



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
May 2, 2023

Administrator  
Kittson Memorial Healthcare Center  
1010 South Birch  
Hallock, MN 56728

RE: CCN: 245247  
Cycle Start Date: April 20, 2023

Dear Administrator:

On April 20, 2023, a survey was completed at your facility by the Minnesota Department of Health 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 immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

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).

#### REMOVAL OF IMMEDIATE JEOPARDY

On April 1, 2023, the situation of immediate jeopardy to potential health and safety cited at F678 was removed.

#### 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 listed below to the CMS Region V Office for imposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

#### SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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 § 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 April 20, 2023. 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.

## 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:

Susie Haben, Rapid Response  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
Midtown Square  
3333 Division Street, Suite 212  
Saint Cloud, Minnesota 56301-4557  
Email: [susie.haben@state.mn.us](mailto:susie.haben@state.mn.us)  
Office: (320) 223-7356 Mobile: (651) 230-2334

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,



Kittson Memorial Healthcare Center

May 2, 2023

Page 3

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:

[Steven.Delich@cms.hhs.gov](mailto:Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to [Steven.Delich@cms.hhs.gov](mailto:Steven.Delich@cms.hhs.gov).

#### INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: [https://mdhprovidercontent.web.health.state.mn.us/ltc\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm)

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day



Kittson Memorial Healthcare Center

May 2, 2023

Page 4

period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:  
[https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

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,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, Minnesota 55164-0970  
Phone: 651-201-4117  
Email: [Melissa.Poepping@state.mn.us](mailto:Melissa.Poepping@state.mn.us)



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

PRINTED: 05/02/2023  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                          |  |                                                                    |
|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245247</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>04/20/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KITTSOON MEMORIAL HEALTHCARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 SOUTH BIRCH</b><br><b>HALLOCK, MN 56728</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 000                                                                          | INITIAL COMMENTS<br><br>On 4/20/23, a standard abbreviated 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, and Requirements for Long Term Care Facilities.<br><br>The following complaint was reviewed: H52479873C (MN92416) and a deficiency was issued at F678 at PAST NON-COMPLIANCE.<br><br>Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.                  | F 000                                                                      | Past noncompliance: no plan of correction required.                                                                      |  |                                                                    |
| F 678<br>SS=J                                                                  | Cardio-Pulmonary Resuscitation (CPR)<br>CFR(s): 483.24(a)(3)<br><br>§483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to initiate cardio-pulmonary resuscitation (CPR) for 1 of 3 residents (R1) who was found unresponsive, no respirations or heartbeat with a full code status who wished to receive CPR.<br><br>The IJ began on 3/31/23, at approximately 2:15 a.m. when R1 had no respirations or pulse, and | F 678                                                                      | Past noncompliance: no plan of correction required.                                                                      |  |                                                                    |

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

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.



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

PRINTED: 05/02/2023  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                          |  |                                                                        |
|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245247</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>04/20/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KITTSOON MEMORIAL HEALTHCARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 SOUTH BIRCH</b><br><b>HALLOCK, MN 56728</b>                             |  |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                             |
| F 678                                                                          | <p>Continued From page 1</p> <p>CPR was not initiated. The IJ was identified on 4/20/23, and the interim administrator and assistant director of nursing (ADON) were notified of the IJ on 4/20/23, at 4:30 p.m. The immediate jeopardy was removed on 4/1/23, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance.</p> <p>Findings include:</p> <p>R1's Orders For Admission dated 3/30/23 and Temporary Plan of Care dated 3/30/23, both indicated code status as Full Code.</p> <p>R1's Resident Progress Notes indicated the following:</p> <p>-3/30/23 (admission) R1 arrived from the hospital and commented she was very tired and did not feel real good. The note indicated R1 received therapy and following therapy staff entered the room to find R1 asleep. A second note dated 3/30/23, indicated R1 planned to work with therapy to improve strength and mobility and return home.</p> <p>-3/31/23, at 3:54 a.m. R1 was found expired at 2:15 a.m. R1 had mottling (occurs when blood flow to tiny vessels under your skin is disrupted, this results in a fine, bluish-red, lace-like pattern) to her legs and hands, no heartbeat and no pulse. Family was notified and physician was notified via facsimile.</p> <p>-3/31/23, a second note written at 4:05 a.m. indicated upon entering R1's room, she was found lying in bed on her back with her eyes closed. Oxygen running at 3 liters. Upon</p> | F 678                                                                      |                                                                                                                          |  |                                                                        |



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

PRINTED: 05/02/2023  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                          |  |                                                                    |
|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245247</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>04/20/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KITTSOON MEMORIAL HEALTHCARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 SOUTH BIRCH</b><br><b>HALLOCK, MN 56728</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 678                                                                          | <p>Continued From page 2</p> <p>assessment no radial pulse was found. Auscultation (the action of listening to sounds from the heart, lungs, or other organs, typically with a stethoscope) was done and no heartbeat was heard. R1's ears, nose, face, hands, legs and feet were completely blue due to mottling, R1's abdomen was distended and rigid, Rigor Mortis (stiffening of the joints and muscles of a body a few hours after death) had already set in as writer was not able to move extremities easily.</p> <p>During interview on 4/20/23, at 2:39 p.m. licensed practical nurse (LPN)-A stated a nursing assistant (NA) came and alerted her of R1's condition so she went to R1's room, LPN-A stated R1's arms and legs were blue and R1 displayed no signs of life. LPN-A said she went back out into the hallway and called for the other NA to come to the room. LPN-A stated they all went back into R1's room. LPN-A stated she was in shock as she had never seen anyone like that before. LPN-A stated she remembered seeing R1's code status at the start of her shift but did not process it, and said "I guess I didn't realize." LPN-A stated if she had realized it she would have called for a crash cart and initiated CPR even though R1 looked like she did not have any chance of survival. LPN-A further stated no call was made to emergency services and said she should have paged the hospital (connected to the facility) to bring the cart, initiated CPR and continued CPR until the physician arrived.</p> <p>During interview on 2:51 p.m. with facility leadership that included registered nurse (RN)-A, assistant director of nursing (ADON) and interim administrator, RN-A stated following the incident, the policy was reviewed and it was determined it had not been followed. RN-A added during the</p> | F 678                                                                      |                                                                                                                          |  |                                                                    |



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

PRINTED: 05/02/2023  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                          |  |                                                                    |
|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245247</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>04/20/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KITTSOON MEMORIAL HEALTHCARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 SOUTH BIRCH</b><br><b>HALLOCK, MN 56728</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 678                                                                          | <p>Continued From page 3</p> <p>investigation they determined not all of the nurses knew where to find the resident code status and updated the policy to include posting the code status on the inside of the resident's closet doors and immediately educated staff about the existing policy and the change. The ADON stated a full review of all resident charts was conducted to verify the code status was accurate. The ADON stated the immediate education provided included initiating CPR immediately for all residents with a full code status. The interim administrator stated they had consulted with the medical director who agreed CPR should have been started.</p> <p>During interview on 4/20/23, at 1:51 p.m. RN-B stated if a resident was found unresponsive she would check the code status either on the care sheet or the back of the closet door and if full code she would page over the intercom and initiate CPR. RN-B stated she had recently received education that included adding the code status to the door and review of the policy that indicated initiating CPR for a full code status both verbally and during a staff meeting.</p> <p>On 4/20/23, at 1:58 p.m. LPN-B stated if she found a resident unresponsive she would check the closet door or the medication administration record for the code status. If the resident was full code LPN-A said she would immediately initiate CPR.</p> <p>On 4/20/23, at 2:12 p.m. the ADON stated if a resident was full code and unresponsive she would call for help and initiate CPR. The ADON said a nurse from the hospital would arrive with a crash cart and CPR would continue until the physician assessed the resident and directed otherwise.</p> | F 678                                                                      |                                                                                                                          |  |                                                                    |



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

PRINTED: 05/02/2023  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                          |  |                                                                        |
|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245247</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>04/20/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KITTSOON MEMORIAL HEALTHCARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 SOUTH BIRCH</b><br><b>HALLOCK, MN 56728</b>                             |  |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                             |
| F 678                                                                          | <p>Continued From page 4</p> <p>On 4/20/23, at 2:20 p.m. RN-C stated if he found a resident unresponsive with a full code status he would call a code over the intercom and initiate CPR. RN-C stated CPR would continue until he received further instruction from the provider.</p> <p>On 4/20/23, at 2:27 p.m. LPN-C stated the residents code status could be found on the back of the closet door, in the computer and on the report sheet. LPN-C stated if a resident was found unresponsive and was full code she would initiate CPR, have another staff call a code over the intercom and continue CPR until further instructed by the physician. LPN-C stated she had received education immediately following the incident with R1.</p> <p>Facility policy titled Cardiopulmonary Resuscitation (CPR) undated, directed staff to determine unresponsiveness, call out for help, delegate an individual to check care plan for code status. The policy directed staff to initiate CPR and continue CPR until qualified help arrived or a physician pronounced the resident dead and gave orders to discontinue CPR.</p> <p>The past noncompliance immediate jeopardy began on 3/31/23. The immediate jeopardy was removed, and the deficient practice corrected by 4/1/23, after the facility implemented a systemic plan that included the following actions:</p> <ul style="list-style-type: none"><li>-Reviewed their policy and system to ensure no system issue.</li><li>-Reviewed all residents' POLST to ensure they were consistent with residents' wishes.</li><li>-Immediate education was provided to facility staff on CPR policy and adhering to advanced directives/POLST with a plan to continue to</li></ul> | F 678                                                                      |                                                                                                                          |  |                                                                        |



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

PRINTED: 05/02/2023  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                |                                                                                                                                                                         |                                                                            |                                                                                                                          |  |                                                                    |
|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245247</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>04/20/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KITTSOON MEMORIAL HEALTHCARE CENTER</b> |                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 SOUTH BIRCH</b><br><b>HALLOCK, MN 56728</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 678                                                                          | Continued From page 5<br>educate staff prior to staff working their shifts.<br>-Interviews with staff on 4/20/23 confirmed the<br>facility's policies will be followed. | F 678                                                                      |                                                                                                                          |  |                                                                    |





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

May 2, 2023

Administrator  
Kittson Memorial Healthcare Center  
1010 South Birch  
Hallock, MN 56728

Re: Event ID: 23PN11

Dear Administrator:

The above facility survey was completed on April 20, 2023 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, Minnesota 55164-0970  
Phone: 651-201-4117  
Email: [Melissa.Poepping@state.mn.us](mailto:Melissa.Poepping@state.mn.us)



Minnesota Department of Health

|                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 |                                                                                                                          |  |                                                   |
|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>00321 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>C<br>04/20/2023 |
| NAME OF PROVIDER OR SUPPLIER<br><br>KITTSOON MEMORIAL HEALTHCARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1010 SOUTH BIRCH<br>HALLOCK, MN 56728                                           |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                                | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| 2 000                                                                   | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:<br/>On 4/20/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure</p> <p>The following complaints were reviewed:<br/>H52479873C (MN92416)</p> | 2 000                                                           |                                                                                                                          |  |                                                   |

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE



Minnesota Department of Health

|                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           |                                                                                                                          |                          |                                                                    |
|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>00321</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>04/20/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KITTSOON MEMORIAL HEALTHCARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1010 SOUTH BIRCH<br/>HALLOCK, MN 56728</b>                                   |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| 2 000                                                                          | <p>Continued From page 1</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p> | 2 000                                                                     |                                                                                                                          |                          |                                                                    |