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	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kittson Healthcare	1010 South Birch Hallock, MN 56728

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to ensure residents were protected from exposure for 1 of 3 residents (R19) observed exposed from the hallway. Findings include: R19's quarterly Minimum Data Set (MDS) dated [DATE], identified R19 had a severe cognitive impairment and diagnoses included Alzheimer's disease and anxiety. R19's care plan revised 3/26/24, identified R19 was dependent for all abilities. The care plan did not identify a plan for staff to maintain R19's privacy, not did the undated Resident Care sheet #4. During an observation on 5/22/24 at 8:21 a.m., R19 was lying in bed on his right side. R19's room door was wide open and R19 was easily seen from the hallway. R19's head of bed was slightly elevated causing R19 to slump down in bed on his right side in a fetal position. R19's blankets and gown were bunched up in front of him causing his back, legs, and incontinent brief to be clearly visible. R19's blinds were halfway open. - At 8:23 a.m., nursing assistant (NA)-B looked into R19's room. NA-B did not cover R19 and left the room. NA-B called on her walkie to have someone check on R19. R19's room door continued to be wide open. - At 8:26 a.m., NA-E walked past R19's room with a female resident. NA-E did not check on R19. - At 8:27 a.m., NA-B went into the room next door but did not enter R19's room. - At 8:28 a.m., NA-E entered R19's room, picked up R19's blankets and covered R19. NA-E stated R19 was still asleep, and she did not wake him for cares. NA-B entered the room and stated R19 frequently kicked off his blankets because he got hot. NA-E stated staff were expected to look into R19's room every time they walked past and cover him when they knew he was exposed. NA-B stated she did look into R19 room earlier but was looking for NA-E and didn't even look at R19. NA-E stated it was important to cover R19 because you never knew when he would expose himself. Then NA-E stated, well yea, he exposed himself so you could pull the privacy curtain too. NA-E stated it was to allow R19 privacy to prevent others seeing him exposed. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/24 at 9:28 a.m., NA-G stated when staff were walking in the hallways you just check on everyone. Staff looked into rooms to make sure everyone was ok. Staff kept room doors open at night to make sure staff could see the residents easily. In the daytime, R19 should get dressed and leave him in bed so he didn't expose himself to others. R19 just threw his stuff off and took off his brief. NA-G stated it wasn't ok for others to see R19 without his blankets covering him. R19 needed to be covered for privacy and dignity. During an interview on 5/22/24 at 9:47 a.m., licensed practical nurse (LPN)-B stated she always tried to walk down the halls and see what's going on. That morning there had been a fall and LPN-B was preoccupied with that. The aides should always look to see how R19 was and to cover him up. LPN-B stated it was an issue and R19 was probably cold and just uncomfortable. During an interview on 5/22/24 at 4:14 p.m., the director of nursing (DON) stated it was important to care plan interventions because R19 exposed himself while in bed. Staff needed to give R19 privacy. The DON stated she had educated staff on the importance of this and to always have eyes and ears open to pay attention. The undated Quality of Life policy, identified the facility must promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality. Maintaining resident privacy of body including keeping residents sufficiently covered while being taken to areas outside of their room, such as a bathing area.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to ensure residents were free from physical restraints for 1 of 2 residents (R13) reviewed for restraints. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], identified R13 had severe cognitive impairment, exhibited wandering behaviors, and required partial to moderate assistance with transfers. R13 did not use restraints. R13's care plan revised 5/20/24, identified R13 had dementia and would wander in the past. Interventions included: staff were directed to monitor that R13's wanderguard was in place twice a day; If noted to be restless, offer 1:1 time, snacks, monitor for pain signs/symptoms, distraction such as activities (such as discuss her love of gardening), look at picture books etc. offer to go for a walk with her or go outside on nice days. Further, R13 was independent with wheeling wheelchair, partial assist with transfers, sit to stand. R13's medical record lacked evidence R13 was assessed for restraints. A complaint received by the State Agency (SA) on 5/20/24 at 5:14 a.m., identified a witnessed incident between R13 and nursing assistant (NA)-C occurred on 5/17/24 around 6:15 p.m. R13 spent her day scooting around her wheelchair and wandering the facility. NA-C grabbed R13 by the under the arms and tugged R13 into a recliner. NA-C then set R13's wheelchair to the side of R13 where R13 could not get back into her wheelchair. R13 left the area and the reporter saw R13 reaching down to the right of the recliner to reach towards the wheelchair. NA-C saw this and removed the wheelchair from where R13 could reach it. NA-C then pulled R13 by her pants into the recliner. R13 did not want to be in a recliner. NA-C said she put R13 into the recliner to prevent R13 from wandering and scooting around in the wheelchair. NA-C wanted to use the recliner as a restraint. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/24 at 4:37 p.m., registered nurse (RN)-A stated she worked 5/17/24. RN-A was getting off work and was in report in the nurses' station. RN-A looked up and saw NA-C walk past the nurses' station and then walked back. NA-C was visibly upset, red faced, scowling. NA-C came back to the common area pushing R13 in her wheelchair while walking another female resident. NA-C grabbed R13 under her arms and put her in the recliner with the wheelchair on R13's right side. R13 wandered in her wheelchair, but, if she's not hurting herself or others, staff just let her go. NA-C walked away, and RN-A saw R13 scooted forward and reached down the side of the recliner and pulled the wheelchair closer to R13. RN-A stated R13 could transfer herself with assist, staff just needed to ask her what she wanted to do. NA-C came back and took the wheelchair away from R13 then pulled R13 back into the recliner from behind so R13's bottom was in the crease of the recliner. RN-A left the nurses' station and asked NA-D to take R13 out of the recliner and into R13's wheelchair. RN-A did not want NA-C to handle R13 anymore. NA-C was in bathroom, but overheard RN-A. NA-C came out of the bathroom and went to move R13. RN-A explained to NA-C that she asked NA-D to move R13. NA-C began yelling at RN-A that RN-A was the problem and RN-A needed to go home. NA-C stated she put R13 into the recliner to prevent R13 from wandering. RN-A stated she called the director of nursing (DON) and talked to her about it. However, RN-A stated the DON encouraged staff to have residents sit in the recliners. RN-A stated there was a difference between asking if a resident wanted to sit in the recliner or making them sit in a recliner. RN-A thought the DON would come to the facility and investigate the situation. However, on 5/19/24, RN-A came to the facility and saw NA-C was working. During an interview on 5/20/24 at 5:10 p.m., NA-C stated staff always put wandering residents into the recliners to prevent them from wandering into other resident rooms. During an interview on 5/21/24 at 10:02 a.m., the DON stated she received a couple phone calls over the weekend. The DON had never had an issue with NA-C and NA-C went above and beyond and felt it was an issue between NA-C and RN-A. The facility did have video surveillance but did not review the video because it honestly never crossed my mind that the recliner could have possibly been used as a restraint or there was rough treatment. On 5/21/24 at 12:22 p.m., a review of surveillance video dated 5/17/24 at 6:08 p.m. to 6:19 p.m. was conducted with the DON. RN-A was observed through the nurses' station window. NA-C was wheeling R13 to a common area recliner in her wheelchair. NA-C placed R13's wheelchair on the right side of the recliner with the seat facing the wall. NA-C then walked down the hall. R13 reached with her right hand until she was able to grasp the wheelchair and turned it towards her. R13 then scooted forward in the recliner. NA-C came back to the common area and grabbed R13's wheelchair and placed it approximately 6 feet away from R13 with the wheelchair facing away from R13. NA-C then lifted R13 back into the recliner by lifting her by the underarms. During an interview on 5/21/24 at 12:37 p.m., the DON stated in the video NA-C did not go above and beyond. Staff were instructed to ask permission before transferring a resident into the recliners. The DON did encourage staff to use the recliners to allow residents a place to rest, but moving the wheelchair out of reach to prevent transfers was a restraint. During a phone interview on 5/22/24 at 11:14 a.m., LPN-C stated it was common for staff to put wandering residents in the recliners, so they don't go and wander into other resident rooms. LPN-C then stated putting a resident in a recliner and removing the wheelchair so the resident was unable to self-transfer was a restraint. (continued on next page)

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	245247	A. Building B. Wing	05/22/2024

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated, facility policy Physical Restraints/Bedrails, identified it was the policy of the facility to keep residents restraint free, both physical and chemical. If a resident was unable to be restraint-free, the facility would provide the least restrictive restraint for each individual resident. The policy defined physical restraints as any item which confined a person in a wheelchair such as a gray wheelchair belt, recliner, lap tray, or velcro belt which the resident was unable to remove independently.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to report an allegation of rough treatment and restraining a resident for 1 of 2 residents (R13); and the facility failed to report an injury of unknown origin for 1 of 2 residents (R4) reviewed for potential abuse. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], identified R13 had severe cognitive impairment, exhibited wandering behaviors and required partial to moderate assistance with transfers. R13 did not utilize restraints. A complaint received by the State Agency (SA) on 5/20/24 at 5:14 a.m., identified a witnessed incident between R13 and nursing assistant (NA)-C occurred on 5/17/24 around 6:15 p.m. R13 spent her day scooting around her wheelchair and wandering the facility. NA-C grabbed R13 by the under the arms and tugged R13 into a recliner. NA-C then set R13's wheelchair to the side of R13 where R13 could not get back into her wheelchair. R13 left the area and the reporter saw R13 reaching down to the right of the recliner to reach towards the wheelchair. NA-C saw this and removed the wheelchair from where R13 could reach it. NA-C then pulled R13 by her pants into the recliner. R13 did not want to be in a recliner. NA-C said she put R13 into the recliner to prevent R13 from wandering and scooting around in the wheelchair. NA-C wanted to use the recliner as a restraint During an interview on 5/20/24 at 4:37 p.m., registered nurse (RN)-A stated she worked 5/17/24. RN-A was getting off work and was in report in the nurses' station. RN-A looked up and saw NA-C walk past the nurses' station and then walked back. NA-C was visibly upset, red faced, scowling. NA-C came back to the common area pushing R13 in her wheelchair while walking another female resident. NA-C grabbed R13 under her arms and put her in the recliner with the wheelchair on R13's right side. R13 wandered in her wheelchair, but, if she's not hurting herself or others, staff just let her go. NA-C walked away, and RN-A saw R13 scooted forward and reached down the side of the recliner and pulled the wheelchair closer to R13. RN-A stated R13 could transfer herself with assist, staff just needed to ask her what she wanted to do. NA-C came back and took the wheelchair away from R13 then pulled R13 back into the recliner from behind so R13's bottom was in the crease of the recliner. RN-A left the nurses' station and asked NA-D to take R13 out of the recliner and into R13's wheelchair. RN-A did not want NA-C to handle R13 anymore. NA-C was in bathroom, but overheard RN-A. NA-C came out of the bathroom and went to move R13. RN-A explained to NA-C that she asked NA-D to move R13. NA-C began yelling at RN-A that RN-A was the problem and RN-A needed to go home. NA-C stated she put R13 into the recliner to prevent R13 from wandering. RN-A stated she called the director of nursing (DON) and talked to her about it. However, RN-A stated the DON encouraged staff to have residents sit in the recliners. RN-A stated there was a difference between asking if a resident wanted to sit in the recliner or making them sit in a recliner. RN-A thought the DON would come to the facility and investigate the situation. However, on 5/19/24, RN-A came to the facility and saw NA-C was working. (continued on next page)

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	245247	A. Building B. Wing	05/22/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 10:02 a.m., the DON stated she received a couple phone calls over the weekend. The DON had never had an issue with NA-C and NA-C went above and beyond and felt it was an issue between NA-C and RN-A. The facility did have video surveillance but did not review the video because it honestly never crossed my mind that the recliner could have possibly been used as a restraint or there was rough treatment. The DON believed it was a personal issue between RN-A and NA-C and it was not reported. On 5/21/24 at 12:22 p.m., a review of surveillance video dated 5/17/24 at 6:08 p.m. to 6:19 p.m. was conducted with the DON. RN-A was observed through the nurses' station window. NA-C was wheeling R13 to a common area recliner in her wheelchair. NA-C placed R13's wheelchair on the right side of the recliner with the seat facing the wall. NA-C then walked down the hall. R13 reached with her right hand until she was able to grasp the wheelchair and turned it towards her. R13 then scooted forward in the recliner. NA-C came back to the common area and grabbed R13's wheelchair and placed it approximately 6 feet away from R13 with the wheelchair facing away from R13. NA-C then lifted R13 back into the recliner by lifting her by the underarms. R4's annual Minimum Data Set (MDS) dated [DATE], identified R4 had severe cognitive impairment and exhibited verbal behavioral symptoms directed towards others, significantly intruded on the privacy or activity of others and significantly disrupted care or the living environment. R4 was at risk for pressure ulcer/injury but had no open areas. R4 was frequently incontinent of bladder and bowel and required staff assistance with activities of daily living (ADLs). R4's Resident Progress Note dated 5/15/24 at 9:19 p.m., identified registered nurse assessed R4's skin upon request. R4 was identified to have a small unmeasurable skin tear to the back area of his left testicle and near his left buttock. R4's medical record failed to identify any other information regarding the skin tear. During an observation on 5/22/24 at 2:02 p.m., R13 had a 1.7 centimeter (cm) by 1 cm skin tear to the left posterior scrotum. During an interview on 5/22/24 at 4:24 p.m., the DON stated she printed out Resident Progress Notes every morning and reviewed them in the interdisciplinary (IDT) team meeting. The DON stated she did recall reading the 5/15/24, note regarding R4's skin and did reach out to the other team members who recalled speaking about it as well. Typically, staff would have followed through with wound care but it slipped through the cracks. The DON stated an injury of unknown origin, especially in a serious area of the body, should have been reported. During a phone interview on 5/22/24 at 7:32 p.m., RN-A stated she documented R4 had a skin tear to his left posterier scrotum. RN-A stated the facility had given her no direction regarding reporting injuries of unknown origin . You learn as you go and you learn from another traveler who is probably learning as they go as well. RN-A stated hindsight was always 20/20 and the injury of unknown origin should have been reported to the SA because it was in a suspicious location and the resident could not explain what happened. (continued on next page)

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	245247	A. Building B. Wing	05/22/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy revised 2/2017, identified it was the policy of this facility that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) were reported per Federal and State Law. The facility would ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, Including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and the Minnesota Department of Health in accordance with state law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. - The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse, including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy identified an injury should be classified as an injury of unknown source when both of the following conditions are met: i. The source of the injury was not observed by any person or the source of the the injury could not be explained by the resident; ii. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. An example of injury of unknown source is a bruise or skin tear without known contact. Immediately upon receiving a report of alleged abuse, the Administrator, and or designee will coordinate delivery of appropriate medical and/or psychological care and attention. Ensuring safety and well-being for the vulnerable individual are of utmost priority. Safety, security and support of the resident, their roommate, if applicable and other residents with the potential to be affected will be provided.

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	245247	A. Building B. Wing	05/22/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to complete a thorough investigation related to an allegation of rough treatment and restraining a resident for 1 of 2 residents (R13); and the facility failed to report an injury of unknown origin for 1 of 2 residents (R4) reviewed for potential abuse. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], identified R13 had a severe cognitive impairment, exhibited wandering behaviors, and required partial to moderate assistance with transfers. R13 did not utilize restraints. A complaint received by the State Agency (SA) on 5/20/24 at 5:14 a.m., identified a witnessed incident between R13 and nursing assistant (NA)-C occurred on 5/17/24 around 6:15 p.m. R13 spent her day scooting around her wheelchair and wandering the facility. NA-C grabbed R13 by the under the arms and tugged R13 into a recliner. NA-C then set R13's wheelchair to the side of R13 where R13 could not get back into her wheelchair. R13 left the area and the reporter saw R13 reaching down to the right of the recliner to reach towards the wheelchair. NA-C saw this and removed the wheelchair from where R13 could reach it. NA-C then pulled R13 by her pants into the recliner. R13 did not want to be in a recliner. NA-C said she put R13 into the recliner to prevent R13 from wandering and scooting around in the wheelchair. NA-C wanted to use the recliner as a restraint. During an interview on 5/20/24 at 4:37 p.m., registered nurse (RN)-A stated she worked 5/17/24. RN-A was getting off work and was in report in the nurses' station. RN-A looked up and saw NA-C walk past the nurses' station and then walked back. NA-C was visibly upset, red faced, scowling. NA-C came back to the common area pushing R13 in her wheelchair while walking another female resident. NA-C grabbed R13 under her arms and put her in the recliner with the wheelchair on R13's right side. R13 wandered in her wheelchair, but, if she's not hurting herself or others, staff just let her go. NA-C walked away, and RN-A saw R13 scooted forward and reached down the side of the recliner and pulled the wheelchair closer to R13. RN-A stated R13 could transfer herself with assist, staff just needed to ask her what she wanted to do. NA-C came back and took the wheelchair away from R13 then pulled R13 back into the recliner from behind so R13's bottom was in the crease of the recliner. RN-A left the nurses' station and asked NA-D to take R13 out of the recliner and into R13's wheelchair. RN-A did not want NA-C to handle R13 anymore. NA-C was in bathroom, but overheard RN-A. NA-C came out of the bathroom and went to move R13. RN-A explained to NA-C that she asked NA-D to move R13. NA-C began yelling at RN-A that RN-A was the problem and RN-A needed to go home. NA-C stated she put R13 into the recliner to prevent R13 from wandering. RN-A stated she called the director of nursing (DON) and talked to her about it. However, RN-A stated the DON encouraged staff to have residents sit in the recliners. RN-A stated there was a difference between asking if a resident wanted to sit in the recliner or making them sit in a recliner. RN-A thought the DON would come to the facility and investigate the situation. However, on 5/19/24, RN-A came to the facility and saw NA-C was working. (continued on next page)

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	245247	A. Building B. Wing	05/22/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/24 at 5:10 p.m., NA-C stated she was a contracted nursing assistant and had worked at the facility since the beginning of February 2024. NA-C was always scheduled for five days in a row, but often picked up additional shifts so usually worked more than seven days in a row. On 5/17/24, NA-C transferred R13 into the recliner after she asked R13 if she wanted to. R13 was sleepy. NA-C stated she had R13 stand up and pivot towards the recliner and stated I just held her. Afterwards, RN-A got upset with NA-C and spoke rudely about NA-C outside the bathroom. I heard her. RN-A said she told another staff member to get R13 out of the recliner because NA-C put R13 in the recliner without permission. NA-C walked out of the bathroom and told RN-A to not worry about it and NA-C would put R13 into her wheelchair. Staff always put R13 in the recliner if she was tired and did not want to go to her bedroom. NA-C stated she did not remember exactly what she said to RN-A but told RN-A to go and to leave me alone because that nurse harasses me. During an interview on 5/21/24 at 4:21 a.m., NA-D stated he worked 5/17/24 but he doesn't know any specifics. NA-C was close to room [ROOM NUMBER], and RN-A came to him and asked him to transfer R13 out of the recliner back into her wheelchair. NA-D stated he did not know if R13 was trying to get out of the recliner or why RN-A asked. NA-D said he would but didn't get a chance to because when the nurse started walking back to the nurses station, NA-C came and transferred R13 back into her wheelchair. NA-C was mad. NA-D could not remember if NA-C said anything but her physical appearance, her face, how she moved told NA-D NA-C was mad. During an interview on 5/21/24 at 10:02 a.m., the DON stated, I honestly think this was between NA-C and RN-A. The DON received a couple phone calls over the weekend. RN-A seemed to target NA-C. RN-A followed NA-C around and didn't give NA-C space. The DON had never had an issue with NA-C and NA-C went above and beyond. The DON had followed NA-C but did not have documentation to reflect that. Over the past 2 months, the DON had to have a lot of communication with RN-A about the way RN-A treated NA-C. The DON stated the facility did have video surveillance but did not review the video because it honestly never crossed my mind that the recliner could have possibly been used as a restraint or there was rough treatment. The DON believed it was a personal issue between RN-A and NA-C. During an interview on 5/21/24 at 10:02 a.m., the DON stated she received a couple phone calls over the weekend. The DON had never had an issue with NA-C and NA-C went above and beyond and felt it was an issue between NA-C and RN-A. The DON believed it was a personal issue between RN-A and NA-C and it was not reported. The DON did say she had followed NA-C but there was no documention to reflect the actions. The facility did have video surveillance but did not review the video because it honestly never crossed my mind that the recliner could have possibly been used as a restraint or there was rough treatment. (continued on next page)

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	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kittson Healthcare	1010 South Birch Hallock, MN 56728

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/24 at 12:22 p.m., a review of surveillance video dated 5/17/24 at 6:08 p.m. to 6:19 p.m. was conducted with the DON. RN-A was observed through the nurses' station window. NA-C was wheeling R13 to a common area recliner in her wheelchair. NA-C placed R13's wheelchair on the right side of the recliner with the seat facing the wall. NA-C then walked down the hall. R13 reached with her right hand until she was able to grasp the wheelchair and turned it towards her. R13 then scooted forward in the recliner. NA-C came back to the common area and grabbed R13's wheelchair and placed it approximately 6 feet away from R13 with the wheelchair facing away from R13. NA-C then lifted R13 back into the recliner by lifting her by the underarms. NA-C spoke with LPN-C who looked around the corner at R13 but did not approach R13. NA-C and LPN-C left the common area. RN-A came out of the nurse' station and approached NA-D. RN-A went into the medication room and spoke with RN-E. At that time, NA-C came from the employee bathroom, turned, and stated, I'll do it. It's not a big issue, pointed and walked to R13. RN-A stated, she doesn't want to be in it. Halfway to R13, NA-C turned and stated, you're the issue, you're the instigator. to RN-A. NA-C grabbed R13's wheelchair and placed it next to R13 on R13's right side, locked the wheelchair brakes, and stated to R13 I have to put you back in your wheelchair because she doesn't want you in the recliner. NA-C did not apply a gait belt and picked up R13 by the underarms, lifting her so R13 did not bear weight and transferred R13 into the wheelchair while R13's feet drug on the floor. NA-C left the area without unlocking R13's wheelchair brakes. RN-A and RN-B performed narcotic count without checking on R13. NA-D walked through the common area with another resident without checking on R13. LPN-C left the nurses' station and walked down the hall without checking on R13. NA-C and LPN-C were observed coming back to the nurses' station while an activity aide squatted down the speak with R13 while the video ended. During an interview on 5/21/24 at 12:37 p.m., the DON stated in the video NA-C did not go above and beyond. There were many problems identified in the video: NA-C did not use a gait belt, did not lock R13's wheelchair brakes to prevent falls, and the way NA-C transferred R13. If R1 wanted to sit in the recliner, R13 should have been asked to transfer herself. The transfer was a little rough. I mean it's very frustrating to see that. The other staff did not intervene for R13 and/or the other residents, visitor and staff observing the incident. Staff were instructed to always use a gait belt, ask for assistance, talk with the residents. Staff were instructed to ask permission before transferring a resident into the recliners, and the DON always told the staff they needed to communicate with each other. The staff needed to remember they were there for the residents and to work together for what's best for the residents. The DON believed RN-A's phone call was to complain about NA-C. I don't know why. I can't even recall what she said. The DON stated she always took everything seriously and had been communicating to the staff about getting along. She encouraged staff to come to her with issues, but the DON had to hear both sides. The DON planned to talk to both staff the following Monday, 5/20/24. NA-C should have been removed from the floor and an investigation completed. I would have reported and investigated this if I was aware. During a phone interview on 5/22/24 at 11:18 a.m., RN-E stated any incident requiring an investigation she would need to call the DON for directions. RN-E stated she was unaware of any incident with R13 on 5/17/24. The facility's investigation file was requested but not received. There was no evidence staff were interviewed regarding the incident along with other residents. Nor evidence the facility implemented steps to protect R13 and other residents pending investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's annual Minimum Data Set (MDS) dated [DATE], identified R4 had a severe cognitive impairment and exhibited verbal behavioral symptoms directed towards others, significantly intruded on the privacy or activity of others and significantly disrupted care or the living environment. R4 was at risk for pressure ulcer/injury but had no open areas. R4 was frequently incontinent of bladder and bowel and required staff assistance with activities of daily living (ADLs). R4's Resident Progress Note dated 5/15/24 at 9:19 p.m., identified registered nurse assessed R4's skin upon request. R4 was noted to have a small unmeasurable skin tear to the posterior aspect of his left testicle and near his left buttock. However, R4's medical record failed to identify any other information regarding the skin tear. During an observation on 5/22/24 at 2:02 p.m., licensed practical nurse (LPN)-B and nursing assistant (NA)-E assisted R4 to lie down. When LPN-B began to remove R4's soaked incontinent brief, LPN-B identified a large amount of bloody urine that contained several large blood clots. R4 began yelling you pull on it and it hurts! LPN-B pulled the brief away from R4's scrotum and exposed a large skin tear to the left posterior scrotum. R4 yelled don't start yanking and pulling now! LPN-B stated, that's been there a while [referring to the skin tear on R4's scrotum]. The loose skin had scrunched up and exposed a large quarter-sized area of beefy red flesh. NA-E stated she was unaware of the area, but that she would notify the nurse first thing. R4 stated, I don't know if anyone hurt me. I can't remember. - At 2:11 p.m., LPN-B stepped out of the room to get the director of nursing (DON). - At 2:18 p.m., the DON entered the room and stated an incident report would be completed, the physician and family would be notified, and a wound team would evaluate R4. The DON then stepped out of the room to have the nurse practitioner (NP)-A evaluate R4. - At 2:22 p.m., the DON and NP-A assessed R4's wound. NP-A stated she was unsure if it was a skin tear, it's a wound but I can't say how it started. NP-A touched R4's scrotum and R4 yelled out yea it hurts! NP-A stated R4 had testicular tenderness as well. The area measured 1.7 centimeters (cm) by 1 cm. NP-A cleansed the area and applied barrier cream to prevent the area sticking to R4's brief and reinjuring the area. - At 2:37 p.m., NA-E stated it depended on R4's mood. Sometimes staff performed cares while R4 was lying in bed but sometimes staff had to do his cares while R4 was standing in the standing lift. When R4 was in the standing lift, staff removed R4's incontinent brief and wiped R4's groin front to back. NA-E stated this could cause a skin tear or injury to R4's scrotum because that movement could cause shearing. NP-A stated the skin was very fragile, however, NP-A, the DON, LPN-B nor NA-E could say how or when R4 obtained the skin tear The facility's investigation file related to the potential causative factors of the injury of unknown source was requested but not received. During an interview on 5/22/24 at 4:24 p.m., the DON stated an injury of unknown origin, especially in a serious area of the body, should have been reported and investigated for causitive factors. (continued on next page)

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	245247	A. Building B. Wing	05/22/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy revised 2/2017, identified it was the policy of this facility that abuse allegations (abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property) aware promptly and thoroughly investigated. Investigation of abuse: When an incident or suspected incident of abuse was reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will Include: i. Who was involved ii. Residents' statements a. For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident; complete an evaluation of resident behavior, affect and response to interaction, and document findings. iii. Resident's roommate statements (if applicable) iv. Involved staff and witness statements of events v. A description of the resident's behavior and environment at the time of the incident vi. Injuries present including a resident assessment. vii. Observation of resident and staff behaviors during the investigation viii. Environmental considerations * All staff must cooperate during the investigation to assure the resident is fully protected. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy identified an injury should be classified as an injury of unknown source when both of the following conditions are met: i. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident, (continued on next page)

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	245247	A. Building B. Wing	05/22/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to identify, comprehensively assess, develop and/or implement appropriate interventions in order to promote skin integrity and healing of skin tear on the scrotum for 1 of 1 resident (R4). Findings include: R4's annual Minimum Data Set (MDS) dated [DATE], identified R4 had severe cognitive impairment with a diagnosis of bladder cancer. R4 was at risk for pressure ulcer/injury but had no open areas. R4 was frequently incontinent of bladder and bowel and required staff assistance with activities of daily living (ADLs). R4's care plan revised 5/7/24, identified R4 was incontinent of bladder and bowel. R4 was able to make needs known and required extensive assist of two for toileting and transfers. R4 was at risk for alteration in skin integrity due to idiopathic peripheral neuropathy, history of lower extremity cellulitis, osteoarthritis resulting in potential limitation in mobility. Interventions included: staff to assist with cleansing and applying barrier cream to groin area when assisting with toileting every shift; protect R4 from injury/trauma.; R4 did bump arms/legs frequently, bruises easily; and continue to monitor bruising(ask if he knows how he got the bruise) but do not need an incident report each time a bruise appeared unless it is suspicious. R4's Skin Risk Assessment with Braded Scale dated 4/18/24, identified R4 was at risk for pressure ulcer/injury. Staff assisted with cleansing and applying barrier cream to groin area when R19 was assisted with toileting every shift. Staff were directed to continue to monitor skin daily with cares and weekly with bathing. Staff were to notify nursing of any areas of concern. R4 used a standard pressure reduction mattress and has a ROHO (specialized air cushion) cushion in wheelchair for pressure reduction. R4 bumped his hands and arms frequently on door jams and furniture. R4 wore gloves on his hands on most days due to stating, I'm cold. R4's Resident Progress Note dated 5/15/24 at 9:19 p.m., identified registered nurse assessed R4's skin upon request. R4 had a small unmeasurable skin tear to the back of his left testicle and near his left buttock. R4's medical record failed to identify any other information regarding the skin tear. During an observation on 5/20/24 at 6:32 p.m., nursing assistant (NA)-B and NA-E transferred R4 from his wheelchair to the bathroom via the standing lift. NA-B removed R4's incontinent brief by pulling from the front to back. R4 was hollering and clamping his legs tightly together. The incontinent brief was soaked with dark, bloody urine and several large blood clots making the brief stick to his skin. R4 was lowered onto the toilet and cares continued. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/22/24 at 2:02 p.m., licensed practical nurse (LPN)-B and nursing assistant (NA)-E assisted R4 to lie down. When LPN-B began to remove R4's soaked incontinent brief, LPN-B identified a large amount of bloody urine that contained several large blood clots. R4 began yelling you pull on it and it hurts! LPN-B pulled the brief away from R4's scrotum and exposed a large skin tear to the left posterior scrotum. R4 yelled don't start yanking and pulling now! LPN-B stated, that's been there a while [referring to the skin tear on R4's scrotum]. The loose skin had scrunched up and exposed a large quarter-sized area of beefy red flesh. NA-E stated she was unaware of the area, but that she would notify the nurse first thing. R4 stated, I don't know if anyone hurt me. I can't remember. - At 2:11 p.m., LPN-B stepped out of the room to get the director of nursing (DON). - At 2:18 p.m., the DON entered the room and stated an incident report would be completed, the physician and family would be notified, and a wound team would evaluate R4. The DON then stepped out of the room to have the nurse practitioner (NP)-A evaluate R4. - At 2:22 p.m., the DON and NP-A assessed R4's wound. NP-A stated she was unsure if it was a skin tear, it's a wound but I can't say how it started. NP-A touched R4's scrotum and R4 yelled out yea it hurts! NP-A stated R4 had testicular tenderness as well. The area measured 1.7 centimeters (cm) by 1 cm. NP-A cleansed the area and applied barrier cream to prevent the area sticking to R4's brief and reinjuring the area. - At 2:37 p.m., NA-E stated it depended on R4's mood. Sometimes staff performed cares while R4 was lying in bed but sometimes staff had to do his cares while R4 was standing in the standing lift. When R4 was in the standing lift, staff removed R4's incontinent brief and wiped R4's groin front to back. NA-E stated this could cause a skin tear or injury to R4's scrotum because that movement could cause shearing. NP-A stated the skin was very fragile, however, NP-A, the DON, LPN-B nor NA-E could say how or when R4 obtained the skin tear. During an interview on 5/22/24 at 2:56 p.m., NA-B stated R4 was usually covered in blood from his urine so she assumed the blood was from that and did not check any further. During an interview on 5/22/24 at 3:24 p.m., NA-E stated she completed R4's cares in the bathroom while he was in the standing lift. NA-E stated the night shift nursing assistant put R4 in the bathroom and removed his brief. R4 didn't holler out during cares. NA-E did see the blood on the washcloth but R4's brief was full of blood from his urine and so I honestly thought it was from that. On 5/22/24 at 3:33 p.m., attempted to call NA-D who was the night shift nursing assistant the morning of 5/22/24 but no response was received. During a phone interview on 5/22/24 at 3:48 p.m., NA-G stated she had toileted R4 since 5/15/24, and R4 hollered out but that was nothing unusual for him. There was lots of blood but that wasn't unusual either. NA-G did not see any open areas but R4 was on the standing lift. NA-G then stated R4 received his weekly bath on Thursday evenings and the staff should have seen it then. On 5/22/24 at 4:03 p.m., attempted to call registered nurse (RN)-B regarding R4's bath skin assessment but no response was received. (continued on next page)

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	245247	A. Building B. Wing	05/22/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/24 at 4:24 p.m., the DON stated she printed out Resident Progress Notes every morning and reviewed them in the interdisciplinary (IDT) team meeting. The DON stated she did recall reading the progress note on 5/15/24, regarding R4's skin and did reach out to the other team members who recalled speaking about it as well. Typically, staff would have followed through with wound care but it slipped through the cracks. There were standing orders in place for wound care and R4 should have been added to the wound rounds and It got past me. An incident form should have been completed and if it had been, the DON would have caught it because she reviewed everything. The DON stated R4 had no interventions in place to promote healing, prevent re-injury, promote good hygiene and, additionally, staff should have brought this to nursing attention. During a phone interview on 5/22/24 at 7:32 p.m., registered nurse (RN)-A stated she documented R4 had a skin tear to his left posterior (back) scrotum. NA-C asked RN-A to look at the area because NA-C wanted to put barrier cream on it. There were two wounds. One on the posterior scrotum and one more near the left buttock. RN-A did not complete an incident report because she was unaware she needed to. RN-A documented in the Resident Progress Notes and told RN-C the next day. RN-C told RN-A it was from R4's brief, to put barrier cream on it and RN-C would take care of it. R4 was in pain, and RN-A quit trying to measure the area because RN-A did not want to cause R4 more discomfort. That's why I put unmeasurable in the nursing note. R4 was not a good historian and was unable to give an answer on how it happened. RN-A could not identify how long the wound had been there. The undated facility Skin Breakdown Prevention Protocol, identified nurses would do weekly skin checks of residents on their bath day and document any problems noted. Nursing would document at least weekly for residents with skin breakdown and newly healed areas of breakdown. Notes should include: a clear description of the ulcer and surrounding skin, description of drainage, what the treatment is, if the treatment was working or not working and notification verification of the practitioner. The RN Care Coordinator would develop, update, and revise the care plan as needed. Document changes on the medication administration record (MAR), treatment record and/or care plan with date of initiation and initial. Staff were to visualize area of pressure every shift to ensure dressing were dry and intact and observe skin changes in skin condition.

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	245247	A. Building B. Wing	05/22/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to ensure interventions for preventing pressure ulcers were implemented for 1 of 2 residents (R10) reviewed who was at risk for the development of pressure ulcers. Findings include: R10's quarterly Minimum Data Assessment (MDS) dated [DATE], identified R10 had severe cognitive impairment and diagnoses included hemiplegia, Alzheimer's disease, and pressure-induced tissue damage to the left heel. R10 was at risk for pressure ulcer/injuries and had one unstageable deep tissue injury. R10's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 1/11/24, identified R10 was at risk for pressure injuries. R10 had no pressure areas at that time. Staff were to monitor skin daily with cares and weekly with bathing. R10 had a standard pressure reduction mattress and pummel cushion in her wheelchair. Notify nursing of areas of concern. R10 had tensoshapes (an elastic tubular bandage suitable for light to medium support) for control of edema. R10's Skin Risk Assessment with Braden Scale dated 4/11/24, identified R10 was at moderate risk for pressure ulcer/injury. R10 had a healing unstageable pressure injury to her left heel. Staff were directed to cleanse, apply PolyMem (wound dressing) and wrap with gauze weekly and as needed if not in place. Staff were to monitor skin daily with cares and weekly with bathing. R10 had a standard pressure reduction mattress and pummel cushion in her wheelchair. Left leg rest to hold up hemiparesis leg. Notify nursing of areas of concern. R10's care plan revised 4/24/24, identified R10 was at risk for pressure ulcer/injury and had a pressure injury to her left heel. Staff were directed to cleanse, apply PolyMem (debridement dressing) and wrap with gauze weekly and as needed if not in place. R10 had a pressure reduction mattress and pummel cushion in her wheelchair. R10's left leg rest to hold up leg. Turn and reposition every 3-4 hours. R10's nursing order dated 4/28/24, identified R10 was to have heel protectors while in bed. activity assessment R10's Resident Care Sheet #3 [NAME] dated 5/6/24, identified R10 was to keep her left foot up on a pillow and have heel protector on. R10's Resident Progress Note dated 4/17/24, identified the pressure injury to R10's left heel had healed. During an observation on 5/21/24 at 4:57 a.m., nursing assistant (NA)-D entered R10's and woke R10 for an incontinence check. R10 was wearing fuzzy slippers with compression bandages, but no heel protectors. NA-D placed R10's calves on a pillow, but R10's heels rested on the mattress. NA-D stated the fuzzy slippers were R10's heel protectors. (continued on next page)

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	245247	A. Building B. Wing	05/22/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/21/24 at 9:53 a.m., NA-E and NA-F assisted R10 to lie down in bed. NA-E placed R10's feet in heel protectors and offloaded her lower extremities with a pillow so R10's feet rested above the mattress. NA-E stated yea, they're not supposed to use the fuzzy slippers when she's in bed. Staff were directed to use heel protectors to protect R10's skin. On 5/22/24 at 10:03 a.m., licensed practical nurse (LPN)-B stated R10 no longer had a pressure injury to her heel. LPN-B removed R10's heel protectors and compression bandages to expose R10's heels. The skin was dry, intact, and blanchable. LPN-B stated R10 was to always wear the heel protectors while in bed to promote skin integrity because R10 was unable to move her left side at all and was unable to move her right side much. During an interview on 5/22/24 at 4:12 p.m., the director of nursing (DON) stated it was important to follow the care plan to prevent recurring of the wound, especially on R10's hemiplegic side. A policy on pressure ulcer care and interventions was requested and not received.

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	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kittson Healthcare	1010 South Birch Hallock, MN 56728

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observations, interview and document review the facility failed to ensure safe resident transfer practices were consistently followed for 1 of 1 residents (R13) reviewed for accidents; and the facility failed to provide a safe environment and supervision for 1 of 3 (R19) residents reviewed for wandering. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], identified R13 had a severe cognitive impairment and required partial to moderate assistance with transfers. R13's care plan revised 5/20/24, identified R13 was independent with wheeling wheelchair, partial assist with transfers, sit to stand. A complaint received by the State Agency (SA) on 5/20/24 at 5:14 a.m., identified a witnessed incident between R13 and nursing assistant (NA)-C occurred on 5/17/24 around 6:15 p.m. R13 tended to spend her day scooting around her wheelchair and wandering the facility. NA-C grabbed R13 by the under the arms and tugged R13 into a recliner. NA-C then set R13's wheelchair to the side of R13 where R13 could not get back into her wheelchair. R13 left the area and the reporter saw R13 reaching down to the right of the recliner to reach towards the wheelchair. NA-C saw this and removed the wheelchair from where R13 could reach it. NA-C then pulled R13 by her pants into the recliner. R13 did not want to be in a recliner. NA-C said she put R13 into the recliner to prevent R13 from wandering and scooting around in the wheelchair. NA-C wanted to use the recliner as a restraint. NA-C then grabbed R13 by the arm and put R13 into the wheelchair. During an interview on 5/20/24 at 4:37 p.m., registered nurse (RN)-A stated she worked 5/17/24. RN-A was getting off work and was in report in the nurses' station. RN-A looked up and saw NA-C walk past the nurses' station and then walked back. NA-C was visibly upset, red faced, scowling. NA-C came back to the common area pushing R13 in her wheelchair while walking another female resident. NA-C grabbed R13 under her arms and put her in the recliner with the wheelchair on R13's right side.Rn-A stated R13 wandered in her wheelchair, but if she's not hurting herself or others, staff just let her go. NA-C walked away, and RN-A saw R13 scooted forward and reached down the side of the recliner and pulled the wheelchair closer to R13. RN-A stated R13 could transfer herself with assist, staff just needed to ask her what she wanted to do. NA-C came back and took the wheelchair away from R13 then pulled R13 back into the recliner from behind so R13's bottom was in the crease of the recliner. RN-A left the nurses' station and asked NA-D to take R13 out of the recliner and into R13's wheelchair. RN-A did not want NA-C to handle R13 anymore. NA-C was in bathroom, but overheard RN-A. NA-C came out of the bathroom and went to move R13. RN-A explained to NA-C that she asked NA-D to transfer R13. NA-C began yelling at RN-A that RN-A was the problem and RN-A needed to go home. NA-C stated she put R13 into the recliner to prevent R13 from wandering. (continued on next page)

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	245247	A. Building B. Wing	05/22/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/24 at 5:10 p.m., NA-C on 5/17/24, she transferred R13 into the recliner after she asked R13 if she wanted to. R13 was sleepy. NA-C stated she had R13 stand up and pivot towards the recliner and I just held her. Afterwards, RN-A got upset with NA-C and spoke rudely about NA-C outside the bathroom. I heard her. RN-A said she told another staff member to get R13 out of the recliner because NA-C put R13 in the recliner without permission. NA-C walked out of the bathroom and told RN-A to not worry about it and NA-C would put R13 into her wheelchair. Staff always put R13 in the recliner if she was tired and did not want to go to her bedroom. NA-C stated she did not remember exactly what she said to RN-A but told RN-A to go and to leave me alone because that nurse harasses me. During an interview on 5/21/24 at 4:21 a.m., NA-D stated he worked 5/17/24, but he didn't know any specifics. NA-C was close to room [ROOM NUMBER], and RN-A came to him and asked him to transfer R13 out of the recliner back into her wheelchair. NA-D stated he did not know if R13 was trying to get out of the recliner or why RN-A asked. NA-D said he would but didn't get a chance to because when the nurse started walking back to the nurses' station, NA-C came and transferred R13 back into her wheelchair. NA-C was mad. NA-D could not remember if NA-C said anything but her physical appearance, her face, how she moved told NA-D NA-C was mad. On 5/21/24 at 12:22 p.m., a review of surveillance video dated 5/17/24 at 6:08 p.m. to 6:19 p.m. was conducted with the DON. RN-A was observed through the nurses' station window. NA-C was wheeling R13 to a common area recliner in her wheelchair. NA-C placed R13's wheelchair on the right side of the recliner with the seat facing the wall. NA-C then walked down the hall. R13 reached with her right hand until she was able to grasp the wheelchair and turned it towards her. R13 then scooted forward in the recliner. NA-C came back to the common area and grabbed R13's wheelchair and placed it approximately 6 feet away from R13 with the wheelchair facing away from R13. NA-C then lifted R13 back into the recliner by lifting her by the underarms. NA-C spoke with LPN-C who looked around the corner at R13 but did not approach R13. NA-C and LPN-C left the common area. RN-A came out of the nurse' station and approached NA-D. RN-A went into the medication room and spoke with RN-E. At that time, NA-C came from the employee bathroom, turned, and stated, I'll do it. It's not a big issue, pointed and walked to R13. RN-A stated, she doesn't want to be in it. Halfway to R13, NA-C turned and stated, you're the issue, you're the instigator. to RN-A. NA-C grabbed R13's wheelchair and placed it next to R13 on R13's right side, locked the wheelchair brakes, and stated to R13 I have to put you back in your wheelchair because she doesn't want you in the recliner. NA-C did not apply a gait belt and picked up R13 by the underarms, lifting her so R13 did not bear weight and transferred R13 into the wheelchair while R13's feet drug on the floor. NA-C left the area without unlocking R13's wheelchair brakes. RN-A and RN-B performed narcotic count without checking on R13. NA-D walked through the common area with another resident without checking on R13. LPN-C left the nurses' station and walked down the hall without checking on R13. NA-C and LPN-C were observed coming back to the nurses' station while an activity aide squatted down the speak with R13 while the video ended. (continued on next page)

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	245247	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 12:37 p.m., the DON stated in the video NA-C did not go above and beyond. There were many problems identified in the video: NA-C did not use a gait belt, did not lock R13's wheelchair brakes to prevent falls, and the way NA-C transferred R13. If R1 wanted to sit in the recliner, R13 should have been asked to transfer herself because R13 can bear weight. The transfer was a little rough. I mean it's very frustrating to see that. The other staff did not intervene for R13 and/or the other residents, visitor and staff observing the incident. Staff were instructed to always use a gait belt, ask for assistance, talk with the residents. Staff were instructed to ask permission before transferring a resident into the recliners, and the DON always told the staff they needed to communicate with each other. The staff needed to remember they were there for the residents and to work together for what's best for the residents. The facility policy Safe Lifting and Movement of Residents revised July 2017, identified in order to protect the safety and well-being of staff and residents, and to promote quality care, the facility used appropriate techniques and devices to lift and move residents. Staff were directed manual lifting of residents shall be eliminated when feasible. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. However, the policy did not direct when staff should use gait belts during resident transfers. R19's quarterly Minimum Data Set (MDS) dated [DATE], identified R19 had a severe cognitive impairment and diagnoses included Alzheimer's disease and anxiety. R19's care plan revised 3/26/24, identified R19 had severe dementia with anxiety and agitation and required extensive assist with locomotion. R19's Resident Care Sheet #4 [NAME] revised 5/6/24, identified R19 needed redirecting and a wanderguard. The care sheet failed to identify staff should keep R19 away from others for safety. During an observation on 5/21/24 at 9:29 a.m., R19 was sitting in his wheelchair in the common area. R19 was wearing gripper socks and his feet brushed against the floor causing his wheelchair to move aimlessly. R19 moved around an approximate 5-foot area. R19 didn't respond when spoken to nor approached other residents. - At 9:31 a.m., R19 was getting close to family member (FM)-A. FM-A grasped the right wheel of R19's wheelchair and pushed R19 away. You're getting too close! No staff intervened. - At 9:32 a.m., R19's wheelchair moves close to FM-A. FM-A loudly stated, Are you ok? R19 doesn't respond and comes closer to FM-A. Nursing assistant (NA)-E walked out of the nurses station but didn't approach R19 or move him away from others. - At 9:37 a.m., R19's wheelchair continued to move in a small circle but doesn't come within touching distance of FM-A. Staff did not intervene. - At 9:49 a.m., R19 backed into FM-A while FM-A. FM-A pushed R19's wheelchair away from him. No staff intervened. (continued on next page)

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	245247	A. Building B. Wing	05/22/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/22/24 at 9:36 a.m., R19 was sitting in the common area in his wheelchair, his feet dangled and brushed against the floor, back and forth. R19's wheelchair bumped into the loveseat. Licensed practical nurse (LPN)-B brought R19 his medications. R19's wheelchair rocked back and forth. LPN-B stated, come here and pulled R19's wheelchair closer to her. R19's wheelchair bumped into the end table. LPN-B giggled and stated again, come here and pulled R19's wheelchair closer to her. LPN-B then stated she was going to turn R19's wheelchair so that if he did run into anything it would be the loveseat. During an interview on 5/22/24 at 9:47 a.m., LPN-B stated staff tried to keep R19 away from other residents. Staff would turn him, so he went in a different direction. There usually was a staff member in the area because the nurses' station was right there. If R19 got really busy usually activities would take him for a walk to burn off energy. LPN-B stated R19's bumping into other residents, visitors or staff could lead to a fall or it was possible for another resident become angry and strike out at R19. During an observation on 5/22/24 at 9:56 a.m., R19 bumped into R11's wheelchair. R11 did not respond. NA-B and NA-F were sitting at the nurses' station and did not intervene. When prompted, NA-F stated R19 could hurt R11's feet or R19 himself could be hurt. Also, it could lead to aggressive behaviors, and someone could get hurt. NA-B stated staff were to separate R19 immediately from others to make sure everyone was safe. During an interview on 5/22/24 at 11:48 a.m., FM-A stated, yea, R19 did that all the time. R19 was getting too close, and FM-A just told him he was getting too close and pushed R19 away. FM-A stated there were residents who got after R19, but FM-A was unable to recall their names. It's just the way it is. You got to let him do his thing. FM-A shrugged and stated staff weren't always around to intervene. You know how it is. During an interview on 5/22/24 at 4:14 p.m., the director of nursing (DON) stated it was important to care plan interventions regarding R19's wheelchair because it was a safety risk. Staff should have intervened during the interaction between R19 and FM-A. Nursing had discussed activities doing more with R19 and the other residents who wandered. It was an ongoing discussion. Even the residents who could not participate could enjoy attending. Staff were directed to separate residents as much as possible when in the common area. The undated facility policy Elopement, Wandering and Missing Resident Procedure, identified the staff were directed to safeguard all residents in the facility. The facility would provide a safe and secure environment and had a duty to exercise reasonable care to prevent injuries. The policy defined an aimless wanderer as a resident confused about where he or she is, but staff knew their whereabouts. The policy provided direction for wandering assessment and if an elopement occurred but did not address how to maintain wandering resident safety while in the facility.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on observation, interview and document review the facility failed to ensure care planned dementia care interventions were provided for 1 of 1 resident (R16) reviewed for dementia care. Findings include: R16's quarterly Minimum Data Set (MDS) dated [DATE], identified R16 had moderate cognitive impairment and required moderate assistance with dressing, grooming, and toileting hygiene. R16 was independent with wheeling his wheelchair and transferring. Diagnoses included Alzheimer's disease, dementia with other behavioral disturbances with agitation, anxiety disorder and other symptoms and signs involving appearance and behavior-aggression. R16 did not exhibited hallucinations or delusions, physical or verbal behaviors, rejection of care or wandering during the assessment period. R16's care plan dated 4/17/24, identified R16 received psychotropic medication for physical and verbal aggression and had incidents of physically aggressive behaviors with other residents. R16 had a history of becoming very agitated and angry and grabbing other people. R16 was identified to have obsessive compulsive and hoarding tendencies with a history of verbal and physical aggression toward others if his 'items' were removed within his eyesight. Interventions included: keep R16 in line of sight when he was out of his room; check R16's room daily and remove items when he was not in sight because if he saw items removed he would become agitated with verbal and physical aggressiveness (as R16 was protective of personal items); and directed staff to use a calm approach, try reapproach later, have another caregiver try, offer reassurances, explain before doing, offer distractions such as one to one or diversional activity. Review of facility video surveillance recorded on 5/18/24, at 4:55 p.m. identified nursing assistant (NA)-C approached R16 in the general lobby area near the nurses station. NA-C told R16 she was going to help R16 to his wheelchair to go to the dining room for supper. NA-C stated she would take R16's banana out of his wheelchair so he would not squash it. R16 loudly and clearly stated no, no, I am not going to let you, and grabbed NA-C's arm and again stated No you are not going to get my banana. I don't care, you are not going to get it. R16 was becoming more agitated and angry and squeezing NA-C's arm firmly. NA-C asked R16 to release her arm in a very loud voice several times. R16 then grabbed NA-C's forearm with both hands and squeezed tightly, hollering angrily. NA-C pulled out of the resident's grasp and backed away, hollering loudly god damn it and left the area. When interviewed on 5/20/24, at 3:30 p.m. registered nurse (RN)-A stated she was working during the incident and heard some of the altercation between NA-C and R16. R16 was hollering something about a banana and not to squish it and to give it back to him. RN-A then heard NA-C scream god damn it and run into the utility room. NA-C told RN-A R16 hurt NA-C's arm. NA-C escalated the incident by trying to take the banana away from R16. RN-A did not report NA-C behavior because she did not witness the entire incident. (continued on next page)

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	245247	A. Building B. Wing	05/22/2024

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/21/24, at 6:40 a.m. NA-C stated R16 could be resistive with cares, especially if R16 was over tired. NA-C would just keep re-approaching him until he eventually would allow her to provide his cares. NA-C had an altercation with R16 during the weekend. NA-C stated R16 was sitting in the lobby and had a banana underneath his wheelchair cushion. NA-C did not want R16 to sit on the banana so NA-C told R16 she was going to take the banana out from his chair. NA-C thought all R16 heard was that she was taking his banana. R16 grabbed her wrist with both hands and would not let go, which caused some bruised nerves. NA-C hollered out a couple of times thinking someone would come and help her with him but no-one came. NA-C eventually pushed on R16's hands and was able to get her arm out of his grip. NA-C filled out an incident report and they said they would look into it and if I did not feel safe caring for R16 she did not have to. NA-C was fine with continuing to care for R16, he did not know what he was doing and he did not frighten her. During interview on 5/22/24, at 11:30 a.m. the director of nursing (DON) stated the interaction between NA-C and R16 reviewed on video was not appropriate. R16's care plan did direct staff to not take things away from R16 when he was rummaging but NA-C was trying to move the banana, not take it away. The DON acknowledged R16 was not aware of the intent to just move the banana and did state on the video to not take his banana several times. The DON stated it was not an appropriate approach to argue with a resident who had dementia and a more effective approach would have been to allow him to calm down and re-approach later. A facility policy on caring for residents with dementia was requested, however, one was not provided.

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	245247	A. Building B. Wing	05/22/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review the facility failed to ensure unlicensed personnel did not administer injectable medications consistent with state requirements for 4 of 4 residents (R25, R28, R31, R35) who received insulin injections; and the facility failed to ensure medications were administered as ordered for 3 of 3 (R3, R16, R21) residents whose medications were omitted during medication pass and medication remained in the pharmacy return medication. Findings include: R25's significant Minimum Data Set (MDS) dated [DATE], identified R25 had severely impaired cognition. Diagnosis included diabetes mellitus and R25 received injectable medication seven days of the week. R25's Medication Administration Record (MAR) dated 5/1/24 through 5/21/24, included insulin glargine solution 100 units per milliliter (ml) administer 32 units subcutaneously (SQ) at bedtime. Novolog Flexpen 100 units per ml, administer 18 units SQ two times per day. The MAR identified certified clinical medical assistant (CCMA)-C administered the glargine insulin on 5/10/24 and the Novolog insulin on 5/6/24, 5/7/24, 5/8/24, 5/20/24 and 5/21/24. R28's quarertly MDS dated [DATE], identified R25 had intact cognition. Diagnosis included diabetes mellitus and R28 received injectable medication seven days of the week. R28's MAR dated 5/1/24 through 5/21/24, included insulin glargine solution 100 units per milliliter (ml), administer 15 units SQ at bedtime. The MAR identified CCMA-C administered the glargine insulin on 5/10/24. R31's annual MDS dated [DATE], identified R31 had intact cognition. Diagnosis included diabetes mellitus and R31 received injectable medication seven days of the week. R31's MAR dated 5/1/24 through 5/21/24, included insulin glargine solution 100 units per milliliter (ml), administer 10 units SQ at bedtime. The MAR identified CCMA-C administered the glargine insulin on 5/10/24. R35's quarterly MDS dated [DATE], identified R35 had moderately impaired cognition. Diagnosis included diabetes mellitus and R35 received injectable medication seven days of the week. R35's MAR dated 5/1/24 through 5/21/24, included insulin glargine solution 100 units per milliliter (ml), administer 33 units SQ at bedtime. Lispro insulin 100 unit per ml, administer 12 units in the evening. The MAR identified CCMA-C administered both the glargine and lispro insulins on 5/11/24 and 5/12/24. (continued on next page)

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	245247	A. Building B. Wing	05/22/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 5/21/24, at 11:00 a.m. CCMA-C stated she passed her exams as a certified clinical medical assistant in February 2024 and started working for the nursing facility in April 2024. Each state was different in what a CCMA could or could not do. CCMA's work was performed according to established rules and procedures with day to day supervision by a registered nurse (RN). Things like new assessments and neurological checks had to be performed with a nurse, as CCMA could not do assessments independently. CCMA did not have to have supervision of a nurse in the room in order to administer injections, blood sugar checks, blood draws or immunizations. An RN just needed to be in the building and available if CCMA needed them. Insulin and injections were within her scope of practice and she saw no reason not to continue to administer the medications as ordered. The administrator had told her to continue to administer medications as ordered as well. On 5/21/24, at 1:15 p.m. a joint interview with the director of nursing (DON) and administrator was conducted. The administrator stated she reviewed the literature regarding the allowed duties of the CCMA, which included medication administration and the administration of injectable medications. CCMA-C had received extensive training on both oral and injectable medication administration and CCMA always worked under RN supervision. National guidelines for nursing delegation indicated certified medical assistants could be taught to give injections. If the state statute does not allow her to administer injectable medications she would have to correct the CCMA job description The undated facility policy Injection (subcutaneous) identified basic responsibility as the licensed nurse for the purpose to inject a small quantity of medication under the skin. Minnesota State Statute 1570 4658.1325 subp. 5 Medications administered by injection may be given only by a physician, physician's assistant, registered nurse, nurse practitioner or licensed practical nurse or may be self administered by a resident. R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 had moderate cognitive impairment and diagnoses included depression, anxiety, chronic atrial fibrillation, hypertension, chronic obstructive pulmonary disease (COPD) and hypothyroidism. R3's Medication Administration Record (MAR) dated 5/1/24 through 5/21/24, identified medications and treatments prescribed by his primary MD. Medications included levothyroxine 175 micrograms (mcg) by mouth once in the morning. On 5/20/24, at 6:30 p.m. observation of medication cart revealed R3's Levothyroxine tablets remained in the morning medication card for the 5/12/24 and 5/15/24 morning medication pass. The medications were signed off as administered by licensed practical nurse (LPN)-A however, remained in the medication card, and not administered. During interview on 5/20/24, at 6:00 p.m. registered nurse (RN)-A stated all morning medications were setup by pharmacy in individual medication cards for each medication to be administered for each shifts. All medications in the am medication cards had been dispensed and were awaiting refill cards from the pharmacy, as it was the end of the two week fill cycle. New medication cards were to arrive that evening for the next two week cycle to begin the next day. R16's quarterly MDS dated [DATE], identified R16 had moderate cognitive impairment and diagnoses included Alzheimer's disease, dementia, anxiety, hypothyroidism, and history of transient ischemic attack and cerebral infarction. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16's MAR dated 5/1/24 through 5/21/24, identified medications and treatments prescribed by his primary MD. Medications included levothyroxine 50 mcg by mouth once in the morning. On 5/20/24, at 6:30 p.m. observation of medication cart revealed R16's levothyroxine tablets was missing a tablet and the card was completely empty and should not have been. During interview on 5/20/24, at 6:00 p.m. registered nurse (RN)-A stated if a tablet was missing out of the card, the nurse was suppose to indicate on the bubble pack that the pill had been wasted. There was no initial or explanation noted on the medication card to account for the missing tablet and there should have been. RN-A stated the pharmacy would have to be contacted to send out an extra tablet so R16 does not miss a dose. R21's quarterly MDS dated [DATE], identified R21 had intact cognition and diagnoses included heart failure, atrial fibrillation, hypertension, diabetes and hypothyroidism. R21's MAR dated 5/1/24 through 5/21/24, identified medications and treatments prescribed by her primary MD. Medications included levothyroxine 112 mcg by mouth once in the morning. On 5/20/24, at 6:30 p.m. observation of the medication cart revealed R21's levothyroxine tablets remained in the morning medication card for the 5/16/24 morning medication pass. The medication was signed off as administered by clinical certified medication assistant (CCMA)-C, however, remained in the medication card and not administered. When interviewed on 5/21/24, at 1:50 p.m. pharmacist (PharmD)-E stated they filled the pills at the nursing home on a two week cycle. When they deliver the new medication cards, they pull the old cards and return them to the pharmacy. When there are pills remaining in the cards they keep them for about six months incase they can recycle them to that resident and if unable to recycle them they get destroyed after the six months. She has been logging the pills remaining in the cards and sending the director of nursing (DON) the list but has not updated the log lately. If there are pills remaining in a residents medication card and there had been no medication changes, then that would be a missed medication administration. The pharmacy had only recently started taking the old cards back because they had a lot of medication cards with medications remaining in them and it was a big concern, so the pharmacy started taking the cards back. She had raised her concerns with the DON with not only the remaining medications in the medication cards but also having to replace missing medications for residents because the nursing home would run out of a residents medication before they should have and not able to find the missing medications. They were working on the problems, had just recently changed to a two week fill cycle and that had helped some. (continued on next page)

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	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kittson Healthcare	1010 South Birch Hallock, MN 56728

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 5/22/24, at 11:30 p.m. the DON stated the extra medications or missing medications from resident medication cards would be medication errors. The facility was aware of the issues with the medications and were trying to do better at tracking resident medications. She had implemented the policy for the nurses to initial and date each bubble on the bubble pack when administering each medication and was trying to get consistency on what order they were popping the pills out of the cards. She had identified the staff that were not consistently doing this and educated them. She has hired an RN resident care coordinator who would be helping her track medications as she knows the facility needs much improvement with medication administration. Missing medications or extra medications in resident medication cards were medication errors. We have a lot of new staff and that is part of the issue. She or RN-D has been going through the medication carts to try to figure out why there would be an extra or a missing pill for a resident and try to narrow down each incident to which nurse was responsible. She has the pharmacy letting he know when a resident is short medications and needs an extra fill. She felt some of the problems is it was to easy for the nurses to just call the pharmacy and get an extra fill when a resident had missing pills, so now they are instructed they can only order extra medications for a resident if it is a vital medication and it would need two nurses to sign off when a medication was short or could not be found and needed to order a short fill. The facility policy Medication Pass Delivery Policy identified the staff must follow the six rights of medication administration. Right medication, right dose, right route, right time, right resident and right documentation. The facility policy Medication Errors dated 4/19, identified medication errors included wrong drug, dose, route or time, omission,and unordered dose. The facility had a process to respond to actual or potential medication errors. All medication errors would be reviewed by the medical staff. The nurse who identified an error would document on an incident report form. all medication error reports would be reviewed by the DON and pharmacist and categorized according to severity.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on observation, interview and document review, the facility failed to ensure prescription eye drops were dated when opened to ensure expired product was not administered for 3 of 3 residents (R13, R23, R38) on 1 of 2 medication carts reviewed for medication storage. Findings include: On [DATE], at 6:00 p.m. a review was completed with registered nurse (RN)-A of two medication carts the facility used for their medication pass. The west medication cart identified the following eye drop vials: -R13's open vial of latanoprost had a dispensed date of [DATE]. The open date of the vial was not identified. -R23's open vial of latanoprost was dispensed from the pharmacy on [DATE]. The open date of the vial was not identified. -R38's open vial of latanoprost indicated it was dispensed on [DATE]. The open date of the vial was not identified. During interview on [DATE], at 6:30 p.m. RN-A stated when a new eye drop bottle or insulin was opened, an open date was written on the medication and a lot of the staff do not remember to do date when opened. RN-A was not sure when the eye drops in the medication cart had been opened and felt new vials should be ordered. During interview on [DATE], at 11:00 a.m. the director of nursing (DON) stated the expectation was for staff to record open dates on the medication bottles but not all the staff are doing it. The facility has a lot of new staff, and they were trying to make sure the new staff were trained in all areas by an RN. The facility's undated policy Medications with Shortened Expiration Dating Once Opened identified latanoprost eye drops would need to be discarded in 42 days once opened. According to Xalatan (latanoprost) website 2022, unopened latanoprost should be stored in the refrigerator and once opened, may be stored at room temperature for six weeks. The facility's undated policy Medication Storage in the Facility identified certain medications such as ophthalmic's, once opened, may require an expiration date shorter than the manufacturer's expiration date to ensure medication purity and potency. When the original seal of a manufacturer's container or vial was opened, the container or vial will be dated with a date opened sticker.

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	245247	A. Building B. Wing	05/22/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to implement timely transmission-based precautions (TBP) and testing for COVID-19 according to the Centers for Disease Control (CDC) for 4 of 4 residents (R31, R1, R12, R30) who were displaying COVID-19 symptoms; and failed to ensure enhanced barrier precautions (EBP) were implemented for an indwelling catheter for 1 of 1 resident (R38) reviewed for catheter care. Findings include: The Nursing Home Infection Control Log (Respiratory Only) updated 4/5/22, identified 8 (R1, R6, R12, R18, R28, R30, R31) residents who exhibited congested cough, chest congestion, shortness of breath, fever, aches, malaise and/or tiredness in the month of May 2024. The log identified all had tested negative for COVID-19. However, the log failed to identify the COVID-19 test type, if a confirmatory test was obtained and/or if isolation had been implemented. R31's undated Resident Face sheet, identified R31 was [AGE] years old, had hypertension, Type 2 diabetes and chronic kidney disease. R31's Resident Progress Notes identified the following: - On 5/19/24 at 2:17 p.m., R31's cough had worsened since yesterday and R31 had clear sputum production. Afebrile (without a fever). Covid test was negative. R31 was requesting to be seen in the clinic on 5/20/24. - On 5/19/24 at 4:29 p.m., despite not feeling well, R31 was still in a pleasant mood. R31 requested as needed cough medicine twice. R31 stated this did help with his cough. R31 rested in bed between meals. R31 was afebrile. - On 5/20/24 at 12:32 p.m., as needed cough syrup given per R31's request for cough. - On 5/21/24 at 9:56 a.m., as needed cough syrup given per R31's request for cough. R31 was to be seen by the provider during rounds. - On 5/21/24 at 1:29 p.m., as needed cough syrup given per R31's request for cough. R31 was to be seen by the provider during rounds. - On 5/22/24 at 4:14 a.m., R31 had a good night. Now on azithromycin (antibiotic) and gabapentin (a medicine used to treat partial seizures, nerve pain from shingles and restless leg syndrome). As needed cough syrup was administered once and was effective. R31's medical record failed to identify if R31 had a confirmatory COVID-19 test and/or if/when R31 had been placed in isolation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/21/24 at 9:45 a.m., R31 was sitting in the common area with 11 other residents in the room which was approximately 12 feet x 20 feet. R31 was unmasked and was observed coughing. R31 stated he reported his cough to nursing and had a COVID-19 test, which was negative. R31 stated he was going to be seen by the doctor to see what was going on. R1's Resident Face Sheet undated, identified R1 was [AGE] years old and diagnoses that included chronic kidney disease, chronic heart failure and Type 2 diabetes. R1's Resident Progress Notes identified the following: - On 5/4//24 at 3:216 p.m., R1 complained of shortness of breath (SOB) earlier today. Oxygen levels, respirations, and temperature were within normal limits. Slight wheezing heard to upper lobes when auscultated. Offered nebulizer treatment and R1 declined at that time. R1 ambulated throughout the facility and did well with her seated walker. No SOB was stated at those times. Will continue to monitor. Did not eat lunch today. R31 stated she felt well, just was not hungry for lunch. - At 3:31 p.m., COVID test completed and was negative. - On 5/14/24 at 11:06 a.m., R1 requested as needed cough syrup this morning, which was effective. No SOB. No signs or symptoms of infection. R1's medical record failed to identify if R1 had a confirmatory COVID-19 test and/or if/ when R1 had been placed in isolation. R12's Resident Face Sheet undated, identified R12 was [AGE] years old and had diagnoses that included atrial fibrillation (irregular heartbeat), and seizure disorder. R12's Resident Progress Notes identified the following: - On 5/2/24 at 11:37 a.m., R12 requested an as needed albuterol nebulizer treatment (relieves muscle tightening in the airways to help a person breathe) after R12 got dressed this morning. Nebulizer was given and effective. - On 5/3/24 at 3:22 p.m., R12 displayed signs/symptoms of COVID-19, was given a test and was negative. - On 5/4/24 at 1:49 p.m., R12's medical provider was contacted and an order for albuterol nebulizer was sent to the pharmacy. However, R12's medical record failed to identify if R12 had a confirmatory COVID-19 test and/or if he had been placed in isolation. R30's Resident Face sheet undated, identified R30 was [AGE] years old and had diagnoses that included dementia and hypertension. R30's Resident Progress Notes identified the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On 5/16/24 at 1:22 p.m., R30's husband requested R30 to be seen in the clinic for her cough that she has had for five to six days. Communication form faxed to clinic. R30 had been in a good mood today. Ate 75% at breakfast. As needed cough syrup given twice. - On 5/17/24 at 3:48 p.m., R30 had an appointment this morning with her physician to address the cough she has been having. R30's husband accompanied R30 to the appointment. R30 was prescribed azithromycin (an antibiotic), (500 milligrams (mg) first day, 250 mg daily for 4 more days) and titrated doses of methylprednisolone (a steroid) for 6 days. R30s medical record failed to identify if R12 had a confirmatory COVID-19 test and/or if/when R30 had been placed in isolation. During an interview on 5/21/24 at 11:19 a.m., the director of nursing stated as the month progresses, she would add residents to the log, but the campus-wide infection preventionist (IP) was ultimately responsible for tracking and trending of infections in the facility. The DON was responsible to ensure staff implemented transmission-based precautions when warranted. The DON stated there was no current COVID-19 positive residents or staff in the facility. The DON confirmed the residents listed on respiratory infection log were tested for COVID-19. Three residents (R6, R18 and R28) had a SARS-COV-2, Influenza A+B and/or RSV Nucleic Acid Testing Panel (multitarget molecular test that aids in simultaneous qualitative detection and differentiation of SARS-CoV-2 (COVID-19), influenza A, influenza B, and respiratory syncytial virus (RSV) viral RNA) completed in the emergency department but R31, R1, R12, R27, R30 were tested using the facility's antigen tests. The DON stated some residents may have stayed in their rooms by choice if not feeling well but this was not implemented by nursing because they did not want to isolate the residents. The DON stated was unaware of guidance to place a symptomatic resident into isolation until a confirmatory test could be obtained. The DON confirmed no symptomatic resident was placed into isolation. During an interview on 5/21/24 at 11:29 a.m., licensed practical nurse (LPN)-A stated if a resident was coughing, congested and/or had a fever or was sick, the first thing they did at the facility was to get a COVID test, then get a set of vitals. If the symptoms had just started, LPN-A would probably fill out a form and send it to the medical provider to see if the resident should be evaluated. If the COVID-19 was positive, the resident would be placed into isolation but, if negative, the resident would not be placed into isolation. No further testing would be done. The facility policy Management of Respiratory Illness updated 10/19/23, identified the use of well-fitting masks in healthcare settings are an important strategy to prevent the spread of respiratory viruses. Well-fitting masks can help block virus particles from reaching the nose and mouth of the wearer (wearer protection) and, if someone is ill, help block virus particles coming out of their nose and mouth from reaching others (source control). However, even when masking is not required by the facility, individuals should continue using a mask or respirator based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease if they are exposed. Evaluating Healthcare Personnel with Symptoms of SARS-CoV-2 Infection HCP with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays. (continued on next page)

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	245247	A. Building B. Wing	05/22/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. - If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT. - If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test. - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period. For HCP who were initially suspected of having COVID-19 but, following evaluation, another diagnosis is suspected or confirmed, return-to-work decisions should be based on their other suspected or confirmed diagnoses. However, the policy failed to provide direction for symptomatic residents who have a negative antigen test. The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 3/18/24, identified the decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a patient with symptoms of COVID-19 can be made based upon having negative results from at least one viral test. - If using NAAT (molecular) (A Nucleic Acid Amplification Test is a type of viral diagnostic test for SARS-CoV-2, the virus that causes COVID-19. NAATs detect genetic material (nucleic acids). NAATs for SARS-CoV-2 specifically identify the RNA (ribonucleic acid) sequences that comprise the genetic material of the virus), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and confirming with a second negative NAAT. - If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test. - If a patient suspected of having SARS-CoV-2 infection is never tested , the decision to discontinue Transmission-Based Precautions can be made based on time from symptom onset as described in the Isolation section below. Ultimately, clinical judgment and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions. 41575 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R38's admission Minimum Data Set (MDS) dated [DATE], identified R38 had intact cognition. Diagnoses included malignant neoplasm of male genital organs, benign prostate hyperplasia with lower urinary tract symptoms and obstructive and reflux uropathy. R38 had an indwelling urinary catheter and required moderate assistance to transfer to and from the toilet and maximal assistance with toileting hygiene. R38's care plan dated 4/17/24, identified R38 had an indwelling catheter due to history of cancer. The goal was for R38 to have his catheter care managed appropriately evidenced by not exhibiting signs of infection or trauma. The care plan did not identify enhanced barrier precautions or when to use personal protective equipment (PPE) when performing catheter care. On 5/21/24, at 11:58 a.m. nursing assistant (NA)-B entered R38's room to assist R38 to the dining room for lunch. NA-B gathered a urinal and alcohol pads and put on gloves in preparation to empty R38's leg bag. NA-B did not put on a gown. After wiping the leg bags port with alcohol swab, NA-B emptied the urine from the leg bag into the urinal and re-secured the tubing. NA-B emptied the urine into R38's toilet carried the urinal from the room to the soiled utility room. NA-B rinsed the urinal in the dirty utility room hopper, sprayed with a cleaning agent and then rinsed the urinal again. NA-B then dried the urinal with paper towels removed gloves performed hand hygeine, and returned it to R38's bathroom . When interviewed on 5/21/24 at 12:05 p.m. NA-B stated she had never put on a gown to perform catheter care. NA-B had been instructed to put on gloves and to wash their hands after removing gloves. NA-B was not instructed on using enhanced barrier precautions with R38. During interview on 5/21/24, at 12:45 p.m. the director of nursing (DON) stated staff had not been instructed on any enhanced barrier precautions related to catheter care. The DON had not heard of the new guidelines as they had been focusing on other areas and so enhanced barrier precautions was not on the facility radar. The Centers of Disease and Control Implementation of Personal Protective Equipment (PPE). Use in Nursing Homes to Prevent Spread of Multi-drug-resistant Organisms (MDROs) dated 4/2/24, identified residents in nursing homes were at increased risk of becoming colonized and developing infection with multiple drug resistant organisms. Focusing only on residents with active infection fails to address the continued risk of transmission from residents with MDRO colonization, who by definition have no symptoms of illness. MDRO colonization may persist for long periods of time (e.g., months) which contributes to the silent spread of MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. The facility's undated policy Catheter Care identified staff were to follow general infection control guidelines which directed staff to observe standard universal precautions or other infection control standards as approved by appropriate facility committee. Wash hands before and after all procedures and wear gloves when appropriate.

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	245247	A. Building B. Wing	05/22/2024

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to implement antibiotic stewardship protocols for 1 of 3 residents (R4) identified to have been taking an antibiotic. This had the potential to affect all 36 residents who were or may receive antibiotic therapy in the future. Findings include: The Nursing Home Infection Control Log updated 4/5/22, identified for May 2024, three residents R4, R6, R35 were diagnosed with urinary tract infection (UTI). Each resident was treated with an antibiotic. The log identified each resident had a urine culture completed, however, the log failed to identify the organism identified. R4's annual Minimum Data Set (MDS) dated [DATE], identified R4 had bladder cancer, chronic kidney disease, and UTI. R4's care plan revised 5/7/24, identified R4 had a diagnosis of bladder spasms and chronic kidney disease. R4 had recurring blood and blood clots in his urine, noted in his incontinent brief. Staff were directed to notify R4's medical provider and await orders. R4 had recurrent UTI's. Staff were also directed to monitor lab work as ordered by the medical provider. R4's Nursing Progress Notes identified the following: - On 5/3/24 at 10:38 a.m., R4 was screaming at the breakfast table. RN asked what was wrong and R4 said, I'm hurting in my penis, RN removed R4 from the dining room and completed an assessment. R4 noted to have blood dots in brief from NOC shift and blood dots in brief he was currently wearing. Vitals signs were stable. RN called provider and received verbal order for urinalysis (UA) and sent suspected infection form to clinic for provider signature. - On 5/3/24 at 3:36 p.m., R4 was hollering about pain in his penis. RN on shift got a verbal order for UA. Writer straight cathed R4 after lunch to obtain UA sample. - On 5/4/24 at 7:45 a.m., R4 complained of dysuria and fullness feeling. Tylenol and gabapentin (a medicine used to treat partial seizures, nerve pain from shingles and restless leg syndrome) were given because of pain. - On 5/4/24 at 1:10 p.m., buddy nurse spoke with provider regarding UA sent to lab. R4 positive for UTI. Provider E-scribed medication to pharmacy and nursing picked up medication and started first dose of Augmentin (antibiotic) 875-125 milligrams (mg) by mouth to be given every 12 hours for 5 days at noon today. - On 5/6/24 at 10:35 a.m., culture and sensitivity results back and sensitive to Augmentln. Physician noted continue as prescribed. R4's medical record lacked evidence of the UA culture results to compare for sensitivity to ensure the correct antibiotic was prescribed, the facility was unable to provide a copy. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/24 at 4:29 p.m., registered nurse (RN)-A stated R4 was not a good historian. R4 had copious amounts of blood and bloodclots in his incontinent brief. R4 would become confused and would holler out in pain. RN-A stated she had previously contacted the provider to see if R4 had a UTI. When RN-A started working at the facility RN-A did not receive an orientation. RN-A was supposed to and had a packet, but there was no one available. RN-A had learned the facility's processes from travel nurses, who also learn as they go. The director of nursing recently spoke to RN-A regarding calling the provider regarding R4's bleeding and UTI because he had a history of bladder cancer. There was supposed to be three symptoms before calling, but RN-A stated she felt that was undermining her nursing assessment skills. During an interview on 5/21/24 at 10:29 a.m., the director of nursing (DON) stated as the month goes on, she adds residents to the log. At the end of the month, she sends the log to the pharmacist and the campus IP nurse for review. Identified the log did not include organisms and stated she no longer had access to the clinic electronic medical record system and did not have access to the UA/UC results to fill in the organism. The DON stated nursing usually received a phone call or a fax from the clinic with the result and that's how they were sure the organism was sensitive to the antibiotic. The campus-wide Infection Preventionist (IP) followed the UA/UC results but kept those records and they were not available to the DON. The IP was not available for the entirety of survey due to a conference. Further, the DON stated the pharmacist did come to the interdisciplinary (IDT) meetings Monday through Friday and may report the organism to the DON, but the DON did not document that. The DON identified it would be important to document the organism to track fro trends. The facility Antibiotic Stewardship Policy reviewed 2/2023, identified it was the policy of the facility to maintain an Antibiotic Stewardship Program (ASP) with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use. Components of this policy were developed by using evidence-based practice guidelines and are aligned with the Core Elements of Antibiotic Stewardship for Nursing Homes, publishes by the CDC and the State Operations Manual. The Kittson Healthcare ASP will incorporate all seven core elements outlined by CDC. Details of each element are described in the Procedure section of this policy document. This Policy, including the Procedure section, will be reviewed yearly to ensure that all objectives and conditions are being met, to streamline procedures and algorithms, and to identify opportunities for enhancement of the ASP. The seven core elements of the Kittson Healthcare ASP are: I. Leadership Commitment: We will dedicate time, financial, and technological ASP resources. 2. Accountability: We will have physician, nursing, and pharmacy leads responsible for promoting and overseeing antibiotic stewardship activities. 3. Drug Expertise: We will establish and maintain access to a consultant pharmacist(s) or other individual with antibiotic stewardship-specific drug expertise. 4. Action: We will implement policies and practices to improve antibiotic use. 5. Tracking: We will monitor antibiotic use and outcome(s) from antibiotic use. (continued on next page)

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	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kittson Healthcare	1010 South Birch Hallock, MN 56728

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Reporting: We will provide regular feedback on antibiotic us and resistance to prescribing clinicians, nursing staff, and other relevant staff. The Minimum Criteria for Initiation of Antibiotics in Long-Term Care Residents reviewed 2/2023, identified when a provider should be contacted regarding a suspected UTI. For a resident with no indwelling catheter: acute dysuria (painful urination) or: fever (greater than 37.9 degrees Celcius (C) (100 degrees Fahrenheit (F)) or a 1.5 degree increase above baseline temperature) and at least one of the following: new or worsening: urgency, frequency, suprapubic pain, gross hematuria, costovertebral angle tenderness, and/or urinary incontinence. For a resident with an indwelling catheter (foley or suprapubic): at least one of the following: fever (greater than 37.9 degrees Celcius (C) (100 degrees Fahrenheit (F)) or a 1.5 degree increase above baseline temperature), new cosotvertebral tenderness, rigors and/or new onset of delirium. Note: foul smelling or cloudy urine is not a valid indication for initiating antibiotics. Asymptomatic bacteriuria should not be treated with antibiotics.