DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 5, 2025

Administrator
Kittson Healthcare
1010 SOUTH BIRCH
HALLOCK, MN 56728

RE: CCN: 245247
Cycle Start Date: June 11, 2025

Dear Administrator:

On June 26, 2025, we notified you a remedy was imposed. On August 20, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 23, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 11, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 26, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 11, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 23, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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June 26, 2025

Administrator
Kittson Healthcare
1010 South Birch
Hallock, MN 56728

RE: CCN: 245247
Cycle Start Date: June 11, 2025

Dear Administrator:

On June 11, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other 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), whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 11, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 11, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 11, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction.

The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 11, 2025. This prohibition is not subject to appeal. 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.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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

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 - Health Regulation Division 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 Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 11, 2025 (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.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 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
202-795-7490

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 at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kittson Healthcare	1010 SOUTH BIRCH , HALLOCK, Minnesota, 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
E0000	Initial Comments On 6/9/25 through 6/11/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		
F0000	INITIAL COMMENTS On 6/9/25 through 6/11/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was not in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F0578	The identified individual’s code status sheet was updated and signed by the responsible party immediately identifying the individual as a DNR. All other resident charts were audited to ensure a correct and complete code status was on file. Admission checklist updated to include review and	07/09/2025

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 reverse for further 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.

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

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F0578 SS = D	Continued from page 1 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure there was a signed copy an advanced directive (identifying whether to do cardiopulmonary resuscitation (CPR) or do not resuscitate (DNR)) for 1 of 16 resident (R31) reviewed for advanced directives. Findings include: R31's quarterly Minimum Data Set (MDS) dated 5/15/25, identified R31 had no cognitive impairment.	F0578	Continued from page 1 update of code status PRIOR to admit for all admissions. The checklist will also be updated to require signature by the admitting RN ensuring that all components of the admission checklist are complete. Review and update code status policy. Admitting coordinator will ensure signed code status sheet is received and placed in the code status binder upon entry to the facility and with any code status changes. DON will add audit to QAPI and review completion of code status sheets quarterly for six months. Medical staff will be educated on new admission checklist requirements via email by July 9, 2025 and reviewed at the July 30, 2025 medical staff meeting. All new admits will be audited to ensure completion of code status requirements by nursing home DON. This will be added as a new QAPI initiative for the nursing home for 6 months. To be corrected by July 9, 2025	

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F0578 SS = D	Continued from page 2 R31's undated face sheet, care plan dated 6/4/25, and the undated admission care plan checklist identified R31 was a DNR. R31's medical record did not have an advanced directive identifying a DNR status signed by R31or representative and the provider. During an interview on 6/9/25 at 2:36 p.m., R31 stated they wanted a DNR status. During an interview on 6/11/25 at 10:30 a.m., the director of nursing (DON) stated the process for when residents were admitted was a copy of signed provider orders and advanced directive were to be received upon admit. Residents who wanted CPR were identified on a list at the nurse's station and R31 was not on the list and would be treated as a DNR. The DON could not locate the advanced directive for R31 and stated it should have been completed and placed in the advanced directive book to be easily accessible. A policy related to advanced directives was requested but not received.	F0578		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure a transfer belt was used during a transfer for 1 of 2 residents (R30) reviewed for falls. This resulted in actual harm to R30 who sustained a left arm fracture. The facility implemented	F0689	"Past Noncompliance - no plan of correction required"	

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F0689 SS = G	Continued from page 3 corrective action prior to the survey; therefore, the deficient practice was issued at past non-compliance. Findings include: R30's Fall Risk (Acuity) observation dated 7/16/24, identified R30 was at risk for falls. R30's quarterly Minimum Data Set (MDS) dated 4/21/25, identified R30 was cognitively aware and had diagnoses that included blindness, type 2 diabetes, and hypertension (high blood pressure). R30 required partial/moderate assistance (helper did less than half the effort. Helper lifted, held or supported trunk or limbs, but provided less than half the effort) to walk 50 feet with two turns. R30's Physical Therapy (PT) Caregiver Education dated 3/11/25, identified R30 was able to complete sit to stand transfers from recliner in room to participate in lower extremity strengthening program but R30 would continue to require stand by assist (SBA) (refers to a caregiving approach where a caregiver remains close to a patient to ensure safety without providing physical assistance. This means the caregiver is ready to intervene if the patient loses balance or needs help during a task.) of one staff to contact guard assist (CGA) (a technique used in occupational and physical therapy where the therapist maintains light physical contact with the patient, typically at the hips or trunk, to provide safety without offering direct support. This method helps with body stabilization and balance, acting as a safety net to prevent falls while allowing the patient to perform movements independently.) of one staff for all mobility in the facility. R30's care plan revised 4/25/25, identified R30 is at risk for deterioration in transfer, walking in room, and walking in corridor, related to being a new resident and being blind. R30 was supervision/part assist with walking. R30 did not do steps due to her blindness. Sit to stand, transfers CGA/partial/moderate with one for safety depending on weakness and risk for unsteady gait. R30's untitled nurse aide care sheet undated, identified R30 used a cane with a gait belt for "walk	F0689		

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F0689 SS = G	Continued from page 4 to dine." R30's resident progress note dated 6/4/25 at 2:48 p.m., identified R30 had a witnessed fall at 1:50 p.m. in day area hall. R30 was ambulating with cane and SBA. R30 lost balance and landed on her left side on floor. Stated "hope I didn't break my left arm again". Large protrusion (bump) with a skin tear noted on left elbow. Stated moderate pain in area. At first R30 was very anxious about fall and with staff offered calm approach and encouraged deep breathing. R30 calmed down. R30 was sent to the emergency room with staff assist for evaluation. R30's resident progress note dated 6/9/25 at 2:27 p.m., R30 had a new diagnosis of left open ulnar (the ulna is a long bone found in the forearm that stretches from the elbow to the smallest finger, and when in anatomical position, is found on the medial side of the forearm. It runs parallel to the radius, the other long bone in the forearm, and is the larger and longer of the two) shaft fracture below elbow fusion hardware - due to fall last week - surgery completed on R30's left arm, R30 was not to remove dressing before follow up visit on 6/23/25. R30 was to be non-weight bearing with left upper extremity. Resident did not have any complications with surgery. During an interview on 6/9/25 at 2:02 p.m., R30 was sitting in her room recliner with her feet elevated. R30's left arm was wrapped in ace bandages, was in a sling and rested on a pillow. R30 stated she was walking in the hallway with a nursing assistant (NA) behind her and R30 really didn't know what happened but R30 and the NA could not "catch" her. R30 stated she "broke" her left arm and pointed to her forearm with her right hand. During an observation on 6/11/25 at 8:00 a.m., NA-B assisted R30 to walk to the dining room while NA-C followed behind with a wheelchair. R30 wore a gait belt around her waist and NA-B held onto the gait belt and remained close to R30. During an interview on 6/11/25 at 8:03 a.m., NA-B stated she was not at the facility when R30 fell but "heard about it". R30 was walking with a nursing assistant, R30 stumbled and fell. NA-B stated she didn't know if R30 was wearing a gait belt or if the	F0689		

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F0689 SS = G	Continued from page 5 nursing assistant was holding the gait belt, but stated staff were expected to always use a gait belt when moving a resident to make it safe. During an interview on 6/11/25 at 8:04 a.m., NA-C stated she wasn't working when R30 fell and didn't know what happened. You always use a gait belt when you're walking someone. It just helps keep them steady in case the resident tripped. It was "better to be safe than sorry." During an interview on 6/11/25 at 8:06 a.m., NA-D stated she was working the day R30 fell. NA-D was coming out of a room and heard a "scream". R30 was walking with a nursing assistant and stumbled. "You know how sometimes your feet stick to the floor? It was like that." NA-D stated she did not know if R30 was wearing a gait belt, but staff were always expected to use a gait belt when walking with a resident. During a phone interview on 6/11/25 at 8:18 a.m., registered nurse (RN)-B stated she was the nurse on duty the day R30 fell. RN-B was in the charting room when it happened. A nursing assistant was walking with R30 when it happened. RN-B stated she couldn't say if R30 was wearing a gait belt and/or if the nursing assistant was in close contact with R30 because she didn't see it happen. During an interview on 6/11/25 at 8:45 a.m., the director of nursing (DON) stated R30 was blind and was care planned to have CGA with walking. There was confusion to what CGA meant and the nursing assistant did not use a gait belt nor were they in close contact with R30. Since R30's fall, the DON had instructed staff to always use a gait belt for safety and had given education what SBA and CGA meant. On 6/11/25 at 10:00 a.m., a review of a surveillance video dated 6/4/25 at 1:54 p.m. to 1:55 p.m. was conducted with the DON. R30 was observed walking with a cane in her right hand with NA-A walking slightly behind her right side. R30 was not wearing a gait belt nor was NA-A in close proximity to R30. R30's stumbled and R30 fell forward, twisting on to her left side, landing on her left elbow/arm. The DON stated staff were expected to use gait belts and to follow care planned interventions to prevent/lessen the risk of falls.	F0689		

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F0689 SS = G	Continued from page 6 During an interview on 6/11/25 at 1:42 p.m., NA-A stated she was walking with R30 to the dining room for bingo and R30 lost her balance and fell. NA-A stated she tried to "catch" R30, but she just couldn't and R30 fell onto her left side. NA-A stated she didn't use a gait belt because R30 was steady and had never needed one. After R30's fall, the DON told staff they always had to use a gait belt when walking or moving residents for safety. The facility' corrective actions were confirmed through observation of staff using transfer belts along with staff interviews that identified staff knew to utilize a transfer belt for all transfers. The facility policy Fall Prevention Program revised 11/21, identified all staff members were responsible for implementing the intent and directives contained within this policy and creating a safe environment of care. Falls Prevention Plan: I. Universal fall precautions are to be implemented for all patients/residents admitted to Kittson Healthcare as they are aimed at keeping the care environment safe. Universal fall precautions include: a. Familiarize the patient with the environment. b. Have the patient demonstrate call light use. c. Maintain call light within reach. d. Keep the patient's personal possessions within patient safe reach. e. Have sturdy handrails in patient bathrooms, room,	F0689		

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F0689 SS = G	Continued from page 7 and hallway. f. Place the bed in a safe position when a patient is resting in bed; raise bed to a comfortable height when the patient is transferring out of bed. g. Keep bed brakes locked. h. Keep wheelchair wheel locks in "locked" position when stationary. i. Keep nonslip, comfortable, well-fitting footwear on the patient. j. Use night lights or supplemental lighting. k. Keep floor surfaces clean and dry. Clean up all spills promptly. l. Keep patient care areas uncluttered. m. Follow safe patient handling practices. II. An individualized care plan utilizing a multidisciplinary approach is to be created and implemented for each patient/resident identified as a fall risk. a. Members of the multidisciplinary team may include the attending physician, nursing, therapy, pharmacy, family, patient/resident or other members of the care team. b. The multidisciplinary team members will collaborate to address modifiable fall risk factors and implement interventions to try to minimize the consequences of risk that are not modifiable	F0689		

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F0689 SS = G	Continued from page 8 c. Interventions are to be patient/resident centered However, the policy failed to direct staff to use a gait belt with all resident transfers and/or ambulation.	F0689		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents with attached bed rails were comprehensively assessed for use on the bed for 1 of 1 resident (R4) who had bed rails. Findings include: R4's quarterly Minimum Data Set (MDS) dated 5/20/25, identified R4 had no cognitive impairment and was independent with bed mobility and transfers. The MDS identified resident did not use bed rails.	F0700	The impacted individual had a Bed Rail/Adaptive equipment assessment completed on 7/2/2025. All other residents currently utilizing bed rails have a Bed Rail/Adaptive Equipment assessment completed by July 25, 2025. During the assessment of this individual it was found that the resident uses the bed rails as assistive equipment to assist with independent bed mobility and transfers. This resident has requested to leave the two bedrails up at all times. Education was provided about the risks of entrapment. Bed and bed rail specifications guide, and are appropriate for her height and weight. The admission packet and bed rail policy will be updated to include an updated process for educating, assessing, and getting informed consent on the utilization of bedrails/adaptive equipment. The bed rail assessment will continue to be completed by the MDS coordinator and the adaptive equipment section will be completed to include bed rails and all other equipment used for increased independence. Education has been provided to the MDS Coordinator. Education on the updated bed rail policy will be provided to the nursing staff at the next scheduled meeting on July 23, 2025. MDS Coordinator will complete the observation Admit, quarterly, annual, and any significant change. This will be audited by the DON with every (3 months and with any changes) observation period for 6 months to ensure compliance. To be completed by July 23, 2025.	07/23/2025

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F0700 SS = D	Continued from page 9 R4's Restraint/Adaptive Equipment assessment dated 5/20/25, did not identfiy bed rails or adaptive equipment was used. R4's medical record lacked an assessment to to include entrapment risk, risk versus benefits, consent, bed dimentions in relation to the residents height and weight and what alternatives were attempted or containdicated before installation. During observation on 6/9/25 at 2:53 p.m., R4 had half bed rails up and locked into position on both side of the upper half of the bed. On 6/11/25 at 1:22 p.m., R4's half side rails were observed were locked in the upright position on R4's bed. R4 stated they used the rails to reposition and assist with getting out of bed. The bed rails did not restrain R4's movement. During an interview on 6/11/25 at 3:06 p.m., registered nurse (RN)-A, who was MDS coordinator, stated restraint/adaptive equipment assessments were done when using bed rails. Since they were half bed rails or less, they did not do an assessment because resident was using them to reposition in bed and transfer out of bed. They did not do an assessment identifying if it was used as a bed rail or adaptive equipment. During an interview on 6/11/25 at 3:32 p.m., the director of nursing (DON) stated it was restraint free facility. When bed rails were used as restraints, a provider's order is required, and an assessment would be done and restraint policy followed but was not sure of what was done when bed rails for use for bed mobility and transfers. The facility's Physical Restraint Policy dated 6/18/24, identified bed rails should only be used when necessary for safety and with the consideration of the resident's ability to use them independently. Document how the restraint will address the medical need, enhance safety, and maintain the resident's physical and psychological well-being.	F0700		
F0732 SS = C	Posted Nurse Staffing Information	F0732	The daily census was immediately added to the staffing	06/11/2025

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F0732 SS = C	Continued from page 10 CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) 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: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. 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. §483.35(i)(4) Facility data retention requirements. 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:	F0732	Continued from page 10 assignment sheet which is publicly available. The task of ensuring the daily census is included on the staffing assignment sheet that has been assigned to the night nurses as a daily duty. Nursing received education on June 11th regarding the requirements for the daily census to be publicly available. The nursing home DON will audit this daily for 6 weeks to ensure compliance. These staffing assignment sheets are also retained as required. This was completed as of June 11, 2025.	

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F0732 SS = C	Continued from page 11 Based on observation, interview and document review, the facility failed to ensure the daily census was on the nurse staff posting. This had the potential to affect all 31 residents residing in the facility and/or visitors who may wish to view the information. Findings include: On 6/9/25 at 4:25 p.m., 6/10/25 at 1:03 p.m. and 6/11/25 at 7:17 a.m., the facility staff posting was observed hanging on the wall across from the nurse's station. The nurse staff posting included the date; the hours of shifts for day, evening and night shifts, the number of registered nurse (RN), licensed practical nurse (LPN) and nursing assistants (NA) with total and actual hours worked; however, the postings were missing the daily census. The nurse staff postings were reviewed from 5/1/25 through 6/8/25. The facility census was not recorded on 37 of 38 days reviewed. On 6/11/25 at 1:53 p.m., health unit coordinator (HUC)-A stated she reviewed the nurse schedule and documented the information on the daily nurse staff posting and the director of nursing (DON) signed off on the form. HUC-A stated she was trained from the previous person but was not trained to document the census on the form. HUC-A stated the census is documented on a white board in the nurse's area, although it was not in a place visible by the residents and/or families. On 6/11/25 at 2:12 p.m., the DON stated she approved the nurse staff posting after the HUC completed the form. The form identified what staff were working, how many RN, LPN, and NA hours per shift, and hours per shift/day. The DON stated although the form should include the resident census, the previous staff had not filled in the census number and therefore, she or HUC-A had not documented the census number on the form. The DON stated the census was not written anywhere within the facility that was visible to the residents and/or visitors. A nurse staff posting policy was requested but not received.	F0732		

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F0732 F0755 SS = C SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure medications were administered according to manufacturers instructions for 1 of 1 residents (R31) observed during medication administration. Findings include: R31's quarterly Minimum Data Set dated 5/15/25, identified R31 was cognitively intact and had a	F0732 F0755	There were no adverse events reported pertaining to the identified individual as a result of this observed finding. Education was completed immediately for nursing staff upon identification of this observation to prevent further incidents. There were no other adverse events reported for other individuals as a result of this observed finding. Education was completed immediately for nursing staff upon identification of this observation to prevent further incidents. The policy on insulin pen administration was reviewed/revised to ensure priming of the pen prior to administration. Education was provided to all nursing staff on this policy update by June 18, 2025. Annual competencies will be performed on all nursing staff to ensure compliance with the updated policy. This may be completed by DON or RN designee. DON or RN designee will complete monitoring/observation of priming insulin pen and injection with new hires, and current nurses monthly for six months. The updated policy and education will be reviewed with all new hires. This was completed as of June 18, 2025.	06/18/2025

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F0755 SS = D	Continued from page 13 diagnosis of diabetes. R31's physician orders report dated 5/11/25 through 6/11/25, identified R31 received Lantus insulin 34 units every morning, Novolog insulin 7 units every morning, 14 units every lunch time and 7 units every evening. R31's care plan dated 3/5/25, identified R31 received insulin related to diabetes. The goal identified R31 would safely receive insulin injections per doctors orders. The nursing approaches included monitoring R31 for signs and symptoms of hypo/hyperglycemia. On 6/10/25 at 6:46 p.m., licensed practical nurse (LPN)-B was observed to prepare insulin for R31. LPN-B scrub the hub of the Novolog FlexPen with alcohol pad and then attach a sterile needle to the hub. LPN-B dialed 7 units of insulin and started to enter R31's room. Upon surveyor intervention and questioning, LPN-B stated she was instructed that she did not need to prime the insulin pen after the initial use. LPN-B stated she always placed a new needle on the insulin pens prior to use and had never primed the new needle prior to administering the insulin. LPN-B reviewed the manufacturer's instructions for "Patient Information Insulin Aspart" which included a section titled "Preparing your Insulin Aspart FlexPen" with picture diagrams and written explanations. The instructions identified giving an airshot of 2 units insulin before each injection. LPN-B stated she had not primed the pen with 2 units prior to administering the insulin to R31. On 6/10/25 at 7:04 p.m., RN-C stated when preparing to give insulin to a resident, she wasted 2 units prior to drawing up the residents ordered dose of insulin. RN-C stated she wasted 2 units to ensure the needle was full with medication to ensure the resident received the correct dose of insulin. On 6/11/25 at 8:38 a.m., director of nursing (DON) stated per facility policy staff are instructed to always prime an insulin pen prior to administering insulin to a resident. The facility Insulin Pen Administration Policy reviewed 4/28/24, identified the policy purpose was to ensure the safe, accurate, and hygienic administration of	F0755		

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F0755 SS = D	Continued from page 14 insulin using insulin pens for patients requiring insulin therapy. The policy applied to all licensed nursing staff and other healthcare professionals authorized to administer medications at the facility. The Insulin Aspart manufacturers instructions included the following instructions to prepare the insulin pen: - Turn the dose selector 2 units - Hold the insulin pen with the needle pointing up. Tap the cartridge gently with your finger a few time to make any air bubls collect at the top of the cartridge - Keep the needle pointing upwards, prss the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. Inyou do not see a drop of insuling after 6 times, do not use the Insulin pen and contact Novo Nordisk. A small air bubble may remain at the needle tip, but it will not be injected - select the dose of insulin	F0755		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F0883	Impacted residents' vaccine status reviewed to identify any needed vaccine recommendations. Impacted resident was found to be up to date with Pneumococcal vaccine. Was not offered 20 or 21 vaccine d/t no recommendation from the admitting physician. MDS Coordinator reviewed the CDC site on the Pneumococcal vaccines for the impacted and current residents. It was noted that a recommendation from the resident's physician and resident/resident representative may receive the updated 20, 21 vaccine. Consultation with the facility IP about the current recommendations. IP will provide the update VIS information to the MDS Coordinator. This education will be provided to residents/representative by July 25, 2025. Standing Orders were updated-removing Prevnar 13, now stating "Pneumococcal Vaccine". All residents' vaccine status reviewed to identify any needed vaccine recommendations. Current review of all residents that have agreed to receive the Pneumococcal vaccine are up to date. MDS Coordinator monitors vaccination status on admission, quarterly, and annually. When new vaccine recommendations are received, education is provided and the vaccine is offered.	09/01/2025

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F0883 SS = D	Continued from page 15 documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits for vaccinations being offered along with offering the most recent pneumococcal vaccine for 3 of 5 residents (R24, R28, R31) reviewed for immunizations. Findings include:	F0883	Continued from page 15 Routine rounding process and form updated to include regular surveillance for updated vaccine needs. Process updated for when residents are due for vaccines, the provider or designee will discuss vaccine recommendations with the resident/resident representative, every 60 days on routine rounds. Education, VIS will be provided by 7/25/25. Consent/declinations will be collected. All of these steps will be documented in the medical record. The Pneumococcal Vaccine consent/declination will be added to the form we currently use for the COVID-19, RSV, Influenza. MDS Coordinator monitors vaccination status on admission, quarterly, annually and with any new education provided by IP. This will be audited by the DON with all new admissions and routine rounds (every 60 days) for 6 months to ensure compliance. To be completed by August 15, 2025	

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F0883 SS = D	Continued from page 16 R24: R24's quarterly Minimum Data Set dated 4/10/25, identified R24 was 82 years old and admitted on 8/17/22. R24 was cognitively intact, and diagnoses included dementia and atrial fibrillation. R24's immunization record dated 6/11/25, identified R24 received Pneumo-poly (PPSV-23) on 2/3/2015, and Pneumo-conjugate (PVC-13) on 6/24/20. R24's vaccination consent form dated 9/7/24, included consent for influenza and COVID-19, however, the form failed to identify if R24 received Vaccine Information Statements (VIS), risk/benefits of the pneumococcal vaccine. R24's medical record failed to identify if R24 was offered, or given/declined the PCV20 or PCV21 vaccine. R28: R28's admission MDS dated 5/1/25, identified R28 was 78 years old and admitted on 4/25/25. The assessment identified R28 was cognitively intact, and diagnoses included seizure disorder and traumatic brain injury. R28's immunization record dated 6/11/25, identified R28 received PPSV23 vaccine on 2/12/13, and PCV-13 vaccine on 1/12/15. R28's vaccination consent form dated 2/10/25, identified R28 previously received pneumococcal vaccine, however, the form failed to identify which pneumococcal vaccine was administered and what education was provided and discussed. R28's medical record failed to identify if R28 was offered, or given/declined the PCV20 or PCV21 vaccine. R31:	F0883		

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F0883 SS = D	Continued from page 17 R31's quarterly MDS dated 5/15/25, identified R31 was 79 years old and admitted on 2/7/25. The assessment identified R31 was cognitively intact, and diagnoses included heart disease, kidney failure, and diabetes. R31's immunization record dated 6/11/25, identified R31 received the PPSV23 vaccine on 1/16/13. R31 preventative health care report dated 2/27/25 through 6/11/25, identified R31 received PCV13 vaccine on 10/26/15. R31's vaccination consent form dated 2/7/25, identified R31 declined the COVID-19 vaccine, although the form failed to identify if R31 received the VIS or risk/benefits of the pneumococcal vaccine. R31's medical record failed to identify if R31 was offered, or given/declined the PCV20 or PCV21 vaccine. The facility standing orders dated 8/8/24, included orders to administer pneumococcal vaccine (Prevnar 13) if not previously given and upon consent from resident or surrogate. On 6/11/25 at 10:48 a.m., registered nurse (RN)-A stated upon admission the residents Minnesota Immunization Information Connection (MIIC) report was reviewed and the admitting nurses were notified which vaccines the resident would need. RN-A stated vaccines, including pneumococcal, influenza and COVID-19, were offered on admission and annually. On 6/11/25 at 3:52 p.m., RN-D stated prior to admission, the provider reviews and recommends vaccines for the resident. The admitting nurse is notified which vaccines should be discussed with the resident and/or family and administered to the resident upon admission. RN-D stated there was a policy in place for vaccinations upon admission, although, the facility is lacking a process to re-evaluate current residents' pneumococcal vaccination status. On 6/11/25 at 4:17 p.m., the director of nursing (DON) stated staff review and offer vaccinations to the resident and/or families upon admission. The facility	F0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kittson Healthcare	1010 SOUTH BIRCH , HALLOCK, Minnesota, 56728

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F0883 SS = D	Continued from page 18 standing orders include orders to administer pneumococcal vaccine Prevnar 13 if not previously given and upon consent from the resident and/or family. The DON stated current residents' vaccination status was reviewed and vaccines are offered annually during their care conferences, although, there was not a procedure in place to catch the current residents for the new pneumococcal vaccines prior to their annual care conference. The facility Pneumococcal Vaccine Program reviewed 5/25, identified it was the policy of the facility that residents would be offered immunization/s against pneumococcal disease in accordance with Advisory Committee on Immunizations Practices (ACIP) recommendation. Pneumococcal disease is a serious illness that can cause sickness and even death. The purpose of the policy was to reduce the incidence of pneumococcal disease, and the morbidity and mortality attributed to the infection. The policy identified residents would be offered vaccinations based on the CDC and ACIP recommendations and physician orders. The policy further identified the facility would utilize the Adult Immunization Schedule, prepared by the CDC, to ensure residents were offered and encouraged to adept the appropriate vaccinations, and the determination to vaccinate or not would be documented in the residents electronic medical record.	F0883		

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	245247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2025**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/10/2025. At the time of this survey, KITTSON MEMORIAL HEALTHCARE CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 07/07/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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. Non-fire retardant	K 000		

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K 000	Continued From page 2 treated wood was discovered in the construction of spaces in the 1968 building which reduced the overall construction type to type V (111) and it was surveyed as one building. The facility has a capacity of 50 beds and had a census of 36 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit discharges per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 7.1.10.1, 7.1.6.1.1, 7.1.6.2, and 7.1.6.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/10/2025 at 11:23am it was revealed by observation that a section of concrete has raised making the sidewalk outside of door 11, unleveled, posing an existing hazard.	K 271	An area of sidewalk had been identified as being uneven at an exit. As of 7/2/2025, the area has been marked to highlight the height variation until it can be properly remedied. The area is going to be permanently fixed with concrete mix to level out the surface by 7/16/2025. During environmental safety rounds in the spring/fall, sidewalks at all entrances will be assessed for uneven surfaces and remedied immediately due to the likely potential for shifting due to seasonal changes. The safety committee and maintenance manager/designee will be	7/16/25

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K 271	Continued From page 3 An interview with the Maintenance Manager verified these deficient findings at the time of discovery.	K 271	responsible for ensuring this is complete by reviewing these rounds at their quarterly safety committee meetings. This will be completed by 7/16/2025.	
K 354 SS=D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility did not properly implement a fire watch protocol for when the fire alarm system is out of service for more than 10 hours in a 24-hour period, according to NFPA 101 2012 edition, Life Safety Code, section 19.3.5.1, 9.7.5, and NFPA 25 2017 edition, Installation, Test and Maintenance of Water Based System, section 15.5.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/10/2025, at 10:45am, it was revealed by	K 354	We were unable to produce our current policy during survey highlighting that we have a fire watch protocol in place for when a fire alarm system is out of service. The policy was located on 6/10/2025 and it was verified that the current policy included the required fire watch protocol. This has been placed in a binder but the organization is also moving to a web based policy management software that will make accessing these types of policies much easier. We will have a binder in the office with our updated policies Review/Revise policies annually	6/10/25

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K 354	Continued From page 4 documentation review that the facility failed to provide an out of service policy that indicated that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire sprinkler system outage lasting longer than ten (10) hours in a 24-hour period. . An interview with the Maintenance Manager verified these deficient findings at the time of discovery.	K 354	or as needed to ensure compliance for the time being. Maintenance Manager or designee is responsible for maintaining this and it was completed 6/10/2025.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/10/2025 at 10:15am it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with the Maintenance Manager	K 355	The organization was unable to produce the fire extinguisher annual inspection document. The inspection document was located on 6/10/2025 and placed in the appropriate location. A new section has been added to the current binder to ensure these inspection reports are accessible. The safety committee and maintenance manager/designee will be responsible for ensuring this is complete by reviewing that these are available at their quarterly safety committee meetings. This was completed 6/10/2025.	6/10/25

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K 355	Continued From page 5 verified these deficient findings at the time of discovery.	K 355		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/10/2025 at 10:15am it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with the Maintenance Manager	K 372	On 6/10/2025 it was revealed that there was a penetration in the smoke barrier. This was fixed on the date it was identified on 6/10/2025. We will be educating contractors to fire caulk any holes made on a smoke barrier wall when they present for scheduled work. Maintenance will inspect area during/after to ensure any penetration is properly sealed. The maintenance Manager or designee will be responsible for this. This was complete 6/10/2025.	6/10/25

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K 372	Continued From page 6 verified these deficient findings at the time of discovery.	K 372		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA	K 918		6/10/25

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K 918	Continued From page 7 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, 5.6.6, 8.3.8,8.4.1, 8.4.2.1, 8.4.2.3,8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/10/2025 at 10:22am, it was revealed by a review of available documentation of the emergency generator maintenance and testing that an annual generator inspection was not performed. An interview with the Maintenance Manager verified these deficient findings at the time of discovery.	K 918	We were unable to produce the annual generator check documentation. The inspection document was located on 6/10/2025 and placed in the appropriate location. A new section has been added to the current binder to ensure these inspection reports are accessible. The safety committee and maintenance manager/designee will be responsible for ensuring this is complete by reviewing that these are available at quarterly safety committee meetings. This was completed 6/10/2025.	