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	06/11/2025

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure there was a signed copy an advanced directive (identifying whether to do cardiopulmonary resuscitation (CPR) or do not resuscitate (DNR)) for 1 of 16 resident (R31) reviewed for advanced directives. Findings include: R31's quarterly Minimum Data Set (MDS) dated [DATE], identified R31 had no cognitive impairment. R31's undated face sheet, care plan dated [DATE], and the undated admission care plan checklist identified R31 was a DNR. R31's medical record did not have an advanced directive identifying a DNR status signed by R31or representative and the provider. During an interview on [DATE] at 2:36 p.m., R31 stated they wanted a DNR status. During an interview on [DATE] at 10:30 a.m., the director of nursing (DON) stated the process for when residents were admitted was a copy of signed provider orders and advanced directive were to be received upon admit. Residents who wanted CPR were identified on a list at the nurse's station and R31 was not on the list and would be treated as a DNR. The DON could not locate the advanced directive for R31 and stated it should have been completed and placed in the advanced directive book to be easily accessible. A policy related to advanced directives was requested but not received.

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

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

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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 0689 Level of Harm - 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** Based on observation, interview and document review the facility failed to ensure a transfer belt was used during a transfer for 1 of 2 residents (R30) reviewed for falls. This resulted in actual harm to R30 who sustained a left arm fracture. The facility implemented corrective action prior to the survey; therefore, the deficient practice was issued at past non-compliance. Findings include: R30's Fall Risk (Acuity) observation dated 7/16/24, identified R30 was at risk for falls. R30's quarterly Minimum Data Set (MDS) dated [DATE], identified R30 was cognitively aware and had diagnoses that included blindness, type 2 diabetes, and hypertension (high blood pressure). R30 required partial/moderate assistance (helper did less than half the effort. Helper lifted, held or supported trunk or limbs, but provided less than half the effort) to walk 50 feet with two turns. R30's Physical Therapy (PT) Caregiver Education dated 3/11/25, identified R30 was able to complete sit to stand transfers from recliner in room to participate in lower extremity strengthening program but R30 would continue to require stand by assist (SBA) (refers to a caregiving approach where a caregiver remains close to a patient to ensure safety without providing physical assistance. This means the caregiver is ready to intervene if the patient loses balance or needs help during a task.) of one staff to contact guard assist (CGA) (a technique used in occupational and physical therapy where the therapist maintains light physical contact with the patient, typically at the hips or trunk, to provide safety without offering direct support. This method helps with body stabilization and balance, acting as a safety net to prevent falls while allowing the patient to perform movements independently.) of one staff for all mobility in the facility. R30's care plan revised 4/25/25, identified R30 is at risk for deterioration in transfer, walking in room, and walking in corridor, related to being a new resident and being blind. R30 was supervision/part assist with walking. R30 did not do steps due to her blindness. Sit to stand, transfers CGA/partial/moderate with one for safety depending on weakness and risk for unsteady gait. R30's untitled nurse aide care sheet undated, identified R30 used a cane with a gait belt for walk to dine. R30's resident progress note dated 6/4/25 at 2:48 p.m., identified R30 had a witnessed fall at 1:50 p.m. in day area hall. R30 was ambulating with cane and SBA. R30 lost balance and landed on her left side on floor. Stated hope I didn't break my left arm again. Large protrusion (bump) with a skin tear noted on left elbow. Stated moderate pain in area. At first R30 was very anxious about fall and with staff offered calm approach and encouraged deep breathing. R30 calmed down. R30 was sent to the emergency room with staff assist for evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R30's resident progress note dated 6/9/25 at 2:27 p.m., R30 had a new diagnosis of left open ulnar (the ulna is a long bone found in the forearm that stretches from the elbow to the smallest finger, and when in anatomical position, is found on the medial side of the forearm. It runs parallel to the radius, the other long bone in the forearm, and is the larger and longer of the two) shaft fracture below elbow fusion hardware - due to fall last week - surgery completed on R30's left arm, R30 was not to remove dressing before follow up visit on 6/23/25. R30 was to be non-weight bearing with left upper extremity. Resident did not have any complications with surgery. During an interview on 6/9/25 at 2:02 p.m., R30 was sitting in her room recliner with her feet elevated. R30's left arm was wrapped in ace bandages, was in a sling and rested on a pillow. R30 stated she was walking in the hallway with a nursing assistant (NA) behind her and R30 really didn't know what happened but R30 and the NA could not catch her. R30 stated she broke her left arm and pointed to her forearm with her right hand. During an observation on 6/11/25 at 8:00 a.m., NA-B assisted R30 to walk to the dining room while NA-C followed behind with a wheelchair. R30 wore a gait belt around her waist and NA-B held onto the gait belt and remained close to R30. During an interview on 6/11/25 at 8:03 a.m., NA-B stated she was not at the facility when R30 fell but heard about it. R30 was walking with a nursing assistant, R30 stumbled and fell. NA-B stated she didn't know if R30 was wearing a gait belt or if the nursing assistant was holding the gait belt, but stated staff were expected to always use a gait belt when moving a resident to make it safe. During an interview on 6/11/25 at 8:04 a.m., NA-C stated she wasn't working when R30 fell and didn't know what happened. You always use a gait belt when you're walking someone. It just helps keep them steady in case the resident tripped. It was better to be safe than sorry. During an interview on 6/11/25 at 8:06 a.m., NA-D stated she was working the day R30 fell. NA-D was coming out of a room and heard a scream. R30 was walking with a nursing assistant and stumbled. You know how sometimes your feet stick to the floor? It was like that. NA-D stated she did not know if R30 was wearing a gait belt, but staff were always expected to use a gait belt when walking with a resident. During a phone interview on 6/11/25 at 8:18 a.m., registered nurse (RN)-B stated she was the nurse on duty the day R30 fell. RN-B was in the charting room when it happened. A nursing assistant was walking with R30 when it happened. RN-B stated she couldn't say if R30 was wearing a gait belt and/or if the nursing assistant was in close contact with R30 because she didn't see it happen. During an interview on 6/11/25 at 8:45 a.m., the director of nursing (DON) stated R30 was blind and was care planned to have CGA with walking. There was confusion to what CGA meant and the nursing assistant did not use a gait belt nor were they in close contact with R30. Since R30's fall, the DON had instructed staff to always use a gait belt for safety and had given education what SBA and CGA meant. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/11/25 at 10:00 a.m., a review of a surveillance video dated 6/4/25 at 1:54 p.m. to 1:55 p.m. was conducted with the DON. R30 was observed walking with a cane in her right hand with NA-A walking slightly behind her right side. R30 was not wearing a gait belt nor was NA-A in close proximity to R30. R30's stumbled and R30 fell forward, twisting on to her left side, landing on her left elbow/arm. The DON stated staff were expected to use gait belts and to follow care planned interventions to prevent/lessen the risk of falls. During an interview on 6/11/25 at 1:42 p.m., NA-A stated she was walking with R30 to the dining room for bingo and R30 lost her balance and fell. NA-A stated she tried to catch R30, but she just couldn't and R30 fell onto her left side. NA-A stated she didn't use a gait belt because R30 was steady and had never needed one. After R30's fall, the DON told staff they always had to use a gait belt when walking or moving residents for safety. The facility' corrective actions were confirmed through observation of staff using transfer belts along with staff interviews that identified staff knew to utilize a transfer belt for all transfers. The facility policy Fall Prevention Program revised 11/21, identified all staff members were responsible for implementing the intent and directives contained within this policy and creating a safe environment of care. Falls Prevention Plan: l. Universal fall precautions are to be implemented for all patients/residents admitted to Kittson Healthcare as they are aimed at keeping the care environment safe. Universal fall precautions include: a. Familiarize the patient with the environment. b. Have the patient demonstrate call light use. c. Maintain call light within reach. d. Keep the patient's personal possessions within patient safe reach. e. Have sturdy handrails in patient bathrooms, room, and hallway. f. Place the bed in a safe position when a patient is resting in bed; raise bed to a comfortable height when the patient is transferring out of bed. g. Keep bed brakes locked. h. Keep wheelchair wheel locks in locked position when stationary. i. Keep nonslip, comfortable, well-fitting footwear on the patient. j. Use night lights or supplemental lighting. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	k. Keep floor surfaces clean and dry. Clean up all spills promptly. l. Keep patient care areas uncluttered. m. Follow safe patient handling practices. II. An individualized care plan utilizing a multidisciplinary approach is to be created and implemented for each patient/resident identified as a fall risk. a. Members of the multidisciplinary team may include the attending physician, nursing, therapy, pharmacy, family, patient/resident or other members of the care team. b. The multidisciplinary team members will collaborate to address modifiable fall risk factors and implement interventions to try to minimize the consequences of risk that are not modifiable c. Interventions are to be patient/resident centered However, the policy failed to direct staff to use a gait belt with all resident transfers and/or ambulation.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure residents with attached bed rails were comprehensively assessed for use on the bed for 1 of 1 resident (R4) who had bed rails. Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 had no cognitive impairment and was independent with bed mobility and transfers. The MDS identified resident did not use bed rails. R4's Restraint/Adaptive Equipment assessment dated [DATE], did not identfiy bed rails or adaptive equipment was used. R4's medical record lacked an assessment to to include entrapment risk, risk versus benefits, consent, bed dimentions in relation to the residents height and weight and what alternatives were attempted or containdicated before installation. During observation on 6/9/25 at 2:53 p.m., R4 had half bed rails up and locked into position on both side of the upper half of the bed. On 6/11/25 at 1:22 p.m., R4's half side rails were observed were locked in the upright position on R4's bed. R4 stated they used the rails to reposition and assist with getting out of bed. The bed rails did not restrain R4's movement. During an interview on 6/11/25 at 3:06 p.m., registered nurse (RN)-A, who was MDS coordinator, stated restraint/adaptive equipment assessments were done when using bed rails. Since they were half bed rails or less, they did not do an assessment because resident was using them to reposition in bed and transfer out of bed. They did not do an assessment identifying if it was used as a bed rail or adaptive equipment. During an interview on 6/11/25 at 3:32 p.m., the director of nursing (DON) stated it was restraint free facility. When bed rails were used as restraints, a provider's order is required, and an assessment would be done and restraint policy followed but was not sure of what was done when bed rails for use for bed mobility and transfers. The facility's Physical Restraint Policy dated 6/18/24, identified bed rails should only be used when necessary for safety and with the consideration of the resident's ability to use them independently. Document how the restraint will address the medical need, enhance safety, and maintain the resident's physical and psychological well-being.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and document review, the facility failed to ensure the daily census was on the nurse staff posting. This had the potential to affect all 31 residents residing in the facility and/or visitors who may wish to view the information. Findings include: On 6/9/25 at 4:25 p.m., 6/10/25 at 1:03 p.m. and 6/11/25 at 7:17 a.m., the facility staff posting was observed hanging on the wall across from the nurse's station. The nurse staff posting included the date; the hours of shifts for day, evening and night shifts, the number of registered nurse (RN), licensed practical nurse (LPN) and nursing assistants (NA) with total and actual hours worked; however, the postings were missing the daily census. The nurse staff postings were reviewed from 5/1/25 through 6/8/25. The facility census was not recorded on 37 of 38 days reviewed. On 6/11/25 at 1:53 p.m., health unit coordinator (HUC)-A stated she reviewed the nurse schedule and documented the information on the daily nurse staff posting and the director of nursing (DON) signed off on the form. HUC-A stated she was trained from the previous person but was not trained to document the census on the form. HUC-A stated the census is documented on a white board in the nurse's area, although it was not in a place visible by the residents and/or families. On 6/11/25 at 2:12 p.m., the DON stated she approved the nurse staff posting after the HUC completed the form. The form identified what staff were working, how many RN, LPN, and NA hours per shift, and hours per shift/day. The DON stated although the form should include the resident census, the previous staff had not filled in the census number and therefore, she or HUC-A had not documented the census number on the form. The DON stated the census was not written anywhere within the facility that was visible to the residents and/or visitors. A nurse staff posting policy was requested but not received.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and document review the facility failed to ensure medications were administered according to manufacturers instructions for 1 of 1 residents (R31) observed during medication administration. Findings include: R31's quarterly Minimum Data Set, dated [DATE], identified R31 was cognitively intact and had a diagnosis of diabetes. R31's physician orders report dated 5/11/25 through 6/11/25, identified R31 received Lantus insulin 34 units every morning, Novolog insulin 7 units every morning, 14 units every lunch time and 7 units every evening. R31's care plan dated 3/5/25, identified R31 received insulin related to diabetes. The goal identified R31 would safely receive insulin injections per doctors orders. The nursing approaches included monitoring R31 for signs and symptoms of hypo/hyperglycemia. On 6/10/25 at 6:46 p.m., licensed practical nurse (LPN)-B was observed to prepare insulin for R31. LPN-B scrub the hub of the Novolog FlexPen with alcohol pad and then attach a sterile needle to the hub. LPN-B dialed 7 units of insulin and started to enter R31's room. Upon surveyor intervention and questioning, LPN-B stated she was instructed that she did not need to prime the insulin pen after the initial use. LPN-B stated she always placed a new needle on the insulin pens prior to use and had never primed the new needle prior to administering the insulin. LPN-B reviewed the manufacturer's instructions for Patient Information Insulin Aspart which included a section titled Preparing your Insulin Aspart FlexPen with picture diagrams and written explanations. The instructions identified giving an airshot of 2 units insulin before each injection. LPN-B stated she had not primed the pen with 2 units prior to administering the insulin to R31. On 6/10/25 at 7:04 p.m., RN-C stated when preparing to give insulin to a resident, she wasted 2 units prior to drawing up the residents ordered dose of insulin. RN-C stated she wasted 2 units to ensure the needle was full with medication to ensure the resident received the correct dose of insulin. On 6/11/25 at 8:38 a.m., director of nursing (DON) stated per facility policy staff are instructed to always prime an insulin pen prior to administering insulin to a resident. The facility Insulin Pen Administration Policy reviewed 4/28/24, identified the policy purpose was to ensure the safe, accurate, and hygienic administration of insulin using insulin pens for patients requiring insulin therapy. The policy applied to all licensed nursing staff and other healthcare professionals authorized to administer medications at the facility. The Insulin Aspart manufacturers instructions included the following instructions to prepare the insulin pen: - Turn the dose selector 2 units (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Hold the insulin pen with the needle pointing up. Tap the cartridge gently with your finger a few time to make any air bubls collect at the top of the cartridge - Keep the needle pointing upwards, prss the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. Inyou do not see a drop of insuling after 6 times, do not use the Insulin pen and contact Novo Nordisk. A small air bubble may remain at the needle tip, but it will not be injected - select the dose of insulin

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits for vaccinations being offered along with offering the most recent pneumococcal vaccine for 3 of 5 residents (R24, R28, R31) reviewed for immunizations. Findings include: R24: R24's quarterly Minimum Data Set, dated [DATE], identified R24 was [AGE] years old and admitted on [DATE]. R24 was cognitively intact, and diagnoses included dementia and atrial fibrillation. R24's immunization record dated 6/11/25, identified R24 received Pneumo-poly (PPSV-23) on 2/3/2015, and Pneumo-conjugate (PVC-13) on 6/24/20. R24's vaccination consent form dated 9/7/24, included consent for influenza and COVID-19, however, the form failed to identify if R24 received Vaccine Information Statements (VIS), risk/benefits of the pneumococcal vaccine. R24's medical record failed to identify if R24 was offered, or given/declined the PCV20 or PCV21 vaccine. R28: R28's admission MDS dated [DATE], identified R28 was [AGE] years old and admitted on [DATE]. The assessment identified R28 was cognitively intact, and diagnoses included seizure disorder and traumatic brain injury. R28's immunization record dated 6/11/25, identified R28 received PPSV23 vaccine on 2/12/13, and PCV-13 vaccine on 1/12/15. R28's vaccination consent form dated 2/10/25, identified R28 previously received pneumococcal vaccine, however, the form failed to identify which pneumococcal vaccine was administered and what education was provided and discussed. R28's medical record failed to identify if R28 was offered, or given/declined the PCV20 or PCV21 vaccine. R31: R31's quarterly MDS dated [DATE], identified R31 was [AGE] years old and admitted on [DATE]. The assessment identified R31 was cognitively intact, and diagnoses included heart disease, kidney failure, and diabetes. R31's immunization record dated 6/11/25, identified R31 received the PPSV23 vaccine on 1/16/13. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31 preventative health care report dated 2/27/25 through 6/11/25, identified R31 received PCV13 vaccine on 10/26/15. R31's vaccination consent form dated 2/7/25, identified R31 declined the COVID-19 vaccine, although the form failed to identify if R31 received the VIS or risk/benefits of the pneumococcal vaccine. R31's medical record failed to identify if R31 was offered, or given/declined the PCV20 or PCV21 vaccine. The facility standing orders dated 8/8/24, included orders to administer pneumococcal vaccine (Prevnar 13) if not previously given and upon consent from resident or surrogate. On 6/11/25 at 10:48 a.m., registered nurse (RN)-A stated upon admission the residents Minnesota Immunization Information Connection (MIIC) report was reviewed and the admitting nurses were notified which vaccines the resident would need. RN-A stated vaccines, including pneumococcal, influenza and COVID-19, were offered on admission and annually. On 6/11/25 at 3:52 p.m., RN-D stated prior to admission, the provider reviews and recommends vaccines for the resident. The admitting nurse is notified which vaccines should be discussed with the resident and/or family and administered to the resident upon admission. RN-D stated there was a policy in place for vaccinations upon admission, although, the facility is lacking a process to re-evaluate current residents' pneumococcal vaccination status. On 6/11/25 at 4:17 p.m., the director of nursing (DON) stated staff review and offer vaccinations to the resident and/or families upon admission. The facility standing orders include orders to administer pneumococcal vaccine Prevnar 13 if not previously given and upon consent from the resident and/or family. The DON stated current residents' vaccination status was reviewed and vaccines are offered annually during their care conferences, although, there was not a procedure in place to catch the current residents for the new pneumococcal vaccines prior to their annual care conference. The facility Pneumococcal Vaccine Program reviewed 5/25, identified it was the policy of the facility that residents would be offered immunization/s against pneumococcal disease in accordance with Advisory Committee on Immunizations Practices (ACIP) recommendation. Pneumococcal disease is a serious illness that can cause sickness and even death. The purpose of the policy was to reduce the incidence of pneumococcal disease, and the morbidity and mortality attributed to the infection. The policy identified residents would be offered vaccinations based on the CDC and ACIP recommendations and physician orders. The policy further identified the facility would utilize the Adult Immunization Schedule, prepared by the CDC, to ensure residents were offered and encouraged to adept the appropriate vaccinations, and the determination to vaccinate or not would be documented in the residents electronic medical record.