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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: V9NB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00321

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/06/2019** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE - NE II 02/08/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 02/08/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/14/2019
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245247

February 8, 2019

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 31, 2019 the above facility is recommended for:

60 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
February 8, 2019

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

RE: Project Number S5247031

Dear Administrator:

On December 17, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 22, 2018. (42 CFR 488.422)

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 17, 2019.

On February 6, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 14, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 31, 2019. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 29, 2018, as of January 31, 2019.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 31, 2019.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 17, 2019 be rescinded as of January 31, 2019. (42 CFR 488.417 (b))

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

In our letter of December 17, 2018, in accordance with Federal law, as specified in the Act at Section

1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 17, 2019, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 31, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 8, 2019

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

Re: Reinspection Results - Project Number S5247031

Dear Administrator:

On February 6, 2019 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 6, 2019, with orders received by you on January 17, 2019. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: V9NB

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

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(L1) **245247**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/29/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Debra Vincent, HFE - NE II — 01/09/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 01/11/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 17, 2018

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

RE: Project Number S5247031

Dear Administrator:

On November 29, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the November 29, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5247011. 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), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this department has recommended and CMS has authorized us to notify you this Department is imposing the following remedy:

- State Monitoring effective December 22, 2018. (42 CFR 488.422)

This Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition, the CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 17, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 17, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 17, 2019.

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.

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 $10,483; 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.

If you have not achieved substantial compliance by February 17, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Kittson Memorial Healthcare Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 17, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 May 29, 2019 (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) 565-9462

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/29/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on November 26, 27, 28, & 29, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On November 26, 27, 28, and 29th, 2018, a standard 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. A complaint investigation(s) for H5247011 was also completed. H5247011 was found to be substantiated. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with	F 577		11/30/18

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

Electronically Signed | 12/26/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	11/29/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577	Continued From page 1 respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure three years of survey results were readily accessible for residents or visitors to view. This had the potential to affect all 55 residents who resided in the facility and visitors. Findings include: On 11/29/18, at 3:03 p.m. a three-ring binder labeled Survey Results was observed on a bookcase shelf in the lower level solarium. The binder contained the most recent life safety code survey results dated 10/3/17. However, the results of the most recent federal recertification	F 577	It is the policy of KMHC that the most recent survey be posted in a place readily accessible to residents, family members and legal representation of the resident. A notice of availability of such reports are located in areas of the facility that are prominent and accessible to the public. A notice was posted on 11-30-2018 in a three ring binder on the shelve located in the sitting area of the lower level nursing home stating the 3 preceding years and any plan of corrections are available to view upon request. The same notice was placed in a 3 ring binder located in the upper level nursing home with a sign posted for the public stating the survey	

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F 577	Continued From page 2 survey were not included. There was no posted information indicating any other results were available. On 11/29/18, at 3:06 p.m. the director of nursing stated the facility had not received any deficiencies last year so they had not included the survey results in the binder. -At 3:14 p.m. the administrator indicated the facility also had a three-ring binder with survey results on the upper level locked unit, however, confirmed the facility had not included three years of survey results in either binder and had not posted notice that the survey results were available upon request as required. No policy regarding posting of survey results was provided.	F 577	book and the last 3 surveys with the plan of correction are available to view upon request. To ensure compliance, the DON or her designee will do QA checks monthly. The results will be brought to the Risk Management Committee for their review. Goal is 100% compliance.	
F 578 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. §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	F 578		1/2/19

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F 578	Continued From page 3 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 advanced directives for emergency care and treatment were accurately reflected in all areas of the medical chart to ensure resident wishes would be implemented correctly in an emergent situation for 1 of 1 resident (R52) reviewed for advanced directives. Findings include: R52's admission Minimum Data Set (MDS) dated 11/8/18, identified R52 was cognitively intact. R52's general order form provided on 11/27/18,	F 578	It is the policy of KMHC to inform and provide written information to all adult residents concerning the right to accept or refuse, or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. The record of R52 was audited and updated on 11-28-18 to reflect the order change from code 1 to DNR. All records were audited on 1-2-2019. A checklist was developed for the nursing staff as a reminder for all records to be up to date and accurate. The checklist once initialed by the nurse	

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F 578	Continued From page 4 revealed a physician's order which indicated "wishes cardiopulmonary resuscitation (CPR)" dated 11/2/18. R52's CPR statement of decision signed and dated on 11/2/18, indicated R52 had wished for CPR to be initiated. The lower level west report sheet and resident care sheets provided on 11/26/18, indicated R52 was a full code (provide CPR). On 11/27/18, at 4:01 p.m. R52 stated upon admission, she had signed a form which indicated CPR was to be preformed in the event of an emergency. -At 4:02 p.m. nursing assistant (NA)-A indicated if she were to find a resident who was not breathing and did not have a pulse, she would call for a nurse immediately. -At 4:02 p.m. licensed practical nurse (LPN)-C stated she would check the report sheet and the chart to determine the code status for a resident. -At 4:03 p.m. LPN-A verified the electronic chart indicated R52 was DNR (do not resuscitate) and the outside of the hard copy chart indicated she was a Full Code. LPN-A verified the lower level west report sheet and the resident care sheets both indicated R52 was Full Code. The chart was reviewed and the CPR statement of decision indicated wishes for CPR. -At 4:04 p.m. registered nurse (RN)-A stated she thought R52 had changed her status and they were awaiting the signed form from the physician although the form could not be located by RN-A. -At 4:15 p.m. director of nursing (DON) stated she also thought R52's code status had been changed to DNR although could not verify this by	F 578	taking the order will be given to the DON or designee. Nursing staff will be educated on the new process by the DON. To ensure compliance, Audits will be done on any new admits or any advance directive changes in the facility throughout the year. The results of the QA will be brought to the Risk Management Committee monthly X3, then quarterly for their review and corrective actions taken as needed. Results of audits will shared at the monthly nurses' meeting.	

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F 578	Continued From page 5 documentation. DON stated she would expect that the electronic chart, hard copy chart, CPR statement of decision, and the physician orders would match. Review of Advance Directive policy and procedure dated 7/2017, indicated the facility would provide basic life support including CPR when a resident required such emergency care and prior to the arrival of emergency medical services but was subject to physician order and resident choice indicated in the resident's advance directive. Nurses and other care staff are educated to initiate CPR, unless a valid DNR order was in place. All advance directive documents and code status sheets are located in the front of the chart. Resident wishes would be communicated to staff via the care plan and to the resident physician.	F 578		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify, comprehensively assess, develop and/or implement appropriate interventions, and adequately monitor skin wounds in order to	F 684	It is the policy of KMHC to identify, assess, develop and/or implement appropriate intervention and adequately monitor skin and wounds in order to promote intact skin integrity and healing.	1/3/19

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F 684	Continued From page 6 promote intact skin integrity and healing of an abrasion on the left great toe for 1 of 1 resident (R34) who had a history of poor wound healing and 1 of 1 resident (R12) who had scabbed, diffuse abrasions on the hands without the application of skin creams as ordered. This failure resulted in actual harm for R34 whose wound worsened and became infected. In addition, the facility failed to comprehensively assess, monitor and implement interventions for 1 of 1 resident (R52) who had increased edema (swelling) of the legs without the application of compression stockings, as ordered. Findings include: R34's quarterly Minimum Data Set (MDS) dated 10/12/18, identified R34 had severely impaired cognition, and diagnoses which included diabetes mellitus, neuropathy, non-pressure chronic ulcer left calf limited to breakdown of skin, and venous insufficiency (poor circulation). The MDS indicated R34 was totally dependent on staff for all activities of daily living except was able to eat with supervision. R34's annual MDS dated 7/12/18, identified R34 had the same diagnoses with no differences in skills noted. R34's Pressure Ulcer Care Area Assessment (CAA) dated 7/12/18, indicated R34 was at risk for pressure sores due to mobility deficits related to poor circulation, stroke, diabetes with insulin use, chronic kidney disease, bowel and bladder incontinence, and anemia. The CAA indicated R34 had a stasis ulcer to the left shin, but no pressure ulcers.	F 684	All residents with skin wounds and compression stocking ordered by a physician in the facility have the potential to be affected. On November 28th, 2018 a comprehensive skin assessment was completed for R34. The care plan was updated on 11/28/2018 with an abrasion to the left great toe. Observations added in EMR for nursing to assess L great toe daily, notify MD if condition worsens. Orders for an antibiotic were received and the left great toe was assessed by a FNP on 11-28-2018. On 11-29-18 the PA checked the wound with no new orders. The wound specialist saw resident R34 on 12-5-18 and "noted wound is improving no signs or symptoms of infection". Order was written to discontinue foot soaks and apply iodine swab to Left great toe. On 12/20/18 R34 saw wound specialist and PA in nursing home during rounds, no new orders. Noted sores scabbed over, in healing stages with no signs or symptoms of infection. On 11-29-18 a skin assessment was completed on R12 with measurements for the scabbed abrasions to the left hand. On 12-4-18 an order to change the hydrocortisone ointment from prn to scheduled BID was given to nursing by the MD. On 12-5-18 the wound specialist saw resident R12 and measured wounds on his left hand. Wounds were measured on: 12-12-18, 12-17-18, 12-19-18, 12-31-18. Wound specialist charted on 12-19-18 that all areas on dorsum of hand	

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R34's Care Plan dated 2/21/18, indicated R34 had a history of an abrasion to the left great toe due to transfer and staff were instructed to avoid bumping toes, to monitor foot placement with transfers and placing by table. The last documentation indicated the wound was almost healed on 9/19/18. No further documentation was evident and R34 obtained a new abrasion to his toe on 11/21/18.

R34's Care Plan dated 3/28/18, indicated staff were instructed to monitor the abrasion daily during cares and to notify the nurse if noted to be worsening.

R34's Kittson Memorial Healthcare dated 9/6/17, indicated R34 had a personal history of circulatory system, probably venous stasis and combination of arterial for the non healing wound of his left shin. R34's physician indicated the wound was a chronic wound and the physician's goal was to prevent infection to the wound.

R34's Progress Notes/ daily nurses notes dated 11/21/18, indicated the staff had identified a scrape on R34's left great toe, however, no further assessment as to how the scrape had been obtained, the size, depth and/or severity was noted.

On 11/26/18, at 6:32 p.m. R34 was observed at the dining table, seated in a reclining wheelchair in a reclined position with feet slightly elevated. R34's left great toe was open to air and visible through the toe hole of a compression sock. An approximately 1-2 centimeters (cm) dark area was noted on the outer aspect of the toe with a reddened area on the outer portion.

are closed. Charting on 12-31-18 indicated wounds were scabbed over.

On 11-26-18 compression stockings were applied to R52. Order on 11-9-18 for compression stockings to be on in am and off in bed. Order changed in EMR on 12-3-18 for nursing to assess edema each day along with applying compression stockings. Orders received on 11-27-18 from MD for daily weight with parameters. R52 died on 12/13/2018.

The facility developed a flow sheet document to prompt staff to appropriately identify skin issues and follow procedures with skin integrity. Skin integrity will be assessed weekly on all residents.
A mandatory training class will be given on 1-9-19 by a wound care specialist to train nurses to identify issues with skin, wounds, dressings, interventions, proper documentation and infection control practices.

Auditing will be done by the DON or designee for: Ted hose application by CNA's, resident care sheet accuracy in regards to compression stockings and care plan accuracy in regards to compression stockings. The audits for compression stocking application will be done daily times 2 weeks, then weekly times 1 month, with the results brought to Risk Management quarterly for 1 year. The whole facility will be audited for accuracy on care plans and resident care sheets for use of compression stockings. Each new admission with orders for

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F 684	Continued From page 8 On 11/28/18, at 1:12 p.m. licensed practical nurse (LPN)- D was observed to perform R34's left shin wound care. At this time, LPN-D indicated R34's toe wound was from an abrasion which he received during a transfer. LPN-D stated the wound had progressed from a simple scratch/abrasion to a blackened area. LPN-D stated a note had been sent to R34's primary physician regarding the toe wound. At this time, an approximately 1-2 cm blackened colored scab was noted on the side of the left great toe and the entire rest of the toe was reddened. LPN-D confirmed the redness and stated the redness was noted on 11/27/18, however, the facility was not providing any type of treatment to the area, at this time. LPN-D stated R34 had a history of a stroke with left sided weakness and poor circulation in the left side, had a chronic stasis ulcer on his left shin, had mobility impairment and poor circulation. LPN-D applied the Prevalon boot (a pillow-like boot to help prevent pressure ulcers on the heels), elevated the foot on a pillow and exited the room. No assessment of the toe wound was completed. R34's Kittson Memorial Healthcare note (clinic office note) dated 11/28/18, indicated R34 was evaluated for a worsening toe abrasion. The nurse practitioner (NP) described the wound as an abrasion appearing like a skin tear in a circular pattern. The wound had dried crusted areas around the perimeter showing redness, warmth to the touch and swelling. NP diagnosed cellulitis (bacterial skin infection) of the left toe. The plan instructed staff to soak the foot three times a day with hibiclens (antibacterial solution) water and to keep the wound clean and dry. An antibiotic (Keflex) was also prescribed.	F 684	compression stockings or any changes in orders will be audited for compliance. The results will be brought back to Risk Management quarterly for 1 year. CNA will be educated on the importance of compression stocking application on 1-7-19. To ensure compliance the DON or designee will do audits on skin integrity assessments, interventions, and auditing daily for 2 weeks, then random audits monthly for 1 year. The results will be brought to the Risk Management Committee for their review and corrective actions taken as needed. DON responsible for compliance.	

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R34's Resident Inadvertent Incident Report dated 11/28/18, indicated the scrape on R34's left great toe occurred on 11/21/18, during a transfer from chair to bed. Recommendations made were for occupational therapy to evaluate for protection of R34's toes, to monitor toes/feet closely with transfers and to follow up with the wound specialist during next rounds.

On 11/29/18, at 9:30 a.m. registered nurse (RN)-B indicated a wound specialist followed R34 weekly for the stasis ulcer on his shin, but had not been aware of the toe wound until 11/27/18.
RN-B stated she was unaware R34 had a wound on his left great toe until 11/27/18, when she was informed R34 had been refusing to wear the Prevalon boots and upon investigation of R34's refusals, RN-B noted the toe wound. RN-B stated R34 had a history of poor circulation and had a chronic stasis ulcer on the left shin.
RN-B had directed the staff regarding the importance of immediately reporting skin concerns to either herself or to the charge nurse on duty due to the possibility of R34's wounds not healing. RN-B confirmed there was no documentation regarding the toe wound between 11/21/18, and 11/27/18, and stated R34's toe abrasion was currently an unstageable wound (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. RN-B stated a comprehensive skin assessment should have been completed on 11/21/18, at the time the wound was identified, however, a comprehensive skin assessment had not been completed.

- 11/29/18, 12:58 p.m. the director of nursing (DON) stated she was unaware R34 had

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developed an unstageable wound to the left great toe. The DON confirmed a comprehensive skin assessment should have been completed at the time the toe wound was identified.

R12's quarterly MDS dated 8/30/18, and annual MDS dated 2/28/18, identified R12 had moderately impaired cognition and diagnoses which included Diabetes Mellitus with chronic kidney disease, history of edema, and staphylococcal arthritis of the left shoulder. The MDS indicated R12 required limited assistance with bed mobility and transfers, supervision/set up with walking with a front wheeled walker (FWW) in room/corridor/unit and extensive assistance with dressing, toileting, and personal hygiene.

R12's CAA dated 3/7/18, indicated R12 had diagnoses which included dementia, peripheral neuropathy, and Diabetes Mellitus. The CAA further indicated R12 usually made needs known and was usually understood by staff. R12's assessment identified the need for limited to extensive assist with ADLs, and R12's dermatitis (inflammation of the skin) would resolve with the current orders.

R12's Care Plan last revised 11/15/18, indicated R12 had a history of cellulitis to the right foot, and scratching the skin until sores formed and then picking at the sores. Staff were instructed to apply Hydrocortisone (steroid cream used to treat inflammation or itching of the skin) cream to itchy areas, apply Hydrophor (a medication used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations) lotion to irritated skin per doctor's orders. The staff were

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also instructed to report any skin breakdown.

R34's Physician Orders dated 3/21/18, indicated Hydrocortisone 2.5% cream was to be applied to itchy areas of R12's skin as needed, Hydrophor lotions were to be applied to open areas twice daily due to itching and nursing to assess skin rash daily. The physician also directed the staff to ensure R12's skin was lotioned well and to ensure R12's fingernails were trimmed and cleaned at least twice daily.

R12's Nursing Progress note dated 10/29/18, identified, "old previous sores from scratching."

On 11/26/18, at 6:26 p.m. scabbed abrasions were noted on the back of R12's left hand. At this time, R12 was observed to reach out with his right hand and scratch the back of the left hand and forefinger. Opened areas were not bleeding and the scabbed areas on the back of the left hand were approximately 1 cm in size. The left pointer finger also had an approximately 1 cm scabbed area and the finger was swollen and reddened. As R12 rubbed the left index finger, he stated his hands were sore and itched. The back of R12's right hand also had an approximately 1 cm scabbed abrasion.

On 11/28/18, at 7:51 a.m. R12 was observed in the dining room. The left hand was noted to be swollen.

-At 8:00 a.m. as R12 rubbed his hands, the left hand was noted to be pink colored and shiny. R12 stated his hands itched.

-At 8:54 a.m. R12 observed to rub and scratch at his left hand.

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-At 11:31 a.m. R12 was observed seated at dining table in dining room, rubbing his hands together and scratch at the back of his hands.

-At 12:52 p.m. NA-E offered R12 restorative exercises, however, R12 refused stating his fingers were sore, itched, were swollen and needed lotions. NA-E offered the exercises twice, however, R12 continued to refuse. NA-E did not provide/offer R12 any type of lotion for his hands.

R34's medical record contained weekly skin checks which indicated:

- 9/3/18, random open areas primarily on R12's legs, none draining and without much change from week prior. The skin check lacked location of the open areas along with a description including the size or if there had been drainage. Causal factors were not identified.

- 9/10/18, scratches on legs (shins), behind right ear, right shoulder, and on right hand. The skin check lacked the size, color or possible drainage and/or causal factors.

- 9/17/18, skin was "about the same" as the week prior skin assessment with scratches on legs (shins), behind right ear, right shoulder, and on the right hand healing. R12 continued to have other areas that needed lotion because they were dry and itchy. No measurements or descriptions were documented.

- 9/24/18, scratches on R12's body were "the same, most healing normally, with a new scratch on upper left thigh." No measurements or descriptions were documented.

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- 10/1/18, scabs and scars where R12 scratched skin. No new areas were noted. No measurements or descriptions documented.

- 11/6/18, "self inflicted" scratch marks to both lower extremities and stomach. Random discolorations to different parts of body. No measurements were documented.

- 11/12/18, old discolorations and bruising to both upper/lower extremities from scratching. Also had open area to the left hand "where he has scratched it open." No measurement were documented.

- 11/27/18, indicated random scratches, especially on R12's hands, ointment was applied. No measurements were documented.

A Nursing Progress Note dated 11/28/18, at 8:33 p.m. indicated R12 utilized Hydrocortisone cream as needed for itching. No further documentation or measurement of sores noted.

R12's Medications Administration Record (MAR) dated 11/1/18 - 11/29/18, indicated Hydrocortisone cream had been applied four times in November 2018.

On 11/29/18, 10:10 a.m. RN-B indicated R12 had a history of scratching himself and picking at his scratches or scabs. RN-B stated she was aware R12 had scratches and open areas on the left hand and that the nursing staff were to measure and document any concerns regarding his skin during the weekly skin checks. RN-B stated R12 also had a history of scratching his skin until he had developed cellulitis which required antibiotic

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therapy due to his picking behaviors. RN-B stated R12 had creams to be used as needed to help relieve any irritated skin concerns/itchy spots. RN-B reviewed R12's MAR and confirmed R12 had only utilized the Hydrocortisone cream four times in November 2018. RN-B stated she was not aware the creams had not been utilized when needed and that a comprehensive skin assessment had not been completed.

-At 10:39 AM, RN-B and RN-C were observed to measure R12's open areas on his hands. The left pointer finger was open and bleeding while RN-C applied a Band-Aid for pressure. RN-C stated R34 had scratched open the right pointer finger wound that morning which required cleaning and a new dressing applied. R12 was noted to have the following wounds:

- Left hand wound closest to the wrist had a pink open flesh wound which measured 0.5 x 0.7 cm.
- Left hand wound closer to fingers had a pink open flesh wound which measured 1.1 x 0.3 cm.
- Left index finger wound was open and actively bleeding and measured 0.3 x 0.3 cm.
- Right hand pointer finger had a dry black scab/wound which measured 0.7 x 0.3 cm.
- Right hand ring finger dry black scab wound measured 0.8 x 0.2 cm.

-At 10:45 a.m. RN-C stated R12 continually picked at the wounds. R12 stated, "They itch all the time." RN-B stated she was not aware R12 had wounds on the right hand and confirmed R12's wounds had gotten worse. RN-B also confirmed the staff had not been documenting the location, size, color or causal factors of the wounds. RN-B stated she would expect the staff to inform her of any additional wounds and

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complete a comprehensive skin assessment at the time new wounds were identified.

- At 12:40 p.m. the DON stated she was not aware R12 had developed new open areas on his hands. The DON stated she was aware R12 had a history of picking at his skin, however, she would expect the nursing staff to complete a comprehensive skin assessment, follow the facility policies and procedures related to wounds, and provide continuous wound care, as needed.

A facility Skin Breakdown Prevention Protocol, undated, identified a system was in place for the prevention, identification, treatment and documentation of non-pressure wounds. The protocol stated nursing would do a weekly skin check for residents at least weekly, on the residents' bath day, and document any problems noted. The notes were to include a clear description of the ulcer and surrounding skin, a description of any drainage, what the treatment was with effectiveness, and verification the practitioner was notified of the status.

R52's admission MDS dated 11/8/18, indicated R52 was cognitively intact and required limited assistance of one staff for dressing.

R52's Occupational Therapy Treatment Encounter note dated 11/9/18, indicated edema bilaterally in lower extremities. Size medium Tensoshape was provided and nursing was notified on communication log, to apply in AM remove at bedtime.

R52's physician order report dated 10/29/18 - 1/31/19, indicated R52 had diagnoses which included chronic kidney disease stage 4 (severe)

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and acute pulmonary edema. Orders included compression stockings to bilateral lower extremities to be on during the day with a start date of 11/9/18.

R52's care plan dated 11/21/18, directed staff to monitor weight daily and notify medical doctor (MD) and family of significant weight change. The care plan also directed staff to evaluate, record and report swelling of the ankles and feet. The care plan did not address use of Tensoshape stockings (compression stockings).

R52's resident care sheet provided on 11/26/18, directed staff to apply Tensoshape stockings to lower extremities (on in AM, off at bedtime).

On 11/28/18, at 7:13 a.m. NA-A was observed to provide R52 morning cares which included dressing. Gripper socks were applied and not the Tensoshape stockings, as directed.

On 11/28/18, during observations from 8:02 p.m. until 12:53 p.m. licensed practical nurse (LPN)-B, LPN-A, and an unidentified occupational therapist had entered R52's room and interacted with R52. During the observation, none of the staff assessed R52 for edema in lower legs or applied the Tensoshape stockings.

-At 12:55 p.m. surveyor requested LPN-A to assess R52's edema in the lower extremities. LPN-A assessed the edema and stated the left extremity edema measured 2+ (2 seconds to rebound when finger pressed into skin) and the right lower extremity measured 3+ (3 seconds to rebound) edema. LPN-A stated R54 should have the Tensoshape stocking applied every morning by the NA. LPN-A proceeded to apply the

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F 684	Continued From page 17 stockings and reminded R52 to keep feet elevated as much as possible. -At 1:05 p.m. RN-A stated R52 should be wearing compression stockings daily and the NA's were responsible to apply them with morning cares. RN-A also stated R52 was to be weighed every morning, however, confirmed there were no parameters for when the MD should be notified of weight changes. -At 1:12 p.m. NA-A stated she was not sure if R52 was to wear compression stockings or if therapy applied leg wraps. NA-A acknowledged she had not applied compression stockings to R52 that morning with cares. On 11/29/18, at 8:07 a.m. the DON stated R52 was to have compression stockings applied each morning by the NA's and confirmed they did not have orders or specific instructions for when to notify the MD regarding any weight changes. The DON stated she would expect the nurse's to use their critical thinking skills as to when to notify the MD. Fallibility policy Weight and Height Measurement (undated), indicated to notify the charge nurse or physician of all weight changes of 5 pounds (or 5%) or more in a 30-day period or ten percent in a 180 day period or per state requirement.	F 684		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 732		12/27/18

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F 732	Continued From page 18 (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(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(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 and visitors. §483.35(g)(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(g)(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: Based on observation, interview and document review, the facility failed to ensure the required nurse staffing information was posted daily. This had the potential to affect all 55 residents who resided in the facility and/or any visitors who may have wished to view the information.	F 732	It is the policy of KMHC to post information that includes the facility name, current date, total number and actual hours worked of staff directly responsible for resident care and resident census. To ensure compliance the ward clerk was educated on 11-29-2018 to accurately fill	

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F 732	Continued From page 19 Findings included: On 11/29/18 at 2:30 p.m. a sheet dated 11/29/18, titled "Kittson Memorial Nursing Home (Lower Level) Staffing Sheet was observed posted on the utility room door across from the nurses station. The sheet identified the resident census, shift, category of staff, and actual hours worked but did not identify the number of staff or total staffing hours for the day. -At 2:41 p.m. a sheet dated 11/29/18, titled "Kittson Memorial Nursing Home (Upper Level) Staffing Sheet was observed posted on a door next to the locked exit doors of the unit. The sheet also identified the resident census, shift, category of staff, and actual hours worked but did not identify the number of staff or total staffing hours for the day. -At 2:57 p.m. the staffing sheets for 11/26/18, 11/27/18, and 11/28/18, were provided by ward clerk (WC)-A who indicated she was in training and could not speak to the sheets' completion. -At 3:14 p.m. the staffing sheets were reviewed with the administrator who indicated they were completed by a ward clerk. The administrator verified the lower level staffing sheets did not include the number of staff or total staffing hours for the dates of the survey (11/26/18 through 11/29/18). The administrator also verified the upper level staffing sheets did not include the number of staff or total staffing hours for 11/26/18 and 11/29/18. The administrator confirmed the forms should have been completed as required. No policy regarding posting of nurse staffing hours was provided.	F 732	out the form with the total staffing hours each day. The nurses were also given a memo on accurately filling out the staffing sheets on 12-19-2018 including an example of the document. Audits of the staff posting sheets began on 11-29-18. If information is missing the nurse responsible will be educated. Results of the audits will be brought to the Risk Management Meeting monthly X3 months then quarterly for review and any needed actions taken. DON is responsible for compliance.	

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		1/2/19

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F 758	Continued From page 21 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify target behaviors for the use of anti-anxiety medication for 2 of 5 residents (R8, R3) reviewed for unnecessary medications. Findings include: R8's annual Minimum Data Set (MDS) dated 8/29/18, indicated R8 was cognitively intact and had diagnoses which included anxiety disorder and depression. The MDS indicated R8 experienced mood symptoms which included feeling down, depressed or hopeless one day of the assessment period and feeling tired or having little energy 2-6 days of the assessment period. The MDS also indicated R8 exhibited no psychosis, behavioral symptoms, and rejection of care or wandering. The MDS further indicated R8 received anti-anxiety medication daily. R8's Mood State Care Area Assessment (CAA) dated 9/5/18, indicated staff documented R8 had been more emotional, had increased anxiety and had indicated she felt she was having a mental breakdown as she couldn't find her sister's phone number.	F 758	It is the policy of KMHC that psychotropic medications will not be used unless behavioral programming and/or environmental changes have failed to sufficiently modify a resident's behavioral disturbances (i.e. target behaviors). Residents will not receive psychotropic medications unless such medication is needed to treat a specific condition and each psychotropic medication will be given to treat clearly defined target behaviors. Consistent monitoring of all target behaviors will be done to assist in the assessment of the risk/benefit relationship of psychotropic drug therapy and the facilities policy has been changed to reflect current regulations. R8 and R3 target behaviors were added to the care plan and to the EMR with monthly documentation on target behaviors. All residents with scheduled psychotropic medication will have monthly documentation on target behaviors. The IDT will monitor the progress of individuals on psychotropic medication, interventions will be adjusted based on the impact on behavior and other symptoms, including any adverse	

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F 758	Continued From page 22 R8's Psychotropic Medication Use CAA dated 9/5/18, indicated R8 took Klonopin (clonazepam) for anxiety, mirtazapine and Celexa for depression and appetite stimulation and experienced no adverse effects from the medication. R8 had unsteady balance and weakness but was showing no signs or symptoms of gaining strength. R8 needed much encouragement and cueing daily to keep doing as much for herself as possible. Staff stressed the positives in her life, redirected and reassured her and encouraged family time. No reduction in dose of medications planned currently but physician was watching closely and would reduce when appropriate. R8's Physician Order Report dated 10/29/2018 - 01/31/2019, included an order for clonazepam 0.5 milligrams (mg) at bedtime. The order start date was 11/13/18. R8's Medication Administration History forms dated 9/1/18-9/30/18, 10/1/18-10/31/18 and 11/1/18-11/30/18, indicated R8 received clonazepam 0.5 mg twice daily until 11/13/18, after which she received the medication once daily. R8's Care Plan dated 9/17/18, indicated R8 had diagnoses of depression and anxiety and directed staff to administer clonazepam per provider orders and monitor for side effects such as: dizziness, headache, fatigue and upset stomach. Social service to visit monthly and 1:1 as needed. Assess, monitor, and document mood and response to medications. Encourage activities of choice and calls and visits with family. Stress positives in her life. Consult clergy as needed.	F 758	consequences related to treatment. To ensure compliance the DON or designee along with the facility consulting pharmacist will do QA checks monthly on documentation of target behaviors. The results will be brought to the Risk Management Committee for their review and corrective actions taken as needed. DON responsible for continued compliance.	

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Be reassuring and listen to concerns. The care plan also indicated R8 had behavioral symptoms exhibited as seen in anxiety episodes, especially with any change in R8's routine. The care plan directed staff to redirect resident as needed, convey acceptance during periods of anxiety, use calm matter of fact approach, explain all cares prior to doing, go slowly with cares, keep daily routine the same as much as able, keep environment calm and relaxed. However, the care plan lacked identification of the target behaviors of R8's anxiety episodes.

R8's Physician Progress Note dated 7/12/18, indicated R8 had obsessive-compulsive disorder and depression with anxiety. Staff noted she had increased obsessions in regard to different things, such as pain in her shoulders and toe. She did not mention the latter today though she does have shoulder pain. The plan indicated R8 had depression with anxiety and obsessed quite a bit about various things and going home. We will try to increase sertraline (antidepressant) from 100 to 150 mg daily and see how she does with this.

R8's Nurse Practitioner Progress Note dated 9/12/18, indicated R8's care plan and medications were reviewed. No changes at this time, as she still was exhibiting some degree of anxiety, but overall, she was stable.

On 11/28/18, at 12:17 p.m. R8 was observed seated in a wheelchair, at a table in the dining room while waiting for the noon meal. R8 was alert, sitting quietly and not conversing with table mates at this time.

On 11/29/18, at 1:21 p.m. R8 was observed seated in a wheelchair in her room. R8 verified

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she had some pain in a toe and her shoulders and received treatment/medications which were effective in treating the pain. R8 denied any anxiety or depression. R8 was alert, pleasant, engaged and made eye contact during the interview.

On 11/29/18, at 3:40 p.m. registered nurse (RN)-D indicated every shift, the staff had been documenting on a progress note indicating symptoms of crying, refusing to come out of room, appetite change, sleeping too much or insomnia but had discontinued doing so on 9/14/18. RN-D verified they did not have target behaviors identified for R8's anxiety at this time.

On 11/29/18, at 3:51 p.m. the director of nursing (DON) stated target behaviors should have been identified and monitored as required.

R3's admission MDS dated 8/13/18, indicated R3 had intact cognition, did not have any behaviors and had diagnoses of anxiety disorder and depression. The MDS also indicated R3 received anti-anxiety, antidepressant and hypnotic medications on a daily basis. The MDS indicated R3 experienced mood symptoms which included feeling down, depressed or hopeless one day of the assessment period and feeling tired or having little energy 2-6 days of the assessment period. R3' Care Area Assessment did not trigger any mood, behavioral, or psychotropic medication use areas.

R3's care plan dated 11/26/18, indicated that R3 was at risk for adverse consequences related to anti-anxiety and antidepressant medications. The care plan directed staff to administer medications as ordered and monitor for side effects which

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included depressed mood and other changes in mood or emotion. The care plan lacked individualized target behaviors to be monitored.

A Behavior Category Report indicated R3 displayed no physical, verbal or other behavior directed towards others, rejection of care, or wandering since admission. No specific individualized target behaviors related to anxiety were being monitored by the facility.

R3's current physician orders included alprazolam 0.25 milligrams (mg) twice per day for anxiety (began 10/10/18). Prior to this order R3 was receiving alprazolam 0.25 mg one time daily as needed (PRN) for anxiety.

R3's Progress Notes where reviewed for monitoring of anxiety and included the following:

- On 8/7/18, at 6:16 p.m. resident's son approached nurse;s station stating his mother was having an "anxiety spell."
- On 8/8/18, at 10:20 p.m. resident requested alprazolam to be given this evening for anxiety.
- On 8/9/18, at 11:42 a.m. order per physician alprazolam 0.25 mg three times daily.
- On 8/12/18, at 3:17 p.m. was feeling a little anxious this afternoon before scheduled alprazolam.
- On 10/10/18, at 11:02 a.m. physician order to change current alprazolam 0.25 mg scheduled three times daily to 0.25 mg twice daily for anxiety and 0.25 mg once daily PRN for anxiety.
- On 10/26/18, physician order to discontinue PRN alprazolam

On 11/26/18, at 5:15 p.m. R3 was observed in the dining room eating the meal and visiting with table

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mates. R3 displayed no signs of anxiety.

On 11/28/18, at 12:07 p.m. R3 was observed in the dining room eating lunch and visiting with table mates. No signs of anxiety were noted.

On 11/29/18, at 4:11 p.m. RN-D stated they used to do specific behavioral monitoring for residents up until 8/9/18, when it was discontinued. RN-D stated R3 had not been experiencing anxiety since the alprazolam was scheduled on 10/10/18. RN-D stated she would expect nursing staff to document when there was any episode of anxiety - At 4:17 p.m. director of nursing stated she could not speak specifically to R3 but all target behaviors should be identified, monitored and documented in progress notes.

The undated Psychotropic Medication Usage policy indicated psychotropic medications would not be used unless behavioral programming and/or environmental changes have failed to sufficiently modify a resident's behavioral disturbances (i.e. target behaviors). Residents would not receive psychotropic medications unless such medication is needed to treat a specific condition and each psychotropic medication would be given to treat clearly defined target behaviors. Consistent monitoring of all target behaviors would be done to assist in the assessment of the risk/benefit relationship of psychotropic drug therapy.

The undated Psychotropic Medication side Effect Monitoring policy and procedure indicated psychotropic medications would not be used unless behavioral programming and/or environmental changes have failed to sufficiently modify a resident's behavioral disturbances (i.e.

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F 758	Continued From page 27 target behaviors). Consistent monitoring of all target behaviors would be done to assist in the assessment of the risk/benefit relationship of psychotropic drug therapy. For each psychotropic medication administered there would be at least one objective and measurable target behavior identified. This target behavior would be monitored daily.	F 758		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		1/31/19

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F 880	Continued From page 28 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 880	the Risk management committee. After	

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F 880	Continued From page 29 review, the facility failed to provide proper hand hygiene when providing personal cares to 3 of 5 residents (R52, R34, R9) observed when receiving personal cares and for 1 of 1 resident (R34) when providing wound care. In addition, the facility failed to provide appropriate infection control practice for 1 of 1 resident (R52) during provision of oxygen treatment. Lastly, the facility failed to develop an infection control program which included the development of protocols and a system to monitor emerging infectious disease. This deficient practice had the potential to affect all 55 residents who resided in the facility. Findings include: R52's admission Minimum Data Set (MDS) dated 11/8/18, indicated R52 had intact cognition, required limited assistance of one staff to toilet and was occasionally incontinent of urine and always incontinent of bowel. R52 also required the use of oxygen therapy. R52's care plan dated 11/21/18, indicated occasional urge urinary incontinence and total loss bowel incontinence requiring staff to provide incontinence care after each incontinent episode. On 11/28/18, at 7:13 a.m. nursing assistant (NA)-A was observed assisting R52 to use the toilet. NA-A pulled down R52's pants and assisted to sit on the toilet. Without applying gloves, NA-A removed a urine and stool soiled incontinence pad from R52's underclothing and placed it in a waste basket. NA-A applied clean slacks to R52's lower extremities while R52 remained seated on toilet. NA-A gave R52 a wet washcloth, which R52 used to cleanse face and upper body. NA-A assisted to wash R52's back	F 880	one month, audits will be done monthly with audit results reviewed by the Risk Management committee for 2 months and then quarterly thereafter.It is the infection Control Policy of Kittson Memorial to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The Infection Control Policy of KMHC includes surveillance of infections in the facility. KMHC uses a Resident Infection log as part of our surveillance practices. Our policy is to list all residents with infectious symptoms on the log, regardless of whether the resident is receiving antibiotics. Clinical Coordinators were given education on the Resident log on 11/30/2018. All nursing staff were given written education from 12/07/18-12/24/2018 on the use and purpose of the Resident Infection log and that they are to include all infectious symptoms that residents display i.e. fever over 99 degrees; cough; vomiting; diarrhea, etc. The infection control manager will audit the Resident infection logs by reviewing event reports from the EMR weekly to be sure all infectious symptoms are being logged on the infection log. The audit will be done weekly and reported to the Quality Improvement Committee quarterly for 2019. It is the Infection Control Policy of Kittson Memorial to educate staff on proper hand hygiene, proper use of gloves and proper disinfecting practices in caring for resident	

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F 880	Continued From page 30 and applied lotion. R52 was given privacy in the bathroom while NA-A went into R52's room, removed the oxygen tubing from the top of the bed and made R52's bed. NA-A re-entered the bathroom, applied a glove to her right hand, used a disposable wipe to cleanse R52's peri and rectal area removing a moderate amount of stool. NA-A removed the glove and applied a clean incontinent pad and pulled up R52's slacks and assisted R52 to a wheelchair. NA-A unlocked the brakes on the wheelchair, pushed the chair into main room and opened the blinds while touching the back of the recliner. NA-A re-entered the bathroom and bagged up the soiled incontinence product. After bagging the soiled items, NA-A washed her hands at the sink. On 11/28/18 at 7:52 a.m. NA-A stated R52's incontinent pad was slightly damp with urine but had a lot of stool on it. NA-A confirmed she did not wash her hands until she had completed all cares for R52 and stated she should have washed her hands immediately after perineal cares were completed. On 11/28/18, at 7:58 a.m. R52's oxygen nasal cannula was observed lying on the floor next to the chair. Licensed practical nurse (LPN)-B entered the room to ask R52 if she wanted to go to the dining room for breakfast. LPN-B did not pick the oxygen cannula up from floor. -At 8:31 a.m. LPN-B entered R52's room and asked R52 if she wanted the oxygen on. LPN-B proceeded to pick up the oxygen tubing from the floor and place it into R52's nares. Following the observation, LPN-B confirmed the tubing had been on the floor and was placed in resident's nares.	F 880	equipment. Courses are assigned to all new staff working in the nursing home on Hand Hygiene. Breaking the Chain of Infection, Blood Borne Pathogens and Personal Protective Equipment as part of their orientation. Annual in-service education is also required of all staff which addresses hand hygiene, Breaking the Chair of infection and Blood Borne Pathogens. On 12/6/2018 and 12/7/2018, staff were educated during an in-service on Hand Hygiene, Use of Gloves and care of o2 equipment. Hands-on education on hand hygiene will be added to our newly developed face to face orientation education for all newly hired staff starting in January, 2019. Hand washing competency will be done by return demonstration of all staff with hands-on care of or contact with residents including housekeeping, dietary, activities, nursing and nursing assistants. Hand washing audits will be done daily on all shifts for 2 weeks, then random weekly audits times 2 months, then monthly random audits until 100% compliance is met. Results will be reviewed at our weekly Medicare meeting. Audit results will be reviewed by the Risk Management committee monthly. Our infection Control policy on "Respiratory Care" has been changed to state: "If the nasal cannula has fallen on	

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F 880	Continued From page 31 R34's quarterly MDS dated 10/12/2018, identified R34 had severely impaired cognition, and diagnoses including diabetes, neuropathy, anemia, history of cellulitis (bacterial skin infection) of the right lower leg (resolved 9/27/16), non-pressure chronic ulcer left calf, limited to breakdown of skin, venous insufficiency (poor circulation). The MDS indicated R34 was totally dependent on staff for all activities of daily living, except was able to eat with supervision. The MDS indicated R34 was always incontinent of bowel and bladder. On 11/28/18, at 7:10 a.m. NA-E was observed providing R34 a bed bath. NA-E had applied clean gloves at the beginning of the procedure. NA-E applied barrier cream to R34's groin, removed the gloves and with bare hands, removed R34's incontinent brief which was wet with urine and feces. Without washing her hands, NA-E applied clean gloves and cleansed R34's bottom which had feces, with a pre-moistened cloth, applied barrier cream to R34's buttocks and bottom, and removed the gloves. Without washing her hands, NA-E donned clean gloves and proceeded to apply a clean brief to R34, remove the gloves, and without washing her hands, proceeded to sort the room touching the full body mechanical lift in addition to other multiple areas of the room. NA-E covered R34 with blankets and raised the head of his bed then went into the bathroom and washed her hands. When asked if if she had washed her hands or used hand sanitizer during R34's perineal cares, NA-E confirmed she had not performed hand hygiene after removing the gloves following the perineal cleansing. On 11/28/18, at 1:12 p.m. LPN-D entered R34's	F 880	the floor or other unclean surface, clean with alcohol wipes as directed before returning to the patient or resident." Care of O2 tubing and cannulas will be audited weekly times 1 month and then followed up with monthly auditing. Weekly audits will be reviewed at our weekly nursing home Medicare meeting and monthly at Risk Management Committee for 2 months and then quarterly thereafter. Wound care residents will have a dedicated wound bucket of supplies for dressing changes. Hand sanitizer will be added to all buckets for ease and efficient hand sanitizing during dressing changes. Scissors in the dressing change bucket will be sanitized before and after use with alcohol per the direction of our wound care specialist. Mandatory Wound care in-service will be given to all nursing staff on 1/9/2019 per our Wound care Specialist. Policy changes include: Instructing staff to have a delegated dressing change bin (including individual hand sanitizers) for each resident needing dressing changes; Scissors will be cleaned with alcohol at the beginning and after completion of a dressing change; and if the resident or patient has several wounds requiring dressing changes, that staff start with the cleanest wound and progress to the dirtiest wound. Dressing changes will be audited weekly	

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F 880	Continued From page 32 room with R34's wound dressing basket and placed the basket directly on top of R34's bed side table. Inside the basket was an opened package with a medicated foam dressing clearly visible, new and unopened packages of medicated foam dressing and a cup which contained a non-sterile scissor, pen and a paper measuring device. LPN-D removed the soiled dressing from R34's left shin stasis ulcer. The dressing was observed to be mostly covered with a yellowish-brown colored drainage. LPN-D cleansed the wound with a pre-wet sterile saline wipe. LPN-D removed her gloves and without performing hand hygiene, applied clean gloves. Skin prep was applied to the skin surrounding the wound and allowed to dry. The previously opened package of medicated foam dressing was taken from R34's dressing basket and a small amount was cut with the non sterile scissor. LPN-D did not clean the scissor prior to use. The medicated foam dressing was applied to the wound and covered with an adhesive foam dressing. LPN-D removed the gloves and the soiled wound dressing/trash. Without performing hand hygiene, LPN-D proceeded to apply R34's Prevalon (a pillow-like boot that assists in the prevention of heel ulcers) and elevated his foot on a pillow, raised R34's head of the bed, lowered the bed to the lowest position, and used hand sanitizer, but did not clean the scissors or R34's dressing basket which was placed on top of R34's bed stand. LPN-D returned R34's dressing basket to the medication room, where it was stored. On 11/28/18, at 1:24 p.m. LPN-D confirmed she did not perform hand hygiene after removing the soiled gloves and prior to putting on clean gloves. In addition, LPN-D confirmed she did not clean	F 880	for 1 month to observe clean technique by the nurse. This audit will be reviewed weekly at the Medicare meeting and monthly by	

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the scissors before or after use.

R9's annual MDS dated 8/29/18, indicated R9 had moderate cognitive impairment and diagnoses including urinary retention and a prostate disorder. The MDS indicated R9 required limited assistance of 1 staff to transfer, ambulate and use the toilet. The MDS indicated R9 was frequently incontinent of bladder.

On 11/26/18 5:30 p.m. R9 was observed in the upper level dining area. R9 stood up to leave and his pants were soaked with urine from waist to the knee. R9's incontinent brief was visibly heavy and noticeable through his pants. Urine was observed to cover the vinyl dining chair and was puddled on the floor under chair and table. Activity aide (AA)-A was obtained a mop and supplies for the floor, chair and table. AA-A proceeded to wipe down the table/chair and mop the floor with bare, ungloved hands. When done, AA-A pick up the cleaning supplies and mop with her bare hands and returned the items to the janitor closet where she removed the mop head. AA-A left the janitor closet and re-locked the door. Hand washing or hand sanitizer was not performed.

On 11/26/18, at 5:37 p.m. AA-A returned to the upper level dining area and proceeded to approach R7 to shake hands. When asked, AA-A confirmed she had not washed her hands nor had she used hand sanitizer. AA-A proceeded to wipe down a table, remove soiled dishes and pick up a resident clothing protector and carried it to the bus cart and covered laundry bin. AA-A opened the covered laundry bin lid and placed the clothing protector inside and placed the dirty dishes on the bus cart. AA-A went to the

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kitchenette door, used a key to open the door, went into the kitchenette where she was observed to wash her hands in the sink.

On 11/29/18, at 9:55 a.m. RN-B confirmed hand hygiene would be expected after perineal care, and between removing a dirty dressing and applying a clean dressing. RN-B also confirmed non-sterile scissors should have been cleaned with a sanitizing wipe prior to use. In addition, RN-B stated opened dressing packages should have been kept in a Ziploc bag to prevent soiling of the dressing. RN-B further verified glove usage and hand hygiene should have been used and performed with cleaning of bodily fluids.

On 11/29/18, at 1:30 p.m. the facility administrator/infection control manager (ICM) confirmed staff complete a hand hygiene section in the online inservice yearly. The staff were monitored by hand hygiene spot checks and visual monitoring. The ICM confirmed visually soiled hands would be washed with soap and water and hand sanitizer be used at other times was the expectation for all staff to perform.

The undated facility Hand Hygiene policy, indicated staff would perform hand hygiene using soap and water when visibly dirty or a hand sanitizer when hands were non-visibly dirty.

Infection Control Program

On 11/29/18, at 1:30 p.m. the facility's infection control program was reviewed with the ICM. The infection control program lacked protocols for a facility-wide system to monitor for emerging infectious disease which included (but not limited

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F 880	Continued From page 35 to) an appropriate infection log of signs and symptoms of infections, and surveillance. The log was reviewed with the ICM, who indicated the log was used for antibiotic related infections only. No viral infections were noted to be documented. The ICM confirmed viral infections, diarrhea, or any type of infectious disease not requiring antibiotics should have been included on the log. Also, the ICM stated no resident had required isolation for many months. The ICM stated Infection logs were kept in each nurses station and the nurses entered the appropriate information into a log whenever an infection was identified. The ICM looked at the log weekly. The ICM also stated a group gathered every Thursday morning and reviewed the infections at that time. The infections were mapped out to determine if any physical locations correlated and hospitalizations, lab results and clinic visits were also reviewed. The community and school systems were monitored for emerging disease. The ICM stated there was also a daily stand up meeting where infections were verbally discussed. Nursing would print out progress notes for review, but the infectious symptoms would not be documented in the log. The ICM did provide a copy of her personal notebook which kept a list of the daily stand up information. Upon review of the notebook with the ICM, incidents of elevated temperatures and loose stools were noted which were not on the facility's infection control log. Also, a resident was noted to have an MRSA (methicillin resistant staphylococcus aureus, an antibiotic resistant organism) infection in a wound documented in June but no isolation had been used. The ICM stated the wound had been covered and nursing used isolation precautions during dressing changes, but the	F 880		

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F 880	Continued From page 36 practitioners were working hard to make sure the right choices were made. The facility Infection Control Surveillance policy, undated, indicated the infection control manager (ICM) would conduct surveillance of healthcare acquired infections among patients and employees by nursing reviewing the lab reports, chart review, staff and resident assessment, monitoring exposures, and monitoring the community for emerging disease. The infections would be reported monthly to the infection control committee and reported to the Minnesota health department as required. The facility assessment dated 11/12/2018, indicated infection surveillance is done throughout the facility by monitoring lab, hospital, clinic, home health and community infections as this may effect residents. Departments within the facility would report employee illnesses monthly to the risk management committee. The nursing home administrator/infection control manager (ICM) would review the employee illness reports daily. Resident signs and symptoms of infections would be logged daily and reviewed at the Medicare Risk meeting weekly in cooperation between nursing. Prevention of infection was done by monitoring of hand hygiene, encouragement of influenza vaccination, two-step Tuberculosis skin testing on new employees and new resident admission, and housekeeping procedures. Also, residents would be placed in isolation as ordered by the practitioner when indicated.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F 881		1/31/19

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	245247	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 881	Continued From page 37 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included the development of protocols and a system to monitor antibiotic use. This deficient practice had the potential to affect all 55 residents who resided in the facility. Findings include: On 11/29/18, at 1:30 p.m. the facility's infection control program was reviewed with the Nursing Home Administrator/Infection Control Manager (ICM). The infection control program lacked protocols for a facility-wide system to monitor the use of antibiotics which included (but not limited to) appropriate prescribing of antibiotics, criteria before antibiotic use and periodic review of antibiotic use by physicians. The program also lacked protocols for review of signs and symptoms, labs, determination of appropriate antibiotic use and reporting of any patterns identified. The facility infection control log indicated the following residents received antibiotics in the month of November 2018: -On 11/7/18, R18 was prescribed doxycycline due	F 881	Kittson Memorial will establish an antibiotic stewardship program by developing protocols and a system to review antibiotic use. This will be a facility wide program and will include the Core Elements of Antibiotic Stewardship outlined by the Center for Disease Control (CDC). Protocols, policies, and procedures are being developed to ensure that residents/patients receive appropriate antibiotics, reduce their risk of adverse events and monitor the use of antibiotics for quality outcomes. The Antibiotic Stewardship Committee (ASC) has been organized with the Directors of Nursing of the Hospital and Nursing Home as members, along with the facility Pharmacist, the Infection Control Manager and the Medical Director. The initial meeting of this committee is scheduled for 12/27/2018 The protocols, policies and procedures will be reviewed by this committee and will then be brought to the Medical Staff	

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F 881	Continued From page 38 to "lungs". -On 11/19/18, R51 was prescribed Amoxicillin 500 mg by mouth 3 times a day for 3 days due to a urinary tract infection. The culture resulted in enterococcus faecalis, which is a bacteria that normally grows in the GI tract. -On 11/26/18, R455 was prescribed Bactrim DS for a urinary tract infection. The culture resulted in Klebsiella pneumoniae, which is also a bacteria that normally grows in the GI tract. -On 11/26/18, R32 was prescribed Keflex and ceftriaxone due to a left great toe. No culture was obtained. -On 11/26/18, R39 was prescribed nystatin-Triamcinolone due to a yeast infection on the right inner thigh. No culture was obtained. -On 11/26/18, R16 was prescribed Bactrim DS due to a urinary tract infection. No culture was obtained. -On 11/28/18, R34 was prescribed cephalexin due to a left great toe wound infection. No culture was obtained. On 11/29/18 at 1:45 p.m. the ICM confirmed the facility had not established an antibiotic stewardship program and stated the facility did not have any type of policies or procedures regarding an antibiotic stewardship.	F 881	Meeting on 1/3/2019 and to the Board of Directors at their first meeting following the Medical Staff meeting. Weekly reviews of antibiotic use will be done by the Infection Control Manager and the Pharmacist. These reviews will be brought to the Antibiotic Stewardship Committee on a monthly basis for review and auditing. Audits will be done on the use of antibiotics for the next year. The audits will be reported to the Quality Assurance/Risk Management Committee on a quarterly basis.	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/26/2018

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	K 000		

Or by e-mail to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

The Kittson Memorial Healthcare Center is made up of two buildings. The original building is north of and separated from, with a 2-hour fire barrier, the Kittson Memorial Hospital building. It is 1-story with a basement and was constructed in 1968 that was determined to be of Type II(000) construction and is now fully sprinkler protected and is called the upper level. In 1981 a 1-story addition without a basement was built to the north of the original building that was determined to be of Type V (111) construction.

The facility is fully sprinkler protected in accordance and has a fire alarm system with smoke detection in the corridor system and in all common areas.

The facility has a capacity of 70 beds and had a census of 51 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 271 SS=E	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 keep exits free of obstructions as stated in the Life Safety Code (NFPA 101) 2012 edition sections 19.2.7 & 7.1.10. This deficient practice could restrict the exiting during an emergency and affect 15 of the 70 residents and an undetermined amount of staff and visitors. Findings Include: During the facility tour between 8:00 am to 11:30 am on 11/27/2018 observations revealed snow blocking the exit discharge of the west wing. This deficient condition was confirmed by the Director of Facilities.	K 271	Snow removed from entrance by maintenance staff. Removed at all exits, maintenance staff instructed to keep areas clear of hazards.	11/27/18
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9.	K 321		12/21/18

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K 321	Continued From page 3 When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility to maintain a hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for 15 of the 70 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00am to 11:30am on 11/27/2018 observations revealed the door to	K 321	New door ordered on 12/21/2018. Will install upon arrival.	

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K 321	Continued From page 4 the soiled utility room on the 2nd floor was damaged to a point that it cannot resist the passage of smoke or latch properly. This deficient condition was confirmed by the Director of Facilities.	K 321		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to verify the DACT signal as required by the Life Safety Code,(LSC) 2012 edition, section 9.6.1.3 and NFPA 72, The National Fire Alarm and Signaling Code, 2010 edition, table 14.3.1. This deficient condition could delay alarm notification to emergency personnel in case of a failure and affect all 70 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00am to 11:30am on 11/27/2018 documentation review revealed there was no record of the DACT being tested from the night shift drills during the 2nd, 3rd & 4th quarters of 2018.	K 345	Staff instructed on 11-27-2018 to contact DACT during fire alarm testing so there is proof of acknowledgement that testing was done.	12/26/18

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K 345	Continued From page 5 This deficient condition was confirmed by the Director of Facilities.	K 345		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect an undetermined amount of residents. Findings include:	K 353	Escutcheons replaced on 11-27-2018.	11/27/18

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K 353	Continued From page 6 On the facility tour between 8:00am to 11:30am on 11/27/2018 Observations revealed two escutcheons missing from the sprinkler heads in resident room 126. This deficient condition was confirmed by the Director of Facilities.	K 353		
K 372 SS=E	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 two of three smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 30 of the 70 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 11:30 am	K 372	Fire caulking was completed on 12-21-2018.	12/21/18

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K 372	Continued From page 7 on 11/27/2018 Observations revealed penetrations not properly fire stopped, in the smoke barrier at the following locations. 1. The 2nd floor east wing above the ceiling at the cross corridor doors, a 1 1/2 inch hole & the ends of 3 conduits. 2. The 2nd floor west wing 2 conduits above the ceiling at the nurses station. This deficient condition was confirmed by the Director of Facilities.	K 372		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility did not maintain the heating, ventilation, and air conditioning in accordance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could effect all 70 residents. Findings include: On the facility tour between 8:00am to 11:30am on 11/27/2018 Documentation review revealed the testing of the fire dampers was past due.	K 521	Inspection will be done every 4 weeks in the nursing home. Inspection done on 12/20/2018.	12/20/18

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K 521	Continued From page 8 This deficient condition was confirmed by the Director of Facilities.	K 521		
K 753 SS=E	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to to prohibit the use of flammable decorations, including candles in accordance with NFPA 101 (12) section 19.7.5.6. This deficient practice could affect approximately 20 of the 70 residents. Findings include: On the facility tour between 8:00 am to 11:30 am on 11/27/2018 observations revealed a candle in resident room 111 with an intact wick.	K 753	Candle has been removed and staff advised and educated that candles are not allowed on 12-21-2018. Information will be added to the admission packet that candles are not allowed in the facility.	12/21/18

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K 753	Continued From page 9 This deficient condition was confirmed by the Director of Facilities.	K 753		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect all residents, as well as an undetermined amount of staff, and visitors. Findings include: On the facility tour between 8:00 am to 11:30 am on 11/27/2018 Documentation review revealed there was no risk assessment available for the survey. This deficient condition was confirmed by the Director of Facilities.	K 901	Risk assessment completed on 12/20/2018.	12/20/18
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		12/21/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 10 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to inspect and test the electrical receptacles in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect all 70 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On the facility tour between 8:00 am to 11:30 am on 11/27/2018 documentation review revealed there was no record of any testing of the receptacles in the patient care areas.	K 914	Receptacles tested 12/21/2018. Release no less than 4 oz. Testing will be done annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/27/2018**

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K 914	Continued From page 11 This deficient condition was confirmed by the Director of Facilities.	K 914		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to limit the use of extension cords as stated in NFPA 70 sections 400.8 & 590.3 item D. This deficient practice could affect an undetermined amount of residents.	K 920	Extension cord removed. Social services to add to the information in the admission packet that extension cords are not to be used in the facility. Education provided by maintenance manager to nursing staff and housekeeping staff on 12/21/2018.	12/21/18

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K 920	Continued From page 12 Findings include: On the facility tour between 8:00 am to 11:30 am on 11/27/2018 observations revealed an extension cord in use in place of permanent wiring in resident room 36. This deficient condition was confirmed by the Director of Facilities.	K 920		

Electronically delivered
December 17, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5247031

Dear Administrator:

The above facility was surveyed on November 26, 2018 through November 29, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5247011. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00321	A. BUILDING: _____ B. WING _____	11/29/2018

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> . The State licensing orders are delineated on the attached Minnesota	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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

Electronically Signed | 12/26/18

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 26, 27, 28, & 29th, 2018, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section.	2 302		12/27/18

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2 302	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Alzheimer's/dementia care training for 3 of 7 nursing assistants (NA-H, NA-G, NA-F) who provided direct care services. This had the potential to affect all 55 residents residing in the facility. Findings include: NA-H was hired on 3/21/16. The employee record lacked evidence of having received the required Alzheimer's training. NA-G was hired on 8/3/18. The employee record lacked evidence of having received the required Alzheimer's training. NA-F was hired on 3/12/18. The employee record lacked evidence of having received the required Alzheimer's training. On 11/29/18, at 2:20 p.m. The administrator stated it was her expectation the required Alzheimer's training would be completed within the first two weeks of employment. The administrator confirmed NA-H, NA-G, and NA-F, had not completed the required Alzheimer's training. The facility Training/Education policy revised 5/2018, indicated all staff working with our long term care patients must take Alzheimer's/Dementia training.	2 302	Corrected	

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2 302	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to the required Alzheimer's training program requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days	2 302		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify, comprehensively assess, develop and/or implement appropriate interventions, and adequately monitor skin wounds in order to promote intact skin integrity and healing of an abrasion on the left great toe for 1 of 1 resident	2 830	Corrected	12/27/18

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2 830	Continued From page 5 (R34) who had a history of poor wound healing and 1 of 1 resident (R12) who had scabbed, diffuse abrasions on the hands without the application of skin creams as ordered. This failure resulted in actual harm for R34 whose wound worsened and became infected. In addition, the facility failed to comprehensively assess, monitor and implement interventions for 1 of 1 resident (R52) who had increased edema (swelling) of the legs without the application of compression stockings, as ordered. Findings include: R34's quarterly Minimum Data Set (MDS) dated 10/12/18, identified R34 had severely impaired cognition, and diagnoses which included diabetes mellitus, neuropathy, non-pressure chronic ulcer left calf limited to breakdown of skin, and venous insufficiency (poor circulation). The MDS indicated R34 was totally dependent on staff for all activities of daily living except was able to eat with supervision. R34's annual MDS dated 7/12/18, identified R34 had the same diagnoses with no differences in skills noted. R34's Pressure Ulcer Care Area Assessment (CAA) dated 7/12/18, indicated R34 was at risk for pressure sores due to mobility deficits related to poor circulation, stroke, diabetes with insulin use, chronic kidney disease, bowel and bladder incontinence, and anemia. The CAA indicated R34 had a stasis ulcer to the left shin, but no pressure ulcers. R34's Care Plan dated 2/21/18, indicated R34 had a history of an abrasion to the left great toe due to transfer and staff were instructed to avoid	2 830		

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2 830	Continued From page 6	2 830		

bumping toes, to monitor foot placement with transfers and placing by table. The last documentation indicated the wound was almost healed on 9/19/18. No further documentation was evident and R34 obtained a new abrasion to his toe on 11/21/18.

R34's Care Plan dated 3/28/18, indicated staff were instructed to monitor the abrasion daily during cares and to notify the nurse if noted to be worsening.

R34's Kittson Memorial Healthcare dated 9/6/17, indicated R34 had a personal history of circulatory system, probably venous stasis and combination of arterial for the non healing wound of his left shin. R34's physician indicated the wound was a chronic wound and the physician's goal was to prevent infection to the wound.

R34's Progress Notes/ daily nurses notes dated 11/21/18, indicated the staff had identified a scrape on R34's left great toe, however, no further assessment as to how the scrape had been obtained, the size, depth and/or severity was noted.

On 11/26/18, at 6:32 p.m. R34 was observed at the dining table, seated in a reclining wheelchair in a reclined position with feet slightly elevated. R34's left great toe was open to air and visible through the toe hole of a compression sock. An approximately 1-2 centimeters (cm) dark area was noted on the outer aspect of the toe with a reddened area on the outer portion.

On 11/28/18, at 1:12 p.m. licensed practical nurse (LPN)- D was observed to perform R34's left shin wound care. At this time, LPN-D indicated R34's toe wound was from an abrasion which he

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2 830	Continued From page 7 received during a transfer. LPN-D stated the wound had progressed from a simple scratch/abrasion to a blackened area. LPN-D stated a note had been sent to R34's primary physician regarding the toe wound. At this time, an approximately 1-2 cm blackened colored scab was noted on the side of the left great toe and the entire rest of the toe was reddened. LPN-D confirmed the redness and stated the redness was noted on 11/27/18, however, the facility was not providing any type of treatment to the area, at this time. LPN-D stated R34 had a history of a stroke with left sided weakness and poor circulation in the left side, had a chronic stasis ulcer on his left shin, had mobility impairment and poor circulation. LPN-D applied the Prevalon boot (a pillow-like boot to help prevent pressure ulcers on the heels), elevated the foot on a pillow and exited the room. No assessment of the toe wound was completed. R34's Kittson Memorial Healthcare note (clinic office note) dated 11/28/18, indicated R34 was evaluated for a worsening toe abrasion. The nurse practitioner (NP) described the wound as an abrasion appearing like a skin tear in a circular pattern. The wound had dried crusted areas around the perimeter showing redness, warmth to the touch and swelling. NP diagnosed cellulitis (bacterial skin infection) of the left toe. The plan instructed staff to soak the foot three times a day with hibiclens (antibacterial solution) water and to keep the wound clean and dry. An antibiotic (Keflex) was also prescribed. R34's Resident Inadvertent Incident Report dated 11/28/18, indicated the scrape on R34's left great toe occurred on 11/21/18, during a transfer from chair to bed. Recommendations made were for occupational therapy to evaluate for protection of	2 830		

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2 830	Continued From page 8 R34's toes, to monitor toes/feet closely with transfers and to follow up with the wound specialist during next rounds. On 11/29/18, at 9:30 a.m. registered nurse (RN)-B indicated a wound specialist followed R34 weekly for the stasis ulcer on his shin, but had not been aware of the toe wound until 11/27/18. RN-B stated she was unaware R34 had a wound on his left great toe until 11/27/18, when she was informed R34 had been refusing to wear the Prevalon boots and upon investigation of R34's refusals, RN-B noted the toe wound. RN-B stated R34 had a history of poor circulation and had a chronic stasis ulcer on the left shin. RN-B had directed the staff regarding the importance of immediately reporting skin concerns to either herself or to the charge nurse on duty due to the possibility of R34's wounds not healing. RN-B confirmed there was no documentation regarding the toe wound between 11/21/18, and 11/27/18, and stated R34's toe abrasion was currently an unstageable wound (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. RN-B stated a comprehensive skin assessment should have been completed on 11/21/18, at the time the wound was identified, however, a comprehensive skin assessment had not been completed. - 11/29/18, 12:58 p.m. the director of nursing (DON) stated she was unaware R34 had developed an unstageable wound to the left great toe. The DON confirmed a comprehensive skin assessment should have been completed at the time the toe wound was identified.	2 830		

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2 830	Continued From page 9 R12's quarterly MDS dated 8/30/18, and annual MDS dated 2/28/18, identified R12 had moderately impaired cognition and diagnoses which included Diabetes Mellitus with chronic kidney disease, history of edema, and staphylococcal arthritis of the left shoulder. The MDS indicated R12 required limited assistance with bed mobility and transfers, supervision/set up with walking with a front wheeled walker (FWW) in room/corridor/unit and extensive assistance with dressing, toileting, and personal hygiene. R12's CAA dated 3/7/18, indicated R12 had diagnoses which included dementia, peripheral neuropathy, and Diabetes Mellitus. The CAA further indicated R12 usually made needs known and was usually understood by staff. R12's assessment identified the need for limited to extensive assist with ADLs, and R12's dermatitis (inflammation of the skin) would resolve with the current orders. R12's Care Plan last revised 11/15/18, indicated R12 had a history of cellulitis to the right foot, and scratching the skin until sores formed and then picking at the sores. Staff were instructed to apply Hydrocortisone (steroid cream used to treat inflammation or itching of the skin) cream to itchy areas, apply Hydrophor (a medication used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations) lotion to irritated skin per doctor's orders. The staff were also instructed to report any skin breakdown. R34's Physician Orders dated 3/21/18, indicated Hydrocortisone 2.5% cream was to be applied to itchy areas of R12's skin as needed, Hydrophor lotions were to be applied to open areas twice daily due to itching and nursing to assess skin	2 830		

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2 830	Continued From page 10	2 830		

rash daily. The physician also directed the staff to ensure R12's skin was lotioned well and to ensure R12's fingernails were trimmed and cleaned at least twice daily.

R12's Nursing Progress note dated 10/29/18, identified, "old previous sores from scratching."

On 11/26/18, at 6:26 p.m. scabbed abrasions were noted on the back of R12's left hand. At this time, R12 was observed to reach out with his right hand and scratch the back of the left hand and forefinger. Opened areas were not bleeding and the scabbed areas on the back of the left hand were approximately 1 cm in size. The left pointer finger also had an approximately 1 cm scabbed area and the finger was swollen and reddened. As R12 rubbed the left index finger, he stated his hands were sore and itched. The back of R12's right hand also had an approximately 1 cm scabbed abrasion.

On 11/28/18, at 7:51 a.m. R12 was observed in the dining room. The left hand was noted to be swollen.

-At 8:00 a.m. as R12 rubbed his hands, the left hand was noted to be pink colored and shiny. R12 stated his hands itched.

-At 8:54 a.m. R12 observed to rub and scratch at his left hand.

-At 11:31 a.m. R12 was observed seated at dining table in dining room, rubbing his hands together and scratch at the back of his hands.

-At 12:52 p.m. NA-E offered R12 restorative exercises, however, R12 refused stating his fingers were sore, itched, were swollen and

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2 830	Continued From page 11 needed lotions. NA-E offered the exercises twice, however, R12 continued to refuse. NA-E did not provide/offer R12 any type of lotion for his hands. R34's medical record contained weekly skin checks which indicated: - 9/3/18, random open areas primarily on R12's legs, none draining and without much change from week prior. The skin check lacked location of the open areas along with a description including the size or if there had been drainage. Causal factors were not identified. - 9/10/18, scratches on legs (shins), behind right ear, right shoulder, and on right hand. The skin check lacked the size, color or possible drainage and/or causal factors. - 9/17/18, skin was "about the same" as the week prior skin assessment with scratches on legs (shins), behind right ear, right shoulder, and on the right hand healing. R12 continued to have other areas that needed lotion because they were dry and itchy. No measurements or descriptions were documented. - 9/24/18, scratches on R12's body were "the same, most healing normally, with a new scratch on upper left thigh." No measurements or descriptions were documented. - 10/1/18, scabs and scars where R12 scratched skin. No new areas were noted. No measurements or descriptions documented. - 11/6/18, "self inflicted" scratch marks to both lower extremities and stomach. Random discolorations to different parts of body. No measurements were documented.	2 830		

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2 830	Continued From page 12 - 11/12/18, old discolorations and bruising to both upper/lower extremities from scratching. Also had open area to the left hand "where he has scratched it open." No measurement were documented. - 11/27/18, indicated random scratches, especially on R12's hands, ointment was applied. No measurements were documented. A Nursing Progress Note dated 11/28/18, at 8:33 p.m. indicated R12 utilized Hydrocortisone cream as needed for itching. No further documentation or measurement of sores noted. R12's Medications Administration Record (MAR) dated 11/1/18 - 11/29/18, indicated Hydrocortisone cream had been applied four times in November 2018. On 11/29/18, 10:10 a.m. RN-B indicated R12 had a history of scratching himself and picking at his scratches or scabs. RN-B stated she was aware R12 had scratches and open areas on the left hand and that the nursing staff were to measure and document any concerns regarding his skin during the weekly skin checks. RN-B stated R12 also had a history of scratching his skin until he had developed cellulitis which required antibiotic therapy due to his picking behaviors. RN-B stated R12 had creams to be used as needed to help relieve any irritated skin concerns/itchy spots. RN-B reviewed R12's MAR and confirmed R12 had only utilized the Hydrocortisone cream four times in November 2018. RN-B stated she was not aware the creams had not been utilized when needed and that a comprehensive skin assessment had not been completed.	2 830		

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2 830	Continued From page 13 -At 10:39 AM, RN-B and RN-C were observed to measure R12's open areas on his hands. The left pointer finger was open and bleeding while RN-C applied a Band-Aid for pressure. RN-C stated R34 had scratched open the right pointer finger wound that morning which required cleaning and a new dressing applied. R12 was noted to have the following wounds: - Left hand wound closest to the wrist had a pink open flesh wound which measured 0.5 x 0.7 cm. - Left hand wound closer to fingers had a pink open flesh wound which measured 1.1 x 0.3 cm. - Left index finger wound was open and actively bleeding and measured 0.3 x 0.3 cm. - Right hand pointer finger had a dry black scab/wound which measured 0.7 x 0.3 cm. - Right hand ring finger dry black scab wound measured 0.8 x 0.2 cm. -At 10:45 a.m. RN-C stated R12 continually picked at the wounds. R12 stated, "They itch all the time." RN-B stated she was not aware R12 had wounds on the right hand and confirmed R12's wounds had gotten worse. RN-B also confirmed the staff had not been documenting the location, size, color or causal factors of the wounds. RN-B stated she would expect the staff to inform her of any additional wounds and complete a comprehensive skin assessment at the time new wounds were identified. - At 12:40 p.m. the DON stated she was not aware R12 had developed new open areas on his hands. The DON stated she was aware R12 had a history of picking at his skin, however, she would expect the nursing staff to complete a comprehensive skin assessment, follow the facility policies and procedures related to wounds, and provide continuous wound care, as needed.	2 830		

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2 830	Continued From page 14 A facility Skin Breakdown Prevention Protocol, undated, identified a system was in place for the prevention, identification, treatment and documentation of non-pressure wounds. The protocol stated nursing would do a weekly skin check for residents at least weekly, on the residents' bath day, and document any problems noted. The notes were to include a clear description of the ulcer and surrounding skin, a description of any drainage, what the treatment was with effectiveness, and verification the practitioner was notified of the status R52's admission MDS dated 11/8/18, indicated R52 was cognitively intact and required limited assistance of one staff for dressing. R52's Occupational Therapy Treatment Encounter note dated 11/9/18, indicated edema bilaterally in lower extremities. Size medium Tensoshape was provided and nursing was notified on communication log, to apply in AM remove at bedtime. R52's physician order report dated 10/29/18 - 1/31/19, indicated R52 had diagnoses which included chronic kidney disease stage 4 (severe) and acute pulmonary edema. Orders included compression stockings to bilateral lower extremities to be on during the day with a start date of 11/9/18. R52's care plan dated 11/21/18, directed staff to monitor weight daily and notify medical doctor (MD) and family of significant weight change. The care plan also directed staff to evaluate, record and report swelling of the ankles and feet. The care plan did not address use of Tensoshape	2 830		

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2 830	Continued From page 15 stockings (compression stockings). R52's resident care sheet provided on 11/26/18, directed staff to apply Tensoshape stockings to lower extremities (on in AM, off at bedtime). On 11/28/18, at 7:13 a.m. NA-A was observed to provide R52 morning cares which included dressing. Gripper socks were applied and not the Tensoshape stockings, as directed. On 11/28/18, during observations from 8:02 p.m. until 12:53 p.m. licensed practical nurse (LPN)-B, LPN-A, and an unidentified occupational therapist had entered R52's room and interacted with R52. During the observation, none of the staff assessed R52 for edema in lower legs or applied the Tensoshape stockings. -At 12:55 p.m. surveyor requested LPN-A to assess R52's edema in the lower extremities. LPN-A assessed the edema and stated the left extremity edema measured 2+ (2 seconds to rebound when finger pressed into skin) and the right lower extremity measured 3+ (3 seconds to rebound) edema. LPN-A stated R54 should have the Tensoshape stocking applied every morning by the NA. LPN-A proceeded to apply the stockings and reminded R52 to keep feet elevated as much as possible. -At 1:05 p.m. RN-A stated R52 should be wearing compression stockings daily and the NA's were responsible to apply them with morning cares. RN-A also stated R52 was to be weighed every morning, however, confirmed there were no parameters for when the MD should be notified of weight changes. -At 1:12 p.m. NA-A stated she was not sure if R52 was to wear compression stockings or if therapy applied leg wraps. NA-A acknowledged she had	2 830		

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2 830	Continued From page 16 not applied compression stockings to R52 that morning with cares. On 11/29/18, at 8:07 a.m. the DON stated R52 was to have compression stockings applied each morning by the NA's and confirmed they did not have orders or specific instructions for when to notify the MD regarding any weight changes. The DON stated she would expect the nurse's to use their critical thinking skills as to when to notify the MD. Fallibility policy Weight and Height Measurement (undated), indicated to notify the charge nurse or physician of all weight changes of 5 pounds (or 5%) or more in a 30-day period or ten percent in a 180 day period or per state requirement. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for edema and skin issues to assure they are receiving the necessary treatment/services to prevent/minimize resident discomfort. The DON or designee could educate all appropriate staff on skin management and edema concerns. The director of nursing (DON) or designee develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing	21375		12/27/18

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21375	Continued From page 17 home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide proper hand hygiene when providing personal cares to 3 of 5 residents (R52, R34, R9) observed when receiving personal cares and for 1 of 1 resident (R34) when providing wound care. In addition, the facility failed to provide appropriate infection control practice for 1 of 1 resident (R52) during provision of oxygen treatment. Lastly, the facility failed to develop an infection control program which included the development of protocols and a system to monitor emerging infectious disease. This deficient practice had the potential to affect all 55 residents who resided in the facility. Findings include: R52's admission Minimum Data Set (MDS) dated 11/8/18, indicated R52 had intact cognition, required limited assistance of one staff to toilet and was occasionally incontinent of urine and always incontinent of bowel. R52 also required the use of oxygen therapy. R52's care plan dated 11/21/18, indicated occasional urge urinary incontinence and total loss bowel incontinence requiring staff to provide incontinence care after each incontinent episode. On 11/28/18, at 7:13 a.m. nursing assistant (NA)-A was observed assisting R52 to use the toilet. NA-A pulled down R52's pants and assisted to sit on the toilet. Without applying gloves, NA-A removed a urine and stool soiled	21375	Corrected	

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incontinence pad from R52's underclothing and placed it in a waste basket. NA-A applied clean slacks to R52's lower extremities while R52 remained seated on toilet. NA-A gave R52 a wet washcloth, which R52 used to cleanse face and upper body. NA-A assisted to wash R52's back and applied lotion. R52 was given privacy in the bathroom while NA-A went into R52's room, removed the oxygen tubing from the top of the bed and made R52's bed. NA-A re-entered the bathroom, applied a glove to her right hand, used a disposable wipe to cleanse R52's peri and rectal area removing a moderate amount of stool. NA-A removed the glove and applied a clean incontinent pad and pulled up R52's slacks and assisted R52 to a wheelchair. NA-A unlocked the brakes on the wheelchair, pushed the chair into main room and opened the blinds while touching the back of the recliner. NA-A re-entered the bathroom and bagged up the soiled incontinence product. After bagging the soiled items, NA-A washed her hands at the sink.

On 11/28/18 at 7:52 a.m. NA-A stated R52's incontinent pad was slightly damp with urine but had a lot of stool on it. NA-A confirmed she did not wash her hands until she had completed all cares for R52 and stated she should have washed her hands immediately after perineal cares were completed.

On 11/28/18, at 7:58 a.m. R52's oxygen nasal cannula was observed lying on the floor next to the chair. Licensed practical nurse (LPN)-B entered the room to ask R52 if she wanted to go to the dining room for breakfast. LPN-B did not pick the oxygen cannula up from floor.
-At 8:31 a.m. LPN-B entered R52's room and asked R52 if she wanted the oxygen on. LPN-B proceeded to pick up the oxygen tubing from the

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floor and place it into R52's nares. Following the observation, LPN-B confirmed the tubing had been on the floor and was placed in resident's nares.

R34's quarterly MDS dated 10/12/2018, identified R34 had severely impaired cognition, and diagnoses including diabetes, neuropathy, anemia, history of cellulitis (bacterial skin infection) of the right lower leg (resolved 9/27/16), non-pressure chronic ulcer left calf, limited to breakdown of skin, venous insufficiency (poor circulation). The MDS indicated R34 was totally dependent on staff for all activities of daily living, except was able to eat with supervision. The MDS indicated R34 was always incontinent of bowel and bladder.

On 11/28/18, at 7:10 a.m. NA-E was observed providing R34 a bed bath. NA-E had applied clean gloves at the beginning of the procedure. NA-E applied barrier cream to R34's groin, removed the gloves and with bare hands, removed R34's incontinent brief which was wet with urine and feces. Without washing her hands, NA-E applied clean gloves and cleansed R34's bottom which had feces, with a pre-moistened cloth, applied barrier cream to R34's buttocks and bottom, and removed the gloves. Without washing her hands, NA-E donned clean gloves and proceeded to apply a clean brief to R34, remove the gloves, and without washing her hands, proceeded to sort the room touching the full body mechanical lift in addition to other multiple areas of the room. NA-E covered R34 with blankets and raised the head of his bed then went into the bathroom and washed her hands. When asked if if she had washed her hands or used hand sanitizer during R34's perineal cares, NA-E confirmed she had not performed hand

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21375	Continued From page 20 hygiene after removing the gloves following the perineal cleansing. On 11/28/18, at 1:12 p.m. licensed practical nurse (LPN)-D entered R34's room with R34's wound dressing basket and placed the basket directly on top of R34's bed side table. Inside the basket was an opened package with a medicated foam dressing clearly visible, new and unopened packages of medicated foam dressing and a cup which contained a non-sterile scissor, pen and a paper measuring device. LPN-D removed the soiled dressing from R34's left shin stasis ulcer. The dressing was observed to be mostly covered with a yellowish-brown colored drainage. LPN-D cleansed the wound with a pre-wet sterile saline wipe. LPN-D removed her gloves and without performing hand hygiene, applied clean gloves. Skin prep was applied to the skin surrounding the wound and allowed to dry. The previously opened package of medicated foam dressing was taken from R34's dressing basket and a small amount was cut with the non-sterile scissor. LPN-D did not clean the scissor prior to use. The medicated foam dressing was applied to the wound and covered with an adhesive foam dressing. LPN-D removed the gloves and the soiled wound dressing/trash. Without performing hand hygiene, LPN-D proceeded to apply R34's Prevalon (a pillow-like boot that assists in the prevention of heel ulcers) and elevated his foot on a pillow, raised R34's head of the bed, lowered the bed to the lowest position, and used hand sanitizer, but did not clean the scissors or R34's dressing basket which was placed on top of R34's bed stand. LPN-D returned R34's dressing basket to the medication room, where it was stored. On 11/28/18, at 1:24 p.m. LPN-D confirmed she	21375		

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did not perform hand hygiene after removing the soiled gloves and prior to putting on clean gloves. In addition, LPN-D confirmed she did not clean the scissors before or after use.

R9's annual MDS dated 8/29/18, indicated R9 had moderate cognitive impairment and diagnoses including urinary retention and a prostate disorder. The MDS indicated R9 required limited assistance of 1 staff to transfer, ambulate and use the toilet. The MDS indicated R9 was frequently incontinent of bladder.

On 11/26/18 5:30 p.m. R9 was observed in the upper level dining area. R9 stood up to leave and his pants were soaked with urine from waist to the knee. R9's incontinent brief was visibly heavy and noticeable through his pants. Urine was observed to cover the vinyl dining chair and was puddled on the floor under chair and table. Activity aide (AA)-A was obtained a mop and supplies for the floor, chair and table. AA-A proceeded to wipe down the table/chair and mop the floor with bare, ungloved hands. When done, AA-A pick up the cleaning supplies and mop with her bare hands and returned the items to the janitor closet where she removed the mop head. AA-A left the janitor closet and relocked the door. Hand washing or hand sanitizer was not performed.

On 11/26/18, at 5:37 p.m. AA-A returned to the upper level dining area and proceeded to approach R7 to shake hands. When asked, AA-A confirmed she had not washed her hands nor had she used hand sanitizer. AA-A proceeded to wipe down a table, remove soiled dishes and pick up a resident clothing protector and carried it to the bus cart and covered laundry bin. AA-A opened the covered laundry bin lid and placed the

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clothing protector inside and placed the dirty dishes on the bus cart. AA-A went to the kitchenette door, used a key to open the door, went into the kitchenette where she was observed to wash her hands in the sink.

On 11/29/18, at 9:55 a.m. RN-B confirmed hand hygiene would be expected after perineal care, and between removing a dirty dressing and applying a clean dressing. RN-B also confirmed non-sterile scissors should have been cleaned with a sanitizing wipe prior to use. In addition, RN-B stated opened dressing packages should have been kept in a Ziploc bag to prevent soiling of the dressing. RN-B further verified glove usage and hand hygiene should have been used and performed with cleaning of bodily fluids.

On 11/29/18, at 1:30 p.m. the facility administrator/infection control manager (ICM) confirmed staff complete a hand hygiene section in the online in-service yearly. The staff were monitored by hand hygiene spot checks and visual monitoring. The ICM confirmed visually soiled hands would be washed with soap and water and hand sanitizer be used at other times was the expectation for all staff to perform.

The undated facility Hand Hygiene policy, indicated staff would perform hand hygiene using soap and water when visibly dirty or a hand sanitizer when hands were non-visibly dirty.

Infection Control Program

On 11/29/18, at 1:30 p.m. the facility's infection control program was reviewed with the ICM. The infection control program lacked protocols for a facility-wide system to monitor for emerging

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infectious disease which included (but not limited to) an appropriate infection log of signs and symptoms of infections, and surveillance.

The log was reviewed with the ICM, who indicated the log was used for antibiotic related infections only. No viral infections were noted to be documented. The ICM confirmed viral infections, diarrhea, or any type of infectious disease not requiring antibiotics should have been included on the log. Also, the ICM stated no resident had required isolation for many months. The ICM stated Infection logs were kept in each nurse's station and the nurses entered the appropriate information into a log whenever an infection was identified. The ICM looked at the log weekly. The ICM also stated a group gathered every Thursday morning and reviewed the infections at that time. The infections were mapped out to determine if any physical locations correlated and hospitalizations, lab results and clinic visits were also reviewed. The community and school systems were monitored for emerging disease. The ICM stated there was also a daily stand up meeting where infections were verbally discussed. Nursing would print out progress notes for review, but the infectious symptoms would not be documented in the log. The ICM did provide a copy of her personal notebook which kept a list of the daily stand up information. Upon review of the notebook with the ICM, incidents of elevated temperatures and loose stools were noted which were not on the facility's infection control log. Also, a resident was noted to have an MRSA (methicillin resistant staphylococcus aureus, an antibiotic resistant organism) infection in a wound documented in June but no isolation had been used. The ICM stated the wound had been covered and nursing used isolation precautions during dressing changes, but the

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practitioners were working hard to make sure the right choices were made.

The facility Infection Control Surveillance policy, undated, indicated the infection control manager (ICM) would conduct surveillance of healthcare acquired infections among patients and employees by nursing reviewing the lab reports, chart review, staff and resident assessment, monitoring exposures, and monitoring the community for emerging disease. The infections would be reported monthly to the infection control committee and reported to the Minnesota health department as required.

The facility assessment dated 11/12/2018, indicated infection surveillance is done throughout the facility by monitoring lab, hospital, clinic, home health and community infections as this may effect residents. Departments within the facility would report employee illnesses monthly to the risk management committee. The nursing home administrator/infection control manager (ICM) would review the employee illness reports daily. Resident signs and symptoms of infections would be logged daily and reviewed at the Medicare Risk meeting weekly in cooperation between nursing. Prevention of infection was done by monitoring of hand hygiene, encouragement of influenza vaccination, two-step Tuberculosis skin testing on new employees and new resident admission, and housekeeping procedures. Also, residents would be placed in isolation as ordered by the practitioner when indicated.

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures for infection

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21375	Continued From page 25 control monitoring, hand hygiene and oxygen equipment. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21375		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by:	21540		12/27/18

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21540	Continued From page 26 Based on observation, interview and document review, the facility failed to identify target behaviors for the use of anti-anxiety medication for 2 of 5 residents (R8, R3) reviewed for unnecessary medications. Findings include: R8's annual Minimum Data Set (MDS) dated 8/29/18, indicated R8 was cognitively intact and had diagnoses which included anxiety disorder and depression. The MDS indicated R8 experienced mood symptoms which included feeling down, depressed or hopeless one day of the assessment period and feeling tired or having little energy 2-6 days of the assessment period. The MDS also indicated R8 exhibited no psychosis, behavioral symptoms, and rejection of care or wandering. The MDS further indicated R8 received anti-anxiety medication daily. R8's Mood State Care Area Assessment (CAA) dated 9/5/18, indicated staff documented R8 had been more emotional, had increased anxiety and had indicated she felt she was having a mental breakdown as she couldn't find her sister's phone number. R8's Psychotropic Medication Use CAA dated 9/5/18, indicated R8 took Klonopin (clonazepam) for anxiety, mirtazapine and Celexa for depression and appetite stimulation and experienced no adverse effects from the medication. R8 had unsteady balance and weakness but was showing no signs or symptoms of gaining strength. R8 needed much encouragement and cueing daily to keep doing as much for herself as possible. Staff stressed the positives in her life, redirected and reassured her and encouraged family time. No reduction in	21540	Corrected	

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21540	Continued From page 27 dose of medications planned currently but physician was watching closely and would reduce when appropriate. R8's Physician Order Report dated 10/29/2018 - 01/31/2019, included an order for clonazepam 0.5 milligrams (mg) at bedtime. The order start date was 11/13/18. R8's Medication Administration History forms dated 9/1/18-9/30/18, 10/1/18-10/31/18 and 11/1/18-11/30/18, indicated R8 received clonazepam 0.5 mg twice daily until 11/13/18, after which she received the medication once daily. R8's Care Plan dated 9/17/18, indicated R8 had diagnoses of depression and anxiety and directed staff to administer clonazepam per provider orders and monitor for side effects such as: dizziness, headache, fatigue and upset stomach. Social service to visit monthly and 1:1 as needed. Assess, monitor, and document mood and response to medications. Encourage activities of choice and calls and visits with family. Stress positives in her life. Consult clergy as needed. Be reassuring and listen to concerns. The care plan also indicated R8 had behavioral symptoms exhibited as seen in anxiety episodes, especially with any change in R8's routine. The care plan directed staff to redirect resident as needed, convey acceptance during periods of anxiety, use calm matter of fact approach, explain all cares prior to doing, go slowly with cares, keep daily routine the same as much as able, keep environment calm and relaxed. However, the care plan lacked identification of the target behaviors of R8's anxiety episodes. R8's Physician Progress Note dated 7/12/18,	21540		

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21540	Continued From page 28 indicated R8 had obsessive-compulsive disorder and depression with anxiety. Staff noted she had increased obsessions in regard to different things, such as pain in her shoulders and toe. She did not mention the latter today though she does have shoulder pain. The plan indicated R8 had depression with anxiety and obsessed quite a bit about various things and going home. We will try to increase sertraline (antidepressant) from 100 to 150 mg daily and see how she does with this. R8's Nurse Practitioner Progress Note dated 9/12/18, indicated R8's care plan and medications were reviewed. No changes at this time, as she still was exhibiting some degree of anxiety, but overall, she was stable. On 11/28/18, at 12:17 p.m. R8 was observed seated in a wheelchair, at a table in the dining room while waiting for the noon meal. R8 was alert, sitting quietly and not conversing with table mates at this time. On 11/29/18, at 1:21 p.m. R8 was observed seated in a wheelchair in her room. R8 verified she had some pain in a toe and her shoulders and received treatment/medications which were effective in treating the pain. R8 denied any anxiety or depression. R8 was alert, pleasant, engaged and made eye contact during the interview. On 11/29/18, at 3:40 p.m. registered nurse (RN)-D indicated every shift, the staff had been documenting on a progress note indicating symptoms of crying, refusing to come out of room, appetite change, sleeping too much or insomnia but had discontinued doing so on 9/14/18. RN-D verified they did not have target behaviors identified for R8's anxiety at this time.	21540		

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21540	Continued From page 29 On 11/29/18, at 3:51 p.m. the director of nursing (DON) stated target behaviors should have been identified and monitored as required. R3's admission MDS dated 8/13/18, indicated R3 had intact cognition, did not have any behaviors and had diagnoses of anxiety disorder and depression. The MDS also indicated R3 received anti-anxiety, antidepressant and hypnotic medications on a daily basis. The MDS indicated R3 experienced mood symptoms which included feeling down, depressed or hopeless one day of the assessment period and feeling tired or having little energy 2-6 days of the assessment period. R3' Care Area Assessment did not trigger any mood, behavioral, or psychotropic medication use areas. R3's care plan dated 11/26/18, indicated that R3 was at risk for adverse consequences related to anti-anxiety and antidepressant medications. The care plan directed staff to administer medications as ordered and monitor for side effects which included depressed mood and other changes in mood or emotion. The care plan lacked individualized target behaviors to be monitored. A Behavior Category Report indicated R3 displayed no physical, verbal or other behavior directed towards others, rejection of care, or wandering since admission. No specific individualized target behaviors related to anxiety were being monitored by the facility. R3's current physician orders included alprazolam 0.25 milligrams (mg) twice per day for anxiety (began 10/10/18). Prior to this order R3 was receiving alprazolam 0.25 mg one time daily as needed (PRN) for anxiety.	21540		

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21540	Continued From page 30 R3's Progress Notes where reviewed for monitoring of anxiety and included the following: - On 8/7/18, at 6:16 p.m. resident's son approached nurse's station stating his mother was having an "anxiety spell." - On 8/8/18, at 10:20 p.m. resident requested alprazolam to be given this evening for anxiety. - On 8/9/18, at 11:42 a.m. order per physician alprazolam 0.25 mg three times daily. - On 8/12/18, at 3:17 p.m. was feeling a little anxious this afternoon before scheduled alprazolam. - On 10/10/18, at 11:02 a.m. physician order to change current alprazolam 0.25 mg scheduled three times daily to 0.25 mg twice daily for anxiety and 0.25 mg once daily PRN for anxiety. - On 10/26/18, physician order to discontinue PRN alprazolam On 11/26/18, at 5:15 p.m. R3 was observed in the dining room eating the meal and visiting with table mates. R3 displayed no signs of anxiety. On 11/28/18, at 12:07 p.m. R3 was observed in the dining room eating lunch and visiting with table mates. No signs of anxiety were noted. On 11/29/18, at 4:11 p.m. RN-D stated they used to do specific behavioral monitoring for residents up until 8/9/18, when it was discontinued. RN-D stated R3 had not been experiencing anxiety since the alprazolam was scheduled on 10/10/18. RN-D stated she would expect nursing staff to document when there was any episode of anxiety - At 4:17 p.m. director of nursing stated she could not speak specifically to R3 but all target behaviors should be identified, monitored and documented in progress notes.	21540		

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21540	Continued From page 31 The undated Psychotropic Medication Usage policy indicated psychotropic medications would not be used unless behavioral programming and/or environmental changes have failed to sufficiently modify a resident's behavioral disturbances (i.e. target behaviors). Residents would not receive psychotropic medications unless such medication is needed to treat a specific condition and each psychotropic medication would be given to treat clearly defined target behaviors. Consistent monitoring of all target behaviors would be done to assist in the assessment of the risk/benefit relationship of psychotropic drug therapy. The undated Psychotropic Medication side Effect Monitoring policy and procedure indicated psychotropic medications would not be used unless behavioral programming and/or environmental changes have failed to sufficiently modify a resident's behavioral disturbances (i.e. target behaviors). Consistent monitoring of all target behaviors would be done to assist in the assessment of the risk/benefit relationship of psychotropic drug therapy. For each psychotropic medication administered there would be at least one objective and measurable target behavior identified. This target behavior would be monitored daily. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures to ensure proper monitoring is conducted to determine medication efficacy. The DON or designee, along with the pharmacist, could audit medication reviews on a	21540		

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21540	Continued From page 32 regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the medical chart to ensure resident wishes would be implemented correctly in an emergent situation for 1 of 1 resident (R52) reviewed for advanced directives. Findings include: R52's admission Minimum Data Set (MDS) dated 11/8/18, identified R52 was cognitively intact.	21840	Corrected	12/27/18

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21840	Continued From page 33 R52's general order form provided on 11/27/18, revealed a physician's order which indicated "wishes cardiopulmonary resuscitation (CPR)" dated 11/2/18. R52's CPR statement of decision signed and dated on 11/2/18, indicated R52 had wished for CPR to be initiated. The lower level west report sheet and resident care sheets provided on 11/26/18, indicated R52 was a full code (provide CPR). On 11/27/18, at 4:01 p.m. R52 stated upon admission, she had signed a form which indicated CPR was to be preformed in the event of an emergency. -At 4:02 p.m. nursing assistant (NA)-A indicated if she were to find a resident who was not breathing and did not have a pulse, she would call for a nurse immediately. -At 4:02 p.m. licensed practical nurse (LPN)-C stated she would check the report sheet and the chart to determine the code status for a resident. -At 4:03 p.m. LPN-A verified the electronic chart indicated R52 was DNR (do not resuscitate) and the outside of the hard copy chart indicated she was a Full Code. LPN-A verified the lower level west report sheet and the resident care sheets both indicated R52 was Full Code. The chart was reviewed and the CPR statement of decision indicated wishes for CPR. -At 4:04 p.m. registered nurse (RN)-A stated she thought R52 had changed her status and they were awaiting the signed form from the physician although the form could not be located by RN-A. -At 4:15 p.m. director of nursing (DON) stated she also thought R52's code status had been changed to DNR although could not verify this by	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00321	A. BUILDING: _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21840	Continued From page 34 documentation. DON stated she would expect that the electronic chart, hard copy chart, CPR statement of decision, and the physician orders would match. Review of Advance Directive policy and procedure dated 7/2017, indicated the facility would provide basic life support including CPR when a resident required such emergency care and prior to the arrival of emergency medical services but was subject to physician order and resident choice indicated in the resident's advance directive. Nurses and other care staff are educated to initiate CPR, unless a valid DNR order was in place. All advance directive documents and code status sheets are located in the front of the chart. Resident wishes would be communicated to staff via the care plan and to the resident physician. SUGGESTED METHODS OF CORRECTION: The DON or designee could develop, review, and /or revise policies and procedures for advanced directives and provide education to the staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21840		