Electronically delivered
April 6, 2020

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

RE: CCN: 245247
Cycle Start Date: March 10, 2020

Dear Administrator:

During this period of pandemic COVID-19 outbreak, the Centers for Medicare and Medicaid Services (CMS) has directed the State Agencies (MDH) to change the process for survey prioritization and enforcement remedies. CMS is delaying revisit surveys and are exercising enforcement discretion during this prioritization period, beginning March 23, 2020. As a result, the below enforcement actions resulting from this survey cycle will be suspended until revisits are again authorized.

This letter also requests that your facility submit an electronic plan of correction (ePOC). Although revisit surveys will not be conducted during the prioritization period, you may still submit your facility's ePOC during this time and the case will be held. Your facility may delay submission of an ePOC until the prioritization period is over.

On March 10, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On February 20, 202, the situation of immediate jeopardy to potential health and safety cited at F686 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office

forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Kittson Memorial Healthcare Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effectiveMarch 10, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" 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

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

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	245247	A. BUILDING _____ B. WING _____	C 03/10/2020

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F 000	INITIAL COMMENTS On 3/5/20 - 3/10/20, an abbreviated standard survey was completed by surveyors of this Department's staff to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Complaint HH5247016C was substantiated at F686 and F600 at past non-compliance. Although the provider had implemented corrective action prior to survey, harm and immediate jeopardy was sustained prior to the correction. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		

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

Electronically Signed

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F 600	Continued From page 1 Based on interview and document review, the facility failed to implement physician orders related to the monitoring of identified skin concerns in order to prevent the development and/or the worsening of a pressure ulcer for 1 of 1 resident (R1) reviewed for pressure ulcers. This failure resulted in actual harm to R1 when the facility failed to conduct daily skin assessments as ordered resulting in the development of a stage 4 pressure ulcer. Although noncompliance was present at the time of the event, the facility implemented appropriate corrective action prior to the survey resulting in a finding of past-noncompliance for R1. Findings include: A Nursing Home Incident Report (NHIR) submitted 2/25/20, indicated R1 had sustained a fracture of the left fibula and tibia on 1/19/20, which was evaluated in the emergency department (ED). Treatment consisted of placement of a splint to the left lower leg. R1 had returned to the facility with a hospital verbal order to not remove the splint. On 1/27/20, R1 was seen by the physician, and an X-ray identified no change to fracture therefore, order were given to continue with the splint. On 1/30/20, the staff notified the physician assistant (PA) regarding swelling to R1's left foot. The PA removed the splint and Ace wrap (elastic wrap) and examined R1's foot and leg. A reddened area was noted behind R1's left leg. The PA added additional padding to the back of R1's knee, and no further orders were received. On 2/5/20, the Ace wrap was removed, and a clean Ace wrap was applied. On 2/19/20, an X-ray indicated the fracture was healing. During physician rounds on 2/20/20, the Ace wrap and splint were removed and a Stage 4	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

(full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer was discovered, and no impact on R1's quality of life was noted. Care plan and orders were followed. The facilty's 5 day investigation form indicted the splint was discontinued and a boot was applied. Nursing order put into place were to check placement of the boot and skin condition every shift.

R1's PA visit summary dated 1/30/20, indicated R1 exhibited severe puffiness with a fluid filled appearance at the top of the left foot from the toes to mid-foot, where the splint edge was. The edge of the splint was very tight on the foot and ankle bone. Ace wraps were removed times two, and the splint was released at the top of left leg and stretched back to loosen. Within two minutes, the swelling at the top of the foot started to decrease, and after five minutes there was minor puffiness noted. Pedal pulse (pulse noted on the top of the foot) was palpable, and the foot was warm and dry with good capillary refill. No open areas were noted. A one millimeter (mm) pink area was noted on the top of the left foot, medial side, without any sloughing of skin, and no raised area or indentation areas. A similar sized area was also noted on the posterior lower leg, lateral area at the bend of the knee. Cast padding was applied to the top of the foot and left lateral ankle. The splint was laid back over the leg and loosely wrapped with two Ace wraps to just below the knee, but not under where knee bends. The visit summary plan directed the nurses to check under R1's splint daily for skin exam, and then to rewrap. The swelling on the top of the left foot had gone down, and the physician had an order for a follow up X-ray for the tibia/fibula fracture to be followed up on, as directed. R1 was to return

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F 600	Continued From page 3	F 600		

for a visit in one week, or if symptoms worsened or failed to improve.

R1's Physician Visit dated 2/20/20, indicated R1's splint was removed, and revealed a Stage 4 pressure ulcer with necrosis (death of cells or tissue) of muscle to left popliteal fossa (space behind the left knee). Dressing changes were implemented, and staff was to ensure R1 was seen by wound care staff. The splint was not to be reapplied, and a midcalf cushion boot was ordered to be worn for the left tibia/fibula fracture.

R1's quarterly Minimum Data Set (MDS) dated 1/2/20, indicated R1 had severe cognitive impairment and diagnoses which included dementia, rheumatoid arthritis, osteoarthritis, and was under weight. R1 required total assistance of two staff for transfers, was unable to walk, and was at risk for pressure ulcers.

R1's care plan dated 1/21/20, indicated R1 was at risk for developing pressure ulcers related to incontinence, immobility, and contractures to lower extremities. The care plan identified a superficial area on buttocks related to shearing, no other skin breakdown areas were identified. The care plan was revised on 2/20/20, identifying a pressure ulcer behind the left knee, and red area on top of left foot, with bi-weekly dressing change directives, and assessment of skin under boot every shift. However, the care plan lacked the directive related to the 1/30/20, PA order for the removal of the splint, and daily skin checks to be conducted under splint.

R1's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 1/30/20-2/20/20, lacked documentation reflecting

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F 600	Continued From page 4 implementation and daily removal of R1's splint and skin checks. R1's Progress Notes reviewed from 1/30/20, through 2/20/20, lacked documentation reflecting daily skin monitoring had been conducted, as ordered. On 3/5/20, at 1:45 p.m. licensed practical nurse (LPN)-B confirmed R1's splint had not been removed, and skin assessments had not been completed prior to the identification of R1's pressure ulcer, because there were no orders to do so. -At 2:40 p.m. LPN-C stated following R1's fracture, she had been told the physician or NP would be following up on R1, and she was not to remove the splint. LPN-C stated R1's skin under the splint and behind the knee were not visible to assess without removing the splint. LPN-C stated removal of the splint and skin checks had not been implemented until after the physician had discovered the Stage 4 pressure ulcer. -At 3:12 p.m. during a telephone interview, PA-A confirmed she had visited R1 on 1/30/20, at which time the nursing staff had requested an evaluation of R1's left foot due to swelling. PA-A stated she had removed R1's splint, and noted two reddened areas on left lateral foot and behind the left knee which were approximately 1.0 mm in diameter, and were not open. PA-A stated she had written orders for the nurse to remove and check under R1's splint daily and to conduct a skin assessment, and then rewrap it. PA-A stated it was her expectation for nursing to implement the orders as written, as the ongoing monitoring of R1's skin would have identified the	F 600		

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F 600	Continued From page 5 change in R1's skin condition thereby preventing R1's development of the Stage 4 pressure ulcer. -At 4:32 p.m. the director of nursing (DON) confirmed the physician identified R1 had developed a Stage 4 pressure ulcer on 2/20/20. The DON stated she reviewed R1's physician and PA visits and orders from the date of R1's fall resulting in fractures on 1/19/20, and on 2/20/20, she had discovered the order from the PA directing nursing staff to remove the splint and check R1's skin daily. The DON stated she discussed the order with the registered nurse (RN) unit coordinator, who confirmed she had not reviewed the summary and had missed the order. The DON stated the RN indicated the NP would add orders to her summaries that were not discussed during the NP visit, which resulted in the RN being unaware of the orders. The DON stated following a visit, the NP would dictate her visit, but verified the RN would have access to the dictated summary and any orders that same day. The DON confirmed the RN had neglected to review R1's PA visit summary, thereby missing the new order resulting in the daily skin assessments not being completed. The DON verified the daily skin checks had not been conducted from 1/30/20, until 2/20/20, when R1's Stage 4 pressure ulcer was identified by her physician. The DON stated it was her expectation for nursing to review provider summaries/orders, and implement changes as directed. The facility's Nurse Care Coordinator Job summary undated, indicated the care coordinator was responsible for transcribing and reviewing physician orders, and also assured that necessary arrangements were made, as ordered.	F 600		

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F 600	Continued From page 6 The past non-compliance that began on 1/30/20, was reviewed to be corrected by 2/20/20, after the facility had implemented the following interventions: -Ensuring all residents had physician orders reviewed and implemented as directed and the physician had been notified, if needed. The Floor nurses were assigned to obtain, monitor, review, and follow up on all resident skin assessments and follow up if needed. -R1's physician orders updated 2/20/20, to reflect pressure ulcer dressing change, skin monitoring, and nursing staff educated to follow orders and document. R1's Care plan revised to reflect skin monitoring and dressing changes. -The identification of all potentially affected residents and reviewed all physician orders as well as documentation -Nurse Unit Managers and MDS RN educated on physician order follow up, with a double check process implemented to ensure physician orders and skin monitoring, and documentation complete, and to notify MD if resident's changes occur. -Continued Quality Assurance: audits implemented to ensure enhanced system compliance. A risk management meeting was scheduled for 3/19/20. Weekly auditing in place and DON responsible for follow up. -Staff education was provided. Verification of corrective action was confirmed by	F 600		

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F 600	Continued From page 7 observations, interviews with a variety of staff including administration, and document review. Training and education was completed by 2/20/20, and ongoing audits conducted verified interventions had been implemented. Nursing staff were educated to the facility policy and revisions were made to include the on-going monitoring of resident skin assessment and follow-up to physician orders in order to prevent future incidents. The facility incorporated the action plan into the facility wide quality assurance program.	F 600		
F 686 SS=J	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement physician orders to prevent the development and worsening of pressure ulcers for 1 of 1 resident (R1) reviewed for pressure ulcers. This failure resulted in an immediate jeopardy (IJ) situation for R1 due to the facility's failure to implement daily skin	F 686	Past noncompliance: no plan of correction required.	

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F 686	Continued From page 8	F 686		

checks, which resulted in the development of a Stage 4 pressure ulcer. However, at the time of the investigation, it was determined the facility had implemented appropriate corrective action prior to the survey, resulting in a finding of past-noncompliance for R1.

On 3/6/2020, at 1:15 p.m. the facility administrator and director of nursing were notified of the facilities failure to prevent the development of pressures ulcers resulting in an IJ situation related to the development of a Stage 4 pressure ulcer for R1. The past non-compliance IJ began on 1/30/20, when the provider had identified pressure related areas under R1's left splint, and ordered daily splint removal and skin assessments which were not implemented until 2/20/20, after R1 had been identified with a Stage 4 pressure ulcer.

Findings include:

A Nursing Home Incident Report (NHIR) submitted 2/25/20, indicated R1 had sustained a fracture of the left fibula and tibia on 1/19/20, which was evaluated in the emergency department (ED). Treatment consisted of placement of a splint to the left lower leg. R1 had returned to the facility with a hospital verbal order to not remove the splint. On 1/27/20, R1 was seen by the physician, and an X-ray identified no change to fracture therefore, order was given to continue with the splint. On 1/30/20, the staff notified the physician assistant (PA) regarding swelling to R1's left foot. The PA removed the splint and Ace wrap (elastic wrap) and examined R1's foot and leg. A reddened area was noted behind R1's left leg. The PA added additional padding to the back of R1's knee, and no further

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F 686	Continued From page 9	F 686		

orders were received. On 2/5/20, the Ace wrap was removed, and a clean Ace wrap was applied. On 2/19/20, an X-ray indicated the fracture was healing. During physician rounds on 2/20/20, the Ace wrap and splint were removed and a Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer was discovered, and no impact on R1's quality of life was noted. Care plan and orders were followed. The facilty's 5 day investigation form indicted the splint was discontinued and a boot was applied. Nursing order was put into place were to check placement of the boot and skin condition every shift.

R1's PA visit summary dated 1/30/20, indicated R1 exhibited severe puffiness with a fluid filled appearance at the top of the left foot from the toes to mid-foot, where the splint edge was. The edge of the splint was very tight on the foot and ankle bone. Ace wraps were removed times two, and the splint was released at the top of left leg and stretched back to loosen. Within two minutes, the swelling at the top of the foot started to decrease, and after five minutes there was minor puffiness noted. Pedal pulse (pulse noted on the top of the foot) was palpable, and the foot was warm and dry with good capillary refill. No open areas were noted. A one millimeter (mm) pink area was noted on the top of the left foot, medial side, without any sloughing of skin, and no raised area or indentation areas. A similar sized area was also noted on the posterior lower leg, lateral area at the bend of the knee. Cast padding was applied to the top of the foot and left lateral ankle. The splint was laid back over the leg and loosely wrapped with two Ace wraps to just below the knee, but not under where knee bends. The visit summary plan directed the nurses to check under

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	245247	A. BUILDING _____ B. WING _____	C 03/10/2020

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

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R1's splint daily for skin exam, and then to rewrap. The swelling on the top of the left foot had gone down, and the physician had an order for a follow up X-ray for the tibia/fibula fracture to be followed up on, as directed. R1 was to return for a visit in one week, or if symptoms worsened or failed to improve.

R1's Physician Visit dated 2/20/20, indicated R1's splint was removed, and revealed a Stage 4 pressure ulcer with necrosis (death of cells or tissue) of muscle to left popliteal fossa (space behind the left knee). Dressing changes were implemented, and staff was to ensure R1 was seen by wound care staff. The splint was not to be reapplied, and a midcalf cushion boot was ordered to be worn for the left tibia/fibula fracture.

R1's quarterly Minimum Data Set (MDS) dated 1/2/20, indicated R1 had severe cognitive impairment and diagnoses which included dementia, rheumatoid arthritis, osteoarthritis, and was under weight. R1 required total assistance of two staff for transfers, was unable to walk, and was at risk for pressure ulcers.

R1's care plan dated 1/21/20, indicated R1 was at risk for developing pressure ulcers related to incontinence, immobility, and contractures to lower extremities. The care plan identified a superficial area on buttocks related to shearing, no other skin breakdown areas were identified. The care plan was revised on 2/20/20, identifying a pressure ulcer behind the left knee, and red area on top of left foot, with bi-weekly dressing change directives, and assessment of skin under boot every shift. However, the care plan lacked the directive related to the 1/30/20, PA order for the removal of the splint, and daily skin checks to

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be conducted under splint.

R1's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 1/30/20-2/20/20, lacked documentation reflecting implementation and daily removal of R1's splint and skin checks.

R1's Progress Notes reviewed from 1/30/20, through 2/20/20, lacked documentation reflecting daily skin monitoring had been conducted, as ordered.

On 3/5/20, at 1:45 p.m. licensed practical nurse (LPN)-B confirmed R1's splint had not been removed, and skin assessments had not been completed prior to the identification of R1's pressure ulcer, because there were no orders to do so.

-At 2:40 p.m. LPN-C stated following R1's fracture, she had been told the physician or NP would be following up on R1, and she was not to remove the splint. LPN-C stated R1's skin under the splint and behind the knee were not visible to assess without removing the splint. LPN-C stated removal of the splint and skin checks had not been implemented until after the physician had discovered the Stage 4 pressure ulcer.

-At 3:12 p.m. during a telephone interview, PA-A confirmed she had visited R1 on 1/30/20, at which time the nursing staff had requested an evaluation of R1's left foot due to swelling. PA-A stated she had removed R1's splint, and noted two reddened areas on left lateral foot and behind the left knee which were approximately 1.0 mm in diameter, and were not open. PA-A stated she had written orders for the nurse to remove and

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F 686	Continued From page 12	F 686		

check under R1's splint daily and to conduct a skin assessment, and then rewrap it. PA-A stated it was her expectation for nursing to implement the orders as written, as the ongoing monitoring of R1's skin would have identified the change in R1's skin condition thereby preventing R1's development of the Stage 4 pressure ulcer.

-At 4:32 p.m. the director of nursing (DON) confirmed the physician identified R1 had developed a Stage 4 pressure ulcer on 2/20/20. The DON stated she reviewed R1's physician and PA visits and orders from the date of R1's fall resulting in fractures on 1/19/20, and on 2/20/20, she had discovered the order from the PA directing nursing staff to remove the splint and check R1's skin daily. The DON stated she discussed the order with the registered nurse (RN) unit coordinator, who confirmed she had not reviewed the summary and had missed the order. The DON stated the RN indicated the NP would add orders to her summaries that were not discussed during the NP visit, which resulted in the RN being unaware of the orders. The DON stated following a visit, the NP would dictate her visit, but verified the RN would have access to the dictated summary and any orders that same day. The DON confirmed the RN had neglected to review R1's PA visit summary, thereby missing the new order resulting in the daily skin assessments not being completed. The DON verified the daily skin checks had not been conducted from 1/30/20, until 2/20/20, when R1's Stage 4 pressure ulcer was identified by her physician. The DON stated it was her expectation for nursing to review provider summaries/orders, and implement changes as directed.

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F 686	Continued From page 13 The facility's Nurse Care Coordinator Job summary undated, indicated the care coordinator was responsible for transcribing and reviewing physician orders, and also assured that necessary arrangements were made, as ordered. The past non-compliance that began on 1/30/20, was reviewed to be corrected by 2/20/20, after the facility had implemented the following interventions: -Ensuring all residents had physician orders reviewed and implemented as directed and the physician had been notified, if needed. The floor nurses were assigned to obtain, monitor, review, and follow up on all resident skin assessments and follow up if needed. -R1's physician orders updated 2/20/20, to reflect pressure ulcer dressing change, skin monitoring, and nursing staff educated to follow orders and document. R1's Care plan revised to reflect skin monitoring and dressing changes. -The identification of all potentially affected residents and reviewed all physician orders as well as documentation -Nurse Unit Managers and MDS RN educated on physician order follow up, with a double check process implemented to ensure physician orders and skin monitoring, and documentation complete, and to notify MD if resident's changes occur. -Continued Quality Assurance: audits implemented to ensure enhanced system compliance. A risk management meeting was scheduled for 3/19/20. Weekly auditing in place	F 686		

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F 686	Continued From page 14 and DON responsible for follow up. -Staff education was provided. Verification of corrective action was confirmed by observations, interviews with a variety of staff including administration, and document review. Training and education was completed by 2/20/20, and ongoing audits conducted verified interventions had been implemented. Nursing staff were educated to the facility policy and revisions were made to include the on-going monitoring of resident skin assessment and follow-up to physician orders in order to prevent future incidents. The facility incorporated the action plan into the facility wide quality assurance program.	F 686		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 6, 2020

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

Re: Event ID: W7UQ11

Dear Administrator:

The above facility survey was completed on March 10, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

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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: On 3/5/20 - 3/10/20, an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found to be in compliance with the MN state licensure. The following complaint was found not to be	2 000		

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2 000	Continued From page 1 substantiated: H5247016C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		