significant amount meaning greater than $20. 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 daily function wait one week before initiating replacement. If lost item is other than those listed (ie: clothing, jewelry, etc.) wait one month. If not found in the time spans listed, refer to DON and/or administrator for decision as to facility liability and reimbursement and/or replacement.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/04/2016

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

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F 225	Continued From page 11 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 immediately. The policy also identified indicators of maltreatment of a Vulnerable Adult included "Theft of patient's property. Any significant amount of money meaning over twenty dollars ($20.00)." The policy further indicated incidents of suspected maltreatment of a vulnerable adult by anyone shall be reported immediately to the administrator and once a report was made to the 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.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 226		12/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 12 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. Findings include: 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 immediately. The policy also identified indicators of maltreatment of a Vulnerable Adult included "Theft of patient's property. Any significant	F 226	It is the policy of KMHC that when a mandated reporter has reason to believe that a vulnerable adult is being or has been mistreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained and/or misappropriation of property, shall immediately report the information to the administrator of the facility and MDH. All residents of KMHC are vulnerable adults and all have the potential to be affected. KMHC□s VA policy has been updated and the portion that states loss amounts over $20 value will be reported has been removed and the wording 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 results of an investigation to ensure 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 on 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 all reported missing items and the log will be monitored by the SSD and DON for appropriate implementation of KMHC□s VA policy. The results of these audits will be brought to the Risk Management Committee monthly for their review and corrective actions taken as needed. DON and Administrator responsible for compliance. A form has been developed by human resources to be used for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/04/2016

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

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F 226	Continued From page 13 amount of money meaning over twenty dollars ($20.00)." The policy further indicated incidents of suspected maltreatment of a vulnerable adult by anyone shall be reported immediately to the administrator and once a report was made to the 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.	F 226	applicants. Reference checks obtained or attempted to be obtained will be documented on this form. The form will be turned into the Human Resources Manager. The HR manager will be responsible for monitoring compliance with the reference checks. All managers will be educated by HR on the use of the form. Completion date 12/09/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/04/2016

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F 226	Continued From page 14	F 226		

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 daily function wait one week before initiating replacement. If lost item is other than those listed (ie: clothing, jewelry, etc.) wait one month. If not found in the time spans listed, refer to DON and/or administrator for decision as to facility liability and reimbursement and/or replacement.

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.

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.

On 11/2/16, at 12:04 p.m. nursing assistant (NA)-G stated she was not aware of R36 having

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/04/2016

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

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F 226	Continued From page 15	F 226		

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).

On 11/2/16, at 12:47 p.m. registered nurse (RN)-A stated R36 was a reliable reporter and RN-A had not heard R36 was missing money. RN-A stated the facility staff took any missing items very seriously, and any amount of missing money was turned into the DON or social services. RN-A stated all missing money or items were reported to the DON and social worker. RN-A stated she would report any amount of money that was missing.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/04/2016

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

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F 226	Continued From page 16	F 226		

facility because she had not looked all over R36's room to truly see if the money was missing or not.

The Vulnerable Adult (VA) reports from 12/15-11/2/16, were reviewed as well as the incident reports for the same time period and there was no report R36 was missing money.

On 11/2/16, at 1:03 p.m. the DON stated R36 was able to report incidents accurately and had no history of making up stories or making false accusations or reports. The DON stated she had not received a report of R36 missing money. The DON confirmed the nursing assistant R36 reported the missing money to should have reported to the charge nurse so it could have been investigated and reported. The DON stated she investigated all missing items and missing money, however, only reported those incidents that had a value of 20 dollars or over.
R36 had reported missing money to a nursing assistant (NA) and the facilities policy on abuse, neglect, including financial exploitation was not implemented as written.

R27's quarterly 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 17	F 226		

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 10:30 a.m., the 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.

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 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 son she could not open it and when he opened it the stamps were gone. R39's son did not know if

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	245247	A. BUILDING _____ 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

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F 226	Continued From page 18	F 226		

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.

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

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.

R9's quarterly MDS dated 8/23/16, indicated severely impaired cognition.

A Missing Item Incident Report dated 7/8/16, indicated R9 was missing a watch which was last seen the day prior on 7/7/16. The report indicated a search of R9's room was conducted. Notification of the missing watch was sent to the upper and lower level maintenance,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 19	F 226		

housekeeping, laundry, activities, dietary departments and the administrator. The SSD's conclusion dated 7/11/16, indicated R9's watch had went to laundry, had been washed and deemed non fixable. Family was notified. The missing property was not immediately reported to the State agency. R9's medical record lacked any documentation regarding the missing watch.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 20 On 11/3/16, at 9:00 a.m. employee records were reviewed with the human resource manager (HRM) and the following was revealed: -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. -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	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/04/2016

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

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F 226	Continued From page 21 obtain information from previous employers with references and the findings would be documented in the employee's file.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 3 of 3 residents (R24, R41, R26) observed to wait for their meal while tablemate's were served. Findings include: R24's quarterly Minimum Data Set (MDS) dated 10/4/16, indicated R24 had severe cognitive impairment and required limited assistance of one person with eating. R24's care plan dated 10/11/16, directed staff to provide set up and assistance as needed for meals and provide cues and reminders. R41's quarterly MDS dated 9/13/16, indicated R41 had severe cognitive impairment and required limited assistance of one person with eating. R41's care plan dated 11/1/16, directed staff to provide setup and assist as needed for all meals.	F 241	It is the policy of KMHC that their residents have the right to be treated with courtesy and respect for their individuality by employees providing services in our health care facility. For residents R24, R41, and R 26 that were a not provided dignified dining services during survey -involved staff were educated as soon as the concern was shared and corrections were made. All of KMHC residents have the potential to be affected. To obtain and maintain compliance, A Dining With Dignity Policy has been developed that includes serving table by table during the noon and evening meals. Education will be provided for all involved staff by our Dietary Technician at a mandatory staff meeting December 5th regarding the new Dining with Dignity Policy. Random audits will be performed of dignified dining experience. Corrective action will be taken during these audits as needed to ensure dignity. The results will be brought monthly x 3 then quarterly to the Risk	12/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/04/2016

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

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F 241	Continued From page 22 R26's quarterly MDS dated 10/18/16, indicated R26 had severe cognitive impairment and required extensive assistance of one person with eating. R26's care plan dated 10/25/16, directed staff to provide set up and assistance for meals and to assist with feeding as warranted. On 11/1/16, the following was observed during the breakfast meal: --at 7:27 a.m. R23, R24, and R74 were observed seated at a table in the dining room. R41 was seated in a recliner next to the table. --at 7:46 a.m. R41 was transferred from the recliner to a wheelchair and seated up to the table with R23, R24 and R74. R23 was served breakfast and also R74, shortly thereafter. R23 and R74 were observed to eat their meals independently. --at 7:50 a.m. R26 was brought to the dining room via wheelchair and seated at the same table. Nursing assistant (NA)-I, NA-J, NA-K and activity aid (AA)-C were observed distributing meals to residents seated at three other tables in the dining room. --at 8:10 a.m. R24 was served breakfast, 24 minutes after R23 was served. R41, who was seated next to R74, was observed to reach toward R74's food. A staff member redirected R41. --at 8:14 a.m. R41 was served breakfast, 28 minutes after R23 was served. --at 8:16 a.m. R26 was served breakfast, 26 minutes after she was brought to the table where tablemate's had already been served.	F 241	Management Committee for their review and corrective actions taken as needed. Completion date 12/09/16	

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F 241	Continued From page 23 On 11/3/16, the breakfast meal was observed: --at 7:54 a.m. R24, R2 and R41 were observed seated at a table in the dining room. R24 and R2 were served breakfast. Staff proceeded to served residents at adjoining tables. R41 was not served. --at 8:04 a.m. R74 and R23 were brought to the table and R23 was served breakfast --at 8:10 a.m. R74 was served breakfast --at 8:13 a.m. NA-G brought R41 her breakfast and sat down to assist her to eat, 19 minutes after other residents at the table had been served. On 11/3/16, at 11:32 a.m. licensed practical nurse (LPN)-C stated there was a seating arrangement for the dining room but staff positioned residents wherever it worked. LPN-C stated the big table was usually for people who needed assistance to eat. LPN-C and AA-D confirmed R41 had to be fed and stated she had to wait to be served until a staff member was available to assist her to eat. On 11/3/16, at 11:38 a.m. registered nurse (RN)-C stated R41's condition was declining. RN-C stated R41 used to feed herself but now required assistance. RN-C also stated she normally would not serve residents so long after everyone else had been fed and did not realize R24, R41 and R26 had waited that long. RN-C confirmed residents should not have to wait at the table without their meal while others were eating and should be served at the same time. On 11/04/16, at 11:25 a.m. the director of nursing	F 241		

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F 241	Continued From page 24 (DON) indicated she would expect all the individuals seated at the same table to be served at the same time and not have to wait for their food while tablemate's were eating. The undated Quality of Life policy indicated staff should interact with the residents in ways that enhance his or her self-esteem and self-worth and promote resident independence and dignity in dining.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with oral hygiene as directed by the care plan for 1 of 3 residents (R53) who required assistance with oral hygiene. Findings include: R53's care plan reviewed 10/18/2016, indicated R53 was to receive oral hygiene twice daily, at a minimum. The care plan instructed the nursing assistants to assist as needed especially when R53 refused to complete oral cares.	F 282	It is the Policy of KMHC that a comprehensive plan of care be used by all personnel involved in the care of the resident. In relation to R53, who was not provided oral care during survey, the staffs involved were educated on the importance of oral care and in following the care plan. Staff ensured that the resident received oral care that day. All residents of the facility have the potential to be affected if they are not provided oral care or cares according to their care plan. Compliance will be monitored with a sign-off sheet has been developed for the CNA to initial after the oral care has been done in accordance with care plan. To	12/13/16

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F 282	Continued From page 25 The current Resident Care Sheet which the 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. On 11/02/16, at 1:35 p.m. NA-B/bath aide confirmed she had given R53 a bath after R53 finished breakfast and only provided bathing, not oral cares. -At 1:40 p.m. NA-A confirmed she had not provided R53 with oral hygiene during the provision or morning cares. -At 1:45 p.m. registered nurse (RN)-A verified the	F 282	ensure compliance,observation audits will be done on various shifts of following the care plan and providing adequate oral care will continue monthly and randomly throughout the entire year by nursing and DON with corrective action taken the day of the audit if noncompliance is found. The audits of care provided in accordance with the care plan will be reviewed periodically by the DON and weekly at the nursing home subcommittee meetings. The initial oral care audit was completed 11/09/16. The policy on care plan implementation will be revised to include the importance of following the care plan. The oral care policy will be revised to include the risks of not receiving adequate oral care and all staff will be educated on care plan implementation and the importance of oral care at a mandatory in-service 12/05/16. The results of these audits will be brought to the Risk Management Committee monthly x three months then quarterly for their review and corrective actions taken as needed. Completion date 12/09/16	

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F 282	Continued From page 26 care plan was correct and stated oral hygiene should be completed two times a day as directed on the care plan. The facility policy, General Resident Care Plan Documentation Guidelines, dated 10/11, indicated oral hygiene would be identified on the care plan with who was responsible for completing oral hygiene and instructions unique to the resident would be addressed on the resident's care plan.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with oral cares for 1 of 3 residents (R53) who required assistance from staff for oral hygiene and did not receive the assistance. Findings include: R53's quarterly Minimum Data Set (MDS) dated 10/4/16, indicated R53's diagnoses included hypertension, had severe cognitive impairment and used a walker to ambulate with. The MDS indicated R53 required limited assistance of one	F 312	It is the policy of KMHC that adequate and proper care is provided for oral care and that assistance is provided as needed with oral hygiene to keep the mouth, teeth or dentures clean and that measures will be taken to prevent dry cracked lips. In relation to R53 who was not provided oral care during survey, the staffs involved were educated on the importance of oral care and in following the care plan. It was ensured that R53received oral care that day. All residents of the facility have the potential to be affected if they are not provided oral care according to their care plan. An oral care compliance sign off	11/30/16

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F 312	Continued From page 27 staff for personal hygiene. R53's care plan dated 10/18/16, indicated R53 was to receive oral hygiene twice daily, at a minimum. The care plan instructed the nursing assistants to assist as needed especially when R53 refused to complete oral cares. The current Resident Care Sheet which the nursing assistants (NAs) 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 was concerned with R53's oral hygiene and questioned whether R53 was receiving oral cares. 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. Oral cares had not been offered or provided. When asked if she had 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	F 312	sheet has been developed for the CNA to initial after the oral care has been done in accordance with care plan. Nursing will check for completeness of this form AM and PM shifts. KMHC oral care policy will be updated to include importance of oral care and all staff will be educated on the policy. Staff will also be educated on the oral changes elderly experience and the importance of adequate oral care by Dr. Ostrosky D.D.S. To ensure compliance, monthly and random audits will continue throughout the entire year of oral care and dry, cracked lips by nursing and DON with corrective action taken the day of the audit if noncompliance is found. The results of the QA will be brought to the Risk Management Committee monthly x 3 then quarterly for their review and corrective actions taken as needed. Results of audits will also be shared with the direct care staff at monthly staff meetings Completion date 12/09/16	

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F 312	Continued From page 28 confirmed she had given R53 a bath after breakfast and only provided bathing, not oral cares. -At 1:40 p.m. NA-A confirmed she had not provided R53 with any oral hygiene when providing morning cares. -At 1:45 p.m. registered nurse (RN)-A stated she would expect R53 to receive oral hygiene when provided morning cares and confirmed oral hygiene should be completed two times a day as directed on the care plan. RN-A stated FM-A had addressed a concern regarding R53's oral hygiene at R53's last care conference. 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 Hygiene policy, undated, indicated oral hygiene should be offered twice daily.	F 312		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed	F 356		12/1/16

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F 356	Continued From page 29 vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the daily nurse staff posting included the resident census, as required for 20 of the 30 days reviewed for the lower level and 19 of the 30 days reviewed for the upper level. This had the potential to affect all residents living in the facility. Findings include: Review of facility's daily nursing staff postings revealed the resident census was not included on the daily posts, as required:	F 356	It is the policy of KMHC to post information that includes the facility name, current date, total number and actual hours worked of staff directly responsible for resident care and resident census. This has the potential to affect all residents living in the facility. To ensure compliance, all nurses were educated at a mandatory nurses meeting November 10th, 2016 on KMHC's policy on staff posting sheets. All nurses were given a copy of KMHC's policy regarding posting sheets and were also given the meeting minutes. Audits of the staff posting sheets began daily on 11/05/16. If information is missing the nurse responsible will be	

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F 356	Continued From page 30 -lower level staff posting sheets for October lacked resident census on the 4th, 5th, 7th, 8-11th, 13th, 15th, 16th, 18th, 19th, 21st -25th, and 31st and also on November 1st and 2nd. -upper level staff posting sheets for October lacked the resident census on the 4th-7th, 9th-13th, 15th, 18th, 22nd-25th, 27th, 28th and also November 1st and 2nd. On 11/4/16, at 11:31 a.m. the director of nursing (DON) confirmed the daily nurse staffing posting was required to reflect the resident census and verified this was missing from the above mentioned postings. The DON stated the night nurse was responsible to complete the daily posting. The DON was asked to provide copies of the aforementioned staffing sheets with the missing resident census information, however, the sheets were returned to the surveyor with the census information filled in. The DON stated, the person designated to make the copies misunderstood and instead of making copies filled in the missing information. Facility policy dated 6/14, indicated the dialing posting of nursing staffing report was to include the resident census at the start of each shift.	F 356	educated. Results of the audits will be brought to the Risk Management Meeting monthly x 3 months then quarterly for review and any needed actions taken. DON responsible for compliance. Completion date 12/01/16	
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in	F 406		11/30/16

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F 406	Continued From page 31 accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a comprehensive assessment and provide needed intellectual disability rehabilitative services for 1 of 1 resident (R74) with a diagnosis of intellectual disability who was not receiving services to prevent regression related to communication. Additionally, R74 was placed in a locked special care unit with no identified needs requiring a locked unit. Findings include: 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). The undated Admission Record indicated R74 had a diagnosis of Down's syndrome. 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	F 406	It is the policy of KMHC to provide a comprehensive assessment and needed intellectual disability rehabilitative services for their residents. Provision of rehabilitation for developmentally disabled residents has the potential to affect 1 resident. R74has been assessed for appropriate placement on the secured Memory Unit as he is at risk for wandering, has made attempts to elope and he requires a wander guard bracelet. To ensure that R74, who has an intellectual disability, receives the required specialized rehabilitation services a referral was made to OT 11/10/16 which employs a COTA who has been trained and has experience working with person□s with intellectual disability. The COTA working with this residents has a certification on Developmental Disorders from Minot State University. She also has experience as a Programming Specialist working with REM. A list of suggested activities has been given to the Activity Department to incorporate in the resident's activity plan of care and monitoring will be done by the Activity Director as to the level of this resident□'s participation in these as well as other activities this resident participates in . This will be reviewed monthly by the COTA. Also ADL goals have been set up by the COTA and results are being recorded by	

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F 406	Continued From page 32 inappropriate behavior symptoms except difficulty focusing attention. R74 required physical assistance of one person for transfers, ambulation, dressing, personal hygiene, eating, and toilet use. R74's medical record did not include an assessment of R74's strengths and needs related to communication. The Level II Pre-Admission Screening and Resident Review (PASRR) for persons with developmental disability (DD) or related conditions dated 8/24/16, indicated R74 had DD, and had medical and health care needs requiring nursing home services. Review of the Level II PASRR screening section, Need for Active Treatment, the following was identified by a check mark indicating: "This person's medical and health care needs are so severe that, in the judgment of the QMRP [qualified mental retardation professional], the person cannot expect to benefit from active treatment." The DD screening was approved by DHS (Department of Health Services) on 10/13/16. R74 was observed living on a locked special care unit for persons with dementia. On 11/1/16, from 9:30 a.m. to 11:00 a.m. R74 was observed to follow staff around the unit and staff was observed to redirect R74 from following them into different resident rooms to provide care. R74 was observed to wander into another resident's room at 10:44 a.m. and the resident told R74 he did not belong in the bedroom and needed to leave. R74 was observed on 11/2/16, at 8:28 a.m. eating breakfast, seated at a table alone. R74 was served cold cereal, a banana, and a piece of banana cake. It was noted R74 used the fork to	F 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 area of ADL dependence for which measureable goals could be developed and a plan implemented. The COTA has provided education specific to this resident and has incorporated family input. A policy will be developed for providing specialized services and on the evaluation of residents for appropriateness of placement on the Memory Care Unit. All staff will be educated on these policies and on working with the developmentally disabled population. COTA, SSD and DON responsible for compliance. The results of these measures will be brought to the Resident's primary physician for review and corrective actions taken as needed. Completion date 12/09/16	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 406	Continued From page 33	F 406		

eat the cold cereal. Nursing assistant (NA)-K was interviewed during this observation and stated R74 was very shy and could sometimes verbalize words. However, it was difficult to understand what R74 was saying because the speech was not clear and was very very soft. NA-K stated she had learned all of R74's sign language and felt she could communicate with R74 effectively. NA-K stated R74 had never attempted to leave the facility unattended, and did not know why R74 lived in the locked unit of the facility, except that there were more activities offered that R74 could participate in on the locked unit. NA-K stated R74 did not have any specialized programs to maintain or achieve as much independence and self-determination as possible.

On 11/2/16, at 9:22 NA-L stated R74 took a long time to eat and needed prompting. NA-L stated R74 generally followed the staff around all day and liked interacting with them. NA-L stated she was not sure why R74 required a locked unit because she had never known R74 to attempt to leave the facility. NA-L stated R74 did not have any specialized programs to maintain or achieve as much independence and self-determination as possible.

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.

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F 406	Continued From page 34 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 who were admitted with diagnoses of DD. The DON stated they had never consulted with the county case manager to determine R74's specialized habilitation needs. Review of the facility's policy for admission to the locked unit (undated) was reviewed and identified an evaluation would be made by the nursing staff, social services, or M.D. to determine the appropriateness of placement on the locked unit. A policy for specialized services for the DD was requested but not provided.	F 406		
F 465	483.70(h)	F 465		11/30/16

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F 465 SS=E	Continued From page 35 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide maintenance services related to ongoing repairs in order to ensure safe and sanitary environment for 6 of 14 resident room doors (rm) (rm41, rm46, rm47, rm49-1, rm49-2, rm45) on the second floor which were observed scratched and marred and in need of repair; and failed to ensure the second floor dining room flooring was maintained to prevent potential injuries due to ripped, raised flooring in 1 of 2 dinning rooms observed. Findings include: On 11/03/16, at 10:19 a.m. an environmental tour of the second floor was completed with maintenance director (MD)-A. The kick panels on the door rm41, rm46, rm47, rm49-1, rm49-2, and rm45 doors were observed scratched and marred. MD-A stated he had a preventative maintenance plan for all of the room scrapes and actual door scrapes and chips, but did not have a system in place to paint/repair the scratched and marred kick panels of the doors. Additionally, there were two areas on the second floor dining room flooring approximately six inches by six inches observed ripped and lifted creating a	F 465	It is the policy of KMHC that the physical plant, including walls, furnishings, floors, ceilings, systems and equipment be kept in a continuous state of good repair and operation with regard to the health, comfort, safety and wellbeing of residents according to a written routine maintenance and repair program. This has the potential to affect all residents. The scratched and marred kick plates identified during survey will be painted. A temporary patching has been performed for the ripped lifted area in the Upper Level dining room floor. We are investigating more permanent options to have these ripped areas permanently removed either by replacing the damaged sections or replacing the entire flooring. A maintenance program of walking around and completing a general building inspection 2 times a month will be implemented to ensure the facility is in good repair to make it a safe, clean,homelike environment. Actions taken will be reported to the administrator. All staff will be educated on the importance of maintaining a safe environment by reporting damaged items promptly at a mandatory in-service	

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F 465	Continued From page 36 potential tripping hazard. MD-A stated the maintenance department was notified of the ripped/raised flooring approximately two weeks prior and had started the repair, but had not finished the repair by tacking down the ripped areas of flooring. A policy related to facility repairs was requested and not provided.	F 465	12/05/16. This monitoring will be reviewed by the Administrator and will be shared at the monthly Management Risk Management Meetings for their review and corrective actions taken as needed. Responsibility for compliance will be the Maintenance Manager, DON and Administrator. Completion date 12/09/16	

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	245247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/02/2016**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Kittson Memorial Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code , (LSC), Chapter 19 Existing Health Care, and the 2012 Health Care Facilities Code (NFPA 99). PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	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) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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KITTSON MEMORIAL HEALTHCARE CENTER	**1010 SOUTH BIRCH** **HALLOCK, MN 56728**

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.kappenman@ state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Kittson Memorial Healthcare Center is made up of two buildings. The original building is north of and separated from, with a 2-hour fire barrier, the Kittson Memorial Hospital building. It is 1-story with a basement and was constructed in 1968 that was determined to be of Type II(000) construction and is now fully sprinkler protected and is called the upper level. In 1981 a 1-story addition without a basement was built to the north of the original building that was determined to be of Type V (111) construction. The facility is fully sprinkler protected in accordance and has a fire alarm system with smoke detection in the corridor system and in all common areas. The facility has a capacity of 70 beds and had a census of 68 at the time of the survey.	K 000		

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	245247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/02/2016**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=E	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide unobstructed access to the corridor from resident rooms as required by the Life Safety Code (NFPA 101) 2012 edition section 19.2.2 & 7.1.10.1. This deficient practice could affect the exiting ability of 21 of the 68 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 7:30 am to 11:00 am on 11-2-2016 observations and staff interview revealed all resident room doors in the memory care wing were unable to open from either side of the door when the bathroom door was left in the open position. This deficient condition was confirmed by the Director of Maintenance.	K 211	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	11/29/16
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier	K 321		11/29/16

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K 321	Continued From page 3 having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility to maintain a hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for 21 of the 68 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 7:30am to 11:00am	K 321	It is the policy of KMHC that hazardous areas are protected by a fire barrier or automatic fire extinguishing system. This has the potential to affect all KMHC residents, visitors and staff. A door closure has been ordered for the oxygen storage room on the second level and will be installed as soon as it arrives. Maintenance Manager responsible for compliance. Maintenance will report to the administrator when the project has been completed. Completion date	

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K 321	Continued From page 4 on 11-2-2016 observations and staff interview revealed the oxygen storage room, north of the admin office on the second level did not have a self closer. This deficient condition was confirmed by the Director of Maintenance.	K 321	12/19/16	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 68 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 7:30 am to 11:00 am on 11-2-2016 record review and staff interview revealed the following fire drills were missed in	K 712	It is the policy of KMHC to hold fire drills at least quarterly on all shifts. This has the potential to affect all KMHC's residents, staff and visitors. A schedule has been devised indicating which shift is due to have a fire dril1. The schedule will be signed off when the drills have been completed. Drill dates and times will be reviewed monthly by the Risk Management Committee. Maintenance manager responsible for compliance. Completion date 12/19/16	11/29/16

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K 712	Continued From page 5 the past 12 months. 1) 2nd shift 1st qtr of 2016 2) 2nd shift 3rd qtr of 2016 3) 3rd shift 4th qtr of 2015 This deficient condition was confirmed by the Director of Maintenance.	K 712		

Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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/infobul.htm . 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00321	A. BUILDING: _____ B. WING _____	11/04/2016

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KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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	00321	A. BUILDING: _____ B. WING _____	11/04/2016

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KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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	00321	A. BUILDING: _____ B. WING _____	11/04/2016

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2 000	Continued From page 1 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 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	2 000		

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with oral hygiene as directed by the care plan for 1 of 3 residents (R53) who required assistance with oral hygiene. Findings include: R53's care plan reviewed 10/18/2016, indicated R53 was to receive oral hygiene twice daily, at a minimum. The care plan instructed the nursing assistants to assist as needed especially when R53 refused to complete oral cares. The current Resident Care Sheet which the	2 565	Corrected	11/30/16

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2 565	Continued From page 3 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. On 11/02/16, at 1:35 p.m. NA-B/bath aide confirmed she had given R53 a bath after R53 finished breakfast and only provided bathing, not oral cares. -At 1:40 p.m. NA-A confirmed she had not provided R53 with oral hygiene during the provision or morning 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.	2 565		

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2 565	Continued From page 4 The facility policy, General Resident Care Plan Documentation Guidelines, dated 10/11, indicated oral hygiene would be identified on the care plan with who was responsible for completing oral hygiene and instructions unique to the resident would be addressed on the resident's care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies and provide education for staff regarding care plan implementation. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 855	MN Rule 4658.0520 Subp. 2 E. Adequate and Proper Nursing Care;Oral Hygiene Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked lips This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with oral cares for 1 of 3 residents (R53) who	2 855	Corrected	11/30/16

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2 855	Continued From page 5 required assistance from staff for oral hygiene and did not receive the assistance. Findings include: R53's quarterly Minimum Data Set (MDS) dated 10/4/16, indicated R53's diagnoses included hypertension, had severe cognitive impairment and used a walker to ambulate with. The MDS indicated R53 required limited assistance of one staff for personal hygiene. R53's care plan dated 10/18/16, indicated R53 was to receive oral hygiene twice daily, at a minimum. The care plan instructed the nursing assistants to assist as needed especially when R53 refused to complete oral cares. The current Resident Care Sheet which the 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 was concerned with R53's oral hygiene and questioned whether R53 was receiving oral cares. 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	2 855		

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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 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 confirmed she had not provided R53 with any oral hygiene when providing morning cares. -At 1:45 p.m. registered nurse (RN)-A stated she would expect R53 to receive oral hygiene when provided morning cares and confirmed oral hygiene should be completed two times a day as directed on the care plan. RN-A stated FM-A had addressed a concern regarding R53's oral hygiene at R53's last care conference. 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 Hygiene policy, undated, indicated oral hygiene should be offered twice daily. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate	2 855		

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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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 855		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21426	Corrected	11/30/16

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21426	Continued From page 8	21426		

facility failed to ensure consistent documentation of the two step tuberculin skin test (TST) which would include the induration and interpretation of the test was completed for 4 of 5 residents (R27, R74, R71, R58) reviewed who lacked the required documentation.

Findings include:

R27 was admitted to the facility on 3/11/16. R27's Resident Immunization Record indicated R27 received the first step TST on 3/11/16. The medical record lacked documentation of both the induration and interpretation of the test. The Medication Administration History indicated R27 received the 2nd step TST on 3/25/16, and the TST was read on 3/28/16, however, the record lacked documentation of both the induration and interpretation of the test.

R74 was admitted to the facility on 8/18/16. R74's Medication Administration History indicated R74 was administered the first step TST on 8/18/16, and the TST was read on 8/21/16. The results were identified as negative, however the induration was not documented. The Medication Administration History indicated the second step TST was administered on 9/1/16, and read on 9/4/16 with results identified as negative. However, the induration was not documented.

R71 was admitted to the facility on 6/30/16. R71's Medication Administration History indicated R71 was administered the first step TST on 6/30/16, and the TST was read on 7/3/16. The results were identified as negative, however, the

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KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

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21426	Continued From page 9	21426		

induration was not documented. The Medication Administration History indicated the second step TST was administered on 7/18/16, and read on 7/21/16 with results identified as negative. However, the induration was not documented.

R58 was admitted to the facility on 5/19/16. R58's Resident Immunization Record from the previous facility indicated R58 had received the first step TST on 4/8/16. The induration was recorded as 0 millimeters (mm), but the date the TST was read and the interpretation of the TST was not recorded. The second TST was given on 4/30/16 and read on 5/2/16. The induration was recorded as 0 mm, but the interpretation of the TST was not recorded.

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.

On 11/3/16 at 10:50 a.m. the director of nursing confirmed R27's TST results should have been documented in the record and the TST results should have included interpretation and induration for R74, R71, and R58 as directed by the facility policy.

The undated Tuberculosis policy indicated documentation of the TST would include the date, time, number of millimeters of induration and interpretation of negative or positive and the signature of the nurse performing the test and signature and date of the nurse reading the results.

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21426	Continued From page 10 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the two step Mantoux process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21510	MN Rule 4658.1200 Subp. 2 A.B. SpecializedRehabilitative Services; Provision Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must: A. provide the required services; or obtain the required services from an outside source according to part 4658.0075. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a comprehensive assessment and provide needed intellectual disability rehabilitative services for 1 of 1 resident (R74) with a diagnosis of intellectual disability who was not receiving services to prevent regression related to communication. Findings include:	21510	Corrected	11/30/16

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21510	Continued From page 11 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). The undated Admission Record indicated R74 had a diagnosis of Down's syndrome. 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 assistance of one person for transfers, ambulation, dressing, personal hygiene, eating, and toilet use. R74's medical record did not include an assessment of R74's strengths and needs related to communication. The Level II Pre-Admission Screening and Resident Review (PASRR) for persons with developmental disability (DD) or related conditions dated 8/24/16, indicated R74 had DD, and had medical and health care needs requiring nursing home services. Review of the Level II PASRR screening section, Need for Active Treatment, the following was identified by a check mark indicating: "This person's medical and health care needs are so severe that, in the judgment of the QMRP [qualified mental	21510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21510	Continued From page 12	21510		

retardation professional], the person cannot expect to benefit from active treatment." The DD screening was approved by DHS (Department of Health Services) on 10/13/16.

R74 was observed living on a locked special care unit for persons with dementia. On 11/1/16, from 9:30 a.m. to 11:00 a.m. R74 was observed to follow staff around the unit and staff was observed to redirect R74 from following them into different resident rooms to provide care. R74 was observed to wander into another resident's room at 10:44 a.m. and the resident told R74 he did not belong in the bedroom and needed to leave.

R74 was observed on 11/2/16, at 8:28 a.m. eating breakfast, seated at a table alone. R74 was served cold cereal, a banana, and a piece of banana cake. It was noted R74 used the fork to eat the cold cereal. Nursing assistant (NA)-K was interviewed during this observation and stated R74 was very shy and could sometimes verbalize words. However, it was difficult to understand what R74 was saying because the speech was not clear and was very very soft. NA-K stated she had learned all of R74's sign language and felt she could communicate with R74 effectively. NA-K stated R74 had never attempted to leave the facility unattended, and did not know why R74 lived in the locked unit of the facility, except that there were more activities offered that R74 could participate in on the locked unit. NA-K stated R74 did not have any specialized programs to maintain or achieve as much independence and self-determination as possible.

On 11/2/16, at 9:22 NA-L stated R74 took a long time to eat and needed prompting. NA-L stated R74 generally followed the staff around all day

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21510	Continued From page 13 and liked interacting with them. NA-L stated she was not sure why R74 required a locked unit because she had never known R74 to attempt to leave the facility. NA-L stated R74 did not have any specialized programs to maintain or achieve as much independence and self-determination as possible. 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. 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	21510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21510	Continued From page 14 who were admitted with diagnoses of DD. The DON stated they had never consulted with the county case manager to determine R74's specialized habilitation needs. Review of the facility's policy for admission to the locked unit (undated) was reviewed and identified an evaluation would be made by the nursing staff, social services, or M.D. to determine the appropriateness of placement on the locked unit. A policy for specialized services for the DD was requested but not provided. A SUGGESTED METHOD FOR CORRECTION: The administrator, social worker or designee could develop and implement policies and procedure related to residents with intellectual disabilities and treatment needs and educate staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21510		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a	21685		11/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00321	A. BUILDING: _____ B. WING _____	11/04/2016

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21685	Continued From page 15 continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide maintenance services related to ongoing repairs in order to ensure safe and sanitary environment for 6 of 14 resident room doors (rm) (rm41, rm46, rm47, rm49-1, rm49-2, rm45) on the second floor which were observed scratched and marred and in need of repair and failed to ensure the second floor dining room flooring was maintained to prevent potential injuries due to ripped, raised flooring in 1 of 2 dinning rooms observed. Findings include: On 11/03/16, at 10:19 a.m. an environmental tour of the second floor was completed with maintenance director (MD)-A. The kick panels on the door rm41, rm46, rm47, rm49-1, rm49-2, and rm45 doors were observed scratched and marred. MD-A stated he had a preventative maintenance plan for all of the room scrapes and actual door scrapes and chips, but did not have a system in place to paint/repair the scratched and marred kick panels of the doors. Additionally, there were two area's on the second floor dining room flooring approximately six inches by six inches observed ripped and lifted creating a potential tripping hazard. MD-A stated the maintenance department was notified of the ripped/raised flooring approximately two weeks	21685	Corrected	

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21685	Continued From page 16 prior and had started the repair, but had not finished the repair by tacking down the ripped area's of flooring. A policy related to facilty repairs was requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop a maintenance program to ensure the facility was in good repair to maintain a safe, clean, homelike environment. The DON or designee could educate all appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21685		
21755	MN Rule 4658.2000 Subp. 3 Secured Units; Criteria Subp. 3. Criteria for assignment to secured unit. A resident may be assigned to placement in a secured unit only if the results of a comprehensive resident assessment as required by part 4658.0400 indicate that resident requires a more secure environment and there is a physician's written order for placement in a secured unit. A resident may choose to reside in a secured unit if the comprehensive resident assessment and plan of care as required by parts 4658.0400 and 4658.0405 determine that placement in a secured unit is appropriate for that resident.	21755		11/30/16

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21755	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation, interview and document 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 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	21755	Corrected	

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21755	Continued From page 18 assistance of one person for transfers, ambulation, dressing, personal hygiene, eating, and toilet use. R74's medical record did not include an assessment of R74's strengths and needs related to communication. The level II PASRR for persons with developmental disability (DD) or related conditions dated 8/24/16, indicated R74 had DD, and had medical and health care needs requiring nursing home services. Review of the level II PASRR screening section Need for Active Treatment the following was identified by a check mark indicating: "This person's medical and health care needs are so severe that, in the judgment of the QMRP (qualified mental retardation professional), the person cannot expect to benefit from active treatment." The DD screening was approved by DHS (Department of Health Services) on 10/13/16. However, this assessment had not identified what health care needs R74 required which precluded him from participating in active treatment, and did not currently reflect the resident's current status based on a comprehensive assessment. R74 was observed living on a locked special care unit for persons with dementia. On 11/1/16, from 9:30 a.m. to 11:00 a.m. R74 was observed to follow staff around the unit and staff was observed to redirect R74 from following them into different resident rooms to provide care. R74 was observed to wander into another resident's room at 10:44 a.m. and the resident told R74 he didn't belong in the bedroom and needed to leave. R74 was observed on 11/2/16, at 8:28 a.m. eating breakfast, seated at a table alone. R74 was	21755		

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21755	Continued From page 19 served cold cereal, a banana, and a piece of banana cake. It was noted R74 used the fork to eat the cold cereal. Nursing assistant (NA)-K was interviewed during this observation and stated R74 was very shy and could sometimes verbalize words. However, it's difficult to understand what R74 was saying because the speech was not clear and was very very soft. NA-K stated she had learned all of R74's sign language and felt she could communicate with R74 effectively. NA-K stated R74 had never attempted to leave the facility unattended, and did not know why R74 lived in the locked unit of the facility, except that there were more activities offered that R74 could participate in on the locked unit. NA-K stated R74 did not have any specialized programs to maintain or achieve as much independence and self-determination as possible. On 11/2/16, at 9:22 NA-L stated R74 took a long time to eat and needed prompting. NA-L stated R74 generally followed the staff around all day and liked interacting with them. NA-L stated she was not sure why R74 required a locked unit because she had never known R74 to attempt to leave the facility. NA-L stated R74 did not have any specialized programs to maintain or achieve as much independence and self-determination as possible. 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. The care plan had not included instruction for the sign language R74 used.	21755		

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21755	Continued From page 20 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 who were admitted with diagnoses of DD. The DON stated they had never consulted with the county case manager to determine R74's specialized habilitation needs. Review of the facilities policy for admission to the locked unit (undated) was reviewed and identified an evaluation would be made by the nursing staff, social services, or M.D. to determine the appropriateness of placement on the locked unit. policy for specialized services for the DD was requested but not provided.	21755		

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21755	Continued From page 21 A SUGGESTED METHOD FOR CORRECTION: The administrator, social worker or designee could develop and implement policies and procedure related to assessment of residents prior to admission to the locked unit and educate staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21755		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and	21800		11/30/16

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21800	Continued From page 22 local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most current nursing home Bill of Rights, revised in March 2016, was posted and used by the facility. This had the potential to affect all 56 residents residing in the facility. Findings include: During the initial tour, on 10/31/16, at 5:30 p.m., observation revealed the Bill of Rights posted in the facility was dated 10/05. On 11/3/16, at 10:30 a.m., social service designee (SSD)-A confirmed the facility's posted Bill of Rights was not the most current version. and stated she was responsible for the posting 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 facility. 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	21800	Corrected	

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21800	Continued From page 23 most current, revised copy was needed. A facility policy on Resident Rights was requested, however no policy was received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents receive the current resident bill of rights, and develop a system to ensure the current resident bill of rights are posted for all residents, family, and staff members. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21800		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 3 of 3 residents (R24, R41, R26) observed to wait for their meal while tablemate's were served.	21805	Corrected	11/30/16

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21805	Continued From page 24 Findings include: R24's quarterly Minimum Data Set (MDS) dated 10/4/16, indicated R24 had severe cognitive impairment and required limited assistance of one person with eating. R24's care plan dated 10/11/16, directed staff to provide set up and assistance as needed for meals and provide cues and reminders. R41's quarterly MDS dated 9/13/16, indicated R41 had severe cognitive impairment and required limited assistance of one person with eating. R41's Care Plan dated 11/1/16, directed staff to provide setup and assist as needed for all meals. R26's quarterly MDS dated 10/18/16, indicated R26 had severe cognitive impairment and required extensive assistance of one person with eating. R26's care plan dated 10/25/16, directed staff to provide set up and assistance for meals and to assist with feeding as warranted. On 11/1/16, the following was observed during the breakfast meal: --at 7:27 a.m. R23, R24, and R74 were observed seated at a table in the dining room. R41 was seated in a recliner next to the table. --at 7:46 a.m. R41 was transferred from the recliner to a wheelchair and seated up to the table with R23, R24 and R74. R23 was served breakfast and also R74, shortly thereafter. R23 and R74 were observed to eat their meals independently. --at 7:50 a.m. R26 was brought to the dining room via wheelchair and seated at the same table.	21805		

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21805	Continued From page 25 Nursing assistant (NA)-I, NA-J, NA-K and activity aid (AA)-C were observed distributing meals to residents seated at three other tables in the dining room. --at 8:10 a.m. R24 was served breakfast, 24 minutes after R23 was served. R41, who was seated next to R74, was observed to reach toward R74's food. A staff member redirected R41. --at 8:14 a.m. R41 was served breakfast, 28 minutes after R23 was served. --at 8:16 a.m. R26 was served breakfast, 26 minutes after she was brought to the table where tablemate's had already been served. On 11/13/16, the breakfast meal was observed: --at 7:54 a.m. R24, R2 and R41 were observed seated at a table in the dining room. R24 and R2 were served breakfast. Staff proceeded to served residents at adjoining tables. R41 was not served. --at 8:04 a.m. R74 and R23 were brought to the table and R23 was served breakfast --at 8:10 a.m. R74 was served breakfast --at 8:13 a.m. NA-G brought R41 her breakfast and sat down to assist her to eat, 19 minutes after other residents at the table had been served. On 11/3/16, at 11:32 a.m. licensed practical nurse (LPN)-C stated there was a seating arrangement for the dining room but staff positioned residents wherever it worked. LPN-C stated the big table was usually for people who needed assistance to eat. LPN-C and activity aide (AA)-D confirmed R41 had to be fed and stated she had to wait to be served until a staff member was available to	21805		

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21805	Continued From page 26 assist her to eat. On 11/3/16, at 11:38 a.m. registered nurse (RN)-C stated R41's condition was declining. RN-C stated R41 used to feed herself but now required assistance. RN-C also stated she normally would not serve residents so long after everyone else had been fed and did not realize R24, R41 and R26 had waited that long. RN-C confirmed residents should not have to wait at the table without their meal while others were eating and should be served at the same time. On 11/04/16, at 11:25 a.m. the director of nursing (DON) indicated she would expect all the individuals seated at the same table to be served at the same time and not have to wait for their food while tablemate's were eating. The undated Quality of Life policy indicated staff should interact with the residents in ways that enhance his or her self-esteem and self-worth and promote resident independence and dignity in dining. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures dignified dining expereience. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21805		

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21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that	21980		11/30/16

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21980	Continued From page 28 the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an allegation of misappropriation of property for 1 of 5 residents (R36) who reported missing money which was not reported to the State agency. The facility also failed to immediately report and/or thoroughly investigate allegations of misappropriation of missing 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 and therefore did not report to the State agency, as required. Findings include: 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	21980	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00321	A. BUILDING: _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 29 effectively verbalize needs and understand verbal communication needs adequately. 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. 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).	21980		

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21980	Continued From page 30 On 11/2/16, at 12:47 p.m. registered nurse (RN)-A stated R36 was a reliable reporter and RN-A had not heard R36 was missing money. RN-A stated the facility staff took any missing items very seriously, and any amount of missing money was turned into the DON or social services. RN-A stated all missing money or items were reported to the DON and social worker. RN-A stated she would report any amount of money that was missing. 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. The Vulnerable Adult (VA) reports from 12/15-11/2/16, were reviewed as well as the incident reports for the same time period and there was no report R36 was missing money. On 11/2/16, at 1:03 p.m. the DON stated R36 was able to report incidents accurately and had no history of making up stories or making false accusations or reports. The DON stated she had not received a report of R36 missing money. The DON confirmed the nursing assistant R36 reported the missing money to should have reported to the charge nurse so it could have been investigated and reported. The DON stated she investigated all missing items and missing money, however, only reported those incidents that had a value of 20 dollars or over.	21980		

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21980	Continued From page 31 R27's quarterly 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 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 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. 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	21980		

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21980	Continued From page 32 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 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. R53's quarterly MDS dated 10/4/16, indicated R53 had severely impaired cognition. 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.	21980		

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21980	Continued From page 33 R9's quarterly Minimum Data Set (MDS) dated 8/23/16, indicated severely impaired cognition. A Missing Item Incident Report dated 7/8/16, indicated R9 was missing a watch which was last seen the day prior on 7/7/16. The report indicated a search of R9's room was conducted. 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 7/11/16, indicated R9's watch had went to laundry, had been washed and deemed non fixable. Family was notified. The missing property was not immediately reported to the State agency. R9's medical record lacked any documentation regarding the missing watch. 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 called into 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 director of nursing (DON) and administrator confirmed the incidents for R39, R53 and R9 were not reported to the	21980		

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21980	Continued From page 34 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. 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 daily function wait one week before initiating replacement. If lost item is other than those listed (ie: clothing, jewelry, etc.) wait one month. If not found in the time spans listed, refer to DON and/or administrator for decision as to facility liability and reimbursement and/or replacement. 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 immediately. The policy also identified indicators of maltreatment of a Vulnerable Adult included "Theft of patient's property. Any significant amount of money meaning over twenty dollars ($20.00)." The policy further indicated incidents of suspected maltreatment of a vulnerable adult by anyone shall be reported immediately to the administrator and once a report was made to the 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	21980		

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21980	Continued From page 35 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. 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 requirement. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21980		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse	22000		11/30/16

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22000	Continued From page 36 prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: 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	22000	Corrected	

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22000	Continued From page 37 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. Findings include: 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 immediately. The policy also identified indicators of maltreatment of a Vulnerable Adult included "Theft of patient's property. Any significant amount of money meaning over twenty dollars ($20.00)." The policy further indicated incidents of suspected maltreatment of a vulnerable adult by anyone shall be reported immediately to the administrator and once a report was made to the	22000		

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22000	Continued From page 38 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 daily function wait one week before initiating replacement. If lost item is other than those listed	22000		

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22000	Continued From page 39 (ie: clothing, jewelry, etc.) wait one month. If not found in the time spans listed, refer to DON and/or administrator for decision as to facility liability and reimbursement and/or replacement. 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. 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. 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.	22000		

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22000	Continued From page 40 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). On 11/2/16, at 12:47 p.m. registered nurse (RN)-A stated R36 was a reliable reporter and RN-A had not heard R36 was missing money. RN-A stated the facility staff took any missing items very seriously, and any amount of missing money was turned into the DON or social services. RN-A stated all missing money or items were reported to the DON and social worker. RN-A stated she would report any amount of money that was missing. 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. The Vulnerable Adult (VA) reports from 12/15-11/2/16, were reviewed as well as the incident reports for the same time period and there was no report R36 was missing money.	22000		

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22000	Continued From page 41 On 11/2/16, at 1:03 p.m. the DON stated R36 was able to report incidents accurately and had no history of making up stories or making false accusations or reports. The DON stated she had not received a report of R36 missing money. The DON confirmed the nursing assistant R36 reported the missing money to should have reported to the charge nurse so it could have been investigated and reported. The DON stated she investigated all missing items and missing money, however, only reported those incidents that had a value of 20 dollars or over. R36 had reported missing money to a nursing assistant (NA) and the facilities policy on abuse, neglect, including financial exploitation was not implemented as written. R27's quarterly 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 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 10:30 a.m., the 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	22000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 42 documentation in R27's medical record was lacking. 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 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 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. R53's quarterly MDS dated 10/4/16, indicated R53 had severely impaired cognition.	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00321	A. BUILDING: _____ B. WING _____	11/04/2016

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22000	Continued From page 43 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. R9's quarterly MDS dated 8/23/16, indicated severely impaired cognition. A Missing Item Incident Report dated 7/8/16, indicated R9 was missing a watch which was last seen the day prior on 7/7/16. The report indicated a search of R9's room was conducted. 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 7/11/16, indicated R9's watch had went to laundry, had been washed and deemed non fixable. Family was notified. The missing property was not immediately reported to the State agency. R9's medical record lacked any documentation regarding the missing watch.	22000		

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22000	Continued From page 44 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: -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.	22000		

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22000	Continued From page 45 -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 obtain information from previous employers with references and the findings would be documented in the employee's file. 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	22000		

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22000	Continued From page 46 requirement. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	22000		