| | | | | | AND TRANSMITTAL TE SURVEY AGENCY | | ID: 16M8 Facility ID: 00002 | |
|---|---------------------------------------|--|---|-------------------------|---|--|---|--|
| 1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245119 2.STATE VENDOR OR MEDICAID NO. (L2) 231247600 | | NAME AND ADDRESS OF FACILITY 3) AITKIN HEALTH SERVICES 4) 301 MINNESOTA AVENUE SOUTH 5) AITKIN, MN | | | (L6) 56431 | 4. TYPE (1. Initial 3. Termi 5. Valida | DF ACTION: <u>7 (</u> L8) 2. Recertification ination 4. CHOW | |
| 5. EFFECTIVE DATE CHANGE OF O' (L9) 07/01/2006 6. DATE OF SURVEY 11/0 | 0 | PROVIDER/SU Hospital SNF/NF/Dual | JPPLIER CATEGC 05 HHA 06 PRTF | ORY 09 ESRD 10 NF | <u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF | 7. On-Sit 8. Full S | te Visit 9. Other urvey After Complaint | |
| 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other | (L10) 0 | 3 SNF/NF/Distinct 4 SNF | 07 X-Ray 08 OPT/SP | 11 ICF/IID 12 RHC | 15 ASC 16 HOSPICE | | AR ENDING DATE: (L35) 6/30 | |
| 11LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12.Total Facility Beds | 44 (L18) | X A. In Complia Program Compliar 1. | Requirements nce Based On: Acceptable POC | | And/Or Approved Waivers Of 7 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code | 6. \$ 7. 1 NF)8. 1 | uirements: Scope of Services Limit Medical Director Patient Room Size Beds/Room | |
| 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDO | | Requirements | ompliance with Prog and/or Applied Wa | - | * Code: A* 15. FACILITY MEETS | (L12) | | |
| 18 SNF 18/19 SNF 44 (L37) (L38) | 19 SNF (L39) | ICF (L42) | IID (L43) | | 1861 (e) (1) or 1861 (j) (1): | (| L15) | |
| 16. STATE SURVEY AGENCY REMA | RKS (IF APPLICABLE SI | HOW LTC CANC | CELLATION DATE | 2): | | | | |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SURVEY AGENCY | APPROVAL | Date: | |
| Brenda Fischer, Unit | Supervisor | | 12/13/2017 | (L19) | Anne Peterson, Enforcement Specialist 01/18/2018 | | | |
| I | PART II - TO BE C | OMPLETED | BY HCFA R | EGIONAI | OFFICE OR SINGLE S | TATE AGEN | CY | |
| DETERMINATION OF ELIGIBILI' X1. Facility is Eligible to I 2. Facility is not Eligible | Participate | | MPLIANCE WITH IGHTS ACT: | CIVIL | Statement of Fin Ownership/Cont Both of the Abov | rol Interest Disclos | ICFA-2572) sure Stmt (HCFA-1513) | |
| 22. ORIGINAL DATE | 23. LTC AGREEMEN | | 24. LTC AGREEM | | 26. TERMINATION ACTION: | | (L30) | |
| OF PARTICIPATION 03/09/1967 | BEGINNING DA' | ſE | ENDING DAT | ΓE | VOLUNTARY 01-Merger, Closure | <u>)0</u> | INVOLUNTARY 05-Fail to Meet Health/Safety | |
| (L24) | (L41) | | (L25) | | 02-Dissatisfaction W/ Reimburser | | 06-Fail to Meet Agreement | |
| 25. LTC EXTENSION DATE: | 27. ALTERNATIVE S A. Suspension of | | (L44) | | 03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal | | OTHER 07-Provider Status Change 00-Active | |
| (L27) | B. Rescind Suspen | sion Date: | (L45) | | | | | |
| 28. TERMINATION DATE: | 29. II | ITERMEDIARY/ | | | 30. REMARKS | | | |
| | | 03001 | | (1.21) | Posted 01/24/2018 Co. | | | |

| | (-) | | | |
|----------------------------|-------|----------------------|---------------|------------------------|
| 31. RO RECEIPT OF CMS-1539 | | 32. DETERMINATION OF | APPROVAL DATE | |
| | | 11/16/2017 | | |
| | (L32) | 11/10/2017 | (L33) | DETERMINATION APPROVAL |

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245119

December 13, 2017

Ms. Michelle Hanneken, Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, MN 56431

Dear Ms. Hanneken:

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

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

Effective October 27, 2017 the above facility is recommended for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Retenson

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 13, 2017

Ms. Michelle Hanneken, Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, MN 56431

RE: Project Number S5119025

Dear Ms. Hanneken:

On October 6, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 21, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On November 6, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 7, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 21, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 27, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 27, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 21, 2017, effective October 27, 2017 and therefore remedies outlined in our letter to you dated October 6, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Anne Retension -

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 21, 2017

Ms. Michelle Hanneken, Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, MN 56431

Subject: Aitkin Health Services - IDR CMS Certification Number (CCN): 245119 Project Number: S5119025

Dear Ms. Hanneken:

This is in response to your email dated October 9, 2017, in regards to your request for an informal dispute resolution (IDR) for the federal deficiencies at tags F250 and F278, issued pursuant to the survey event 16M811, completed on September 21, 2017.

The information submitted by the facility, the CMS 2567 dated September 21, 2017 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F250 (S/S D) 42 CFR § 483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE

Summary of the facility's reason for IDR of this tag:

The facility states that documentation submitted for review, shows a timeline of continued attempts to assist R56 with discharge planning when therapy completed a home visit and recommended 24 hour supervision in preparation for discharge from the facility.

Summary of facts.

R56 resided independently at home prior to admission to the facility. After an accident occurred, R56 admitted to the facility for rehab. A careplan, with start date of 6/14/17, identified a discharge plan would be developed by the interdisciplinary team (IDT) including physician. A 30-Day Minimum Data Set (MDS) identified there was, "an active discharge plan" in place for R56 to return to the community. Facility progress notes from 7/1/17 through 7/17/17 consistently identified R56 continued with skilled therapies to work towards discharge goals. On 7/13/17, a home visit was conducted by therapy and recommendations were made for 24 hour supervision at home or an Assisted Living Facility (ALF).

Aitkin Health Services Page 2

On 7/17/17, R56 was informed that he would no longer be receiving care at a skilled level and therapy would be discontinued on 7/19/17. R56 was given a Medicare denial notice at this time.

Facility progress notes dated 7/17 and 7/18/17, identified R56 was independent with activities of daily living. A 7/19/17 progress note indicated R56 was able to self-propel throughout the facility, had a good appetite, and was compliant. On 7/20/17, R56 remained at the facility with no justification as to why he was not being discharged. There was no evidence that 24 hour supervision in R56's home or alternative placement to an ALF had been pursued. From 7/20/17 to 8/24/17 there was no evidence of the facility actively seeking alternative placement for R56. A progress note entry dated 8/24/17, identified an IDT meeting had been held. Although the note indicated R56 had medical assistance pending, which would need to be in place prior to placement at assisted living, there was no indication that a discharge plan had been discussed.

In addition to recommendations made by therapy on 7/13/17 for R56 to discharge from the facility with 24 hour supervision or ALF, an Aitkin Health Services Consult Report dated 8/11/17 identified R56 was encouraged to try assisted living. Another Aitkin Health Service Progress Note, dated 8/17/17, identified R56 reported being seen by a Dr. last week, "which he in fact did" and is wondering if he will be able to go to assisted living. Although additional recommendations were made and R56 questioned if he would be moved to ALF, R56 remained in the facility, with no documentation provided to show that discussions related to discharge or continuous attempts to assist R56 with discharge planning had been initiated between the time period of 7/20/17 and 8/24/17.

Summary of findings:

Recommendations from therapy were made for 24 hour supervision or ALF. There was no evidence that 24 hour supervision in R56's home or alternative placement to an ALF had been pursued. From 7/20/17 to 8/24/17 there was no evidence of the facility actively seeking alternative placement for R56.

This is a valid deficiency at this tag and at the correct scope and severity of (D).

F278 (S/S D) 42 CFR § 483.20(g-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

Summary of the facility's reason for IDR of this tag.

The facility states the assessment is accurate, resident (R)53 is frequently incontinent of bladder and is on a toileting plan. Toileting plan and current interventions are appropriate for R53 who is frequently incontinent based upon the assessment. The MDS was not an inaccurate assessment but simply a coding error in which the wrong button was clicked.

Summary of facts.

The Federal Regulation for F278 states under 483.20:

(g): Accuracy of Assessments: The assessment must accurately reflect the resident's status.

(h) Coordination: A registered nurse must conduct or coordinate each assessment with the appropriate

Aitkin Health Services
Page 3
participation of health professionals.
(i) Certification:
(1) A registered nurse must sign and certify that the assessment is completed.
(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Summary of findings

The facility failed to accurately code urinary incontinence on the Minimum Data Set (MDS) for R53.

This is a valid deficiency at this tag and at the correct scope and severity of (D).

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Susanne Reuss

Susanne Reuss, Unit Supervisor Licensing and Certification Program Health Regulation Division Telephone: 651-201-3793

cc: Office of Ombudsman for Long-Term Care
 Maria King, Assistant Program Manager
 Licensing and Certification File
 Brenda Fischer, Duluth District Office Unit Supervisor

| DEPARTMENT OF HEALT | | | | | | EDICARE & MEDICAID SERVICES |
|--|------------------------|--------------------------------------|-------------------------------|------------------|---|---|
| | | | | | AND TRANSMITTAL | ID: 16M8 |
| | PART I | - TO BE COME | PLETED BY | THE STAT | TE SURVEY AGENCY | Facility ID: 00002 |
| 1. MEDICARE/MEDICAID PROVIDE (L1) 245119 | ER NO. | 3. NAME AND AL (L3) AITKIN HE | | | | 4. TYPE OF ACTION: <u>2 (</u> L8) 1. Initial 2. Recertification |
| 2.STATE VENDOR OR MEDICAID NO |). | (L4) 301 MINNE | SOTA AVENU | E SOUTH | | 3. Termination 4. CHOW |
| (L2) 231247600 | | (L5) AITKIN, M | N | | (L6) 56431 | 5. Validation 6. Complaint |
| 5. EFFECTIVE DATE CHANGE OF O | WNERSHIP | 7. PROVIDER/SU | | | <u>02</u> (L7) | 7. On-Site Visit 9. Other 8. Full Survey After Complaint |
| (L9) 07/01/2006 | 31/3015 (1.24) | 01 Hospital 02 SNF/NF/Dual | 05 HHA 06 PRTF | 09 ESRD 10 NF | 13 PTIP 22 CLIA | |
| DATE OF SURVEY 09/2 ACCREDITATION STATUS: | 21/2017 (L34) (L10) | 02 SNF/NF/Duai 03 SNF/NF/Distinct | 06 FK1F 07 X-Ray | 10 NF | 14 CORF 15 ASC | FISCAL YEAR ENDING DATE: (L35) |
| O Unaccredited 1 TJC | (L10) | 03 SNF/NF/Distillet 04 SNF | 07 A-Ray 08 OPT/SP | 12 RHC | 16 HOSPICE | 06/30 |
| 2 AOA 3 Other | | 0.5.0 | 00 01 1/01 | | 10 11001102 | |
| 11LTC PERIOD OF CERTIFICATION | 1 | 10.THE FACILITY | IS CERTIFIED A | AS: | | |
| From (a): | | A. In Complia | | | And/Or Approved Waivers Of Th | e Following Requirements: |
| To (b) : | | | Requirements nce Based On: | | 2. Technical Personnel | 6. Scope of Services Limit |
| | | | | | 3. 24 Hour RN | 7. Medical Director |
| 12.Total Facility Beds | 44 (L18) | 1. | Acceptable POC | | 4. 7-Day RN (Rural SNF | 8. Patient Room Size |
| 13.Total Certified Beds | 44 (L17) | X B. Not in Co | ompliance with Pro | gram | 5. Life Safety Code | 9. Beds/Room |
| | | | and/or Applied W | • | * Code: B * | (L12) |
| 14. LTC CERTIFIED BED BREAKDO | WN | | | | 15. FACILITY MEETS | |
| 18 SNF 18/19 SNF | 19 SNF | ICF | IID | | 1861 (e) (1) or 1861 (j) (1): | (L15) |
| 44 | | | | | | |
| (L37) (L38) | (L39) | (L42) | (L43) | | | |
| | | | | | | |
| 16. STATE SURVEY AGENCY REMA | AKKS (IF APPLICABL | E SHOW LTC CANC | ELLATION DATI | E): | | |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SURVEY AGENCY A | APPROVAL Date: |
| Austin Fry, HFE-NE I | I | 10/: | 23/2017 | (L19) | Anne Peterson, Enfo | cement Specialist 11/13/2017 |
|] | PART II - TO BE | COMPLETED | BY HCFA R | EGIONAI | OFFICE OR SINGLE ST | ATE AGENCY |
| 19. DETERMINATION OF ELIGIBILI | ITY | | MPLIANCE WITH | I CIVIL | 21. 1. Statement of Finar 2. Ownership/Control | cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) |
| X 1. Facility is Eligible to | Participate | K | IOITIS ACT. | | 3. Both of the Above | |
| 2. Facility is not Eligibl | | | | | | |
| | (L21) | | | | | |
| 22. ORIGINAL DATE | 23. LTC AGREEM | ENT | 24. LTC AGREE | MENT | 26. TERMINATION ACTION: | (L30) |
| OF PARTICIPATION | BEGINNING | DATE | ENDING DA | TE | VOLUNTARY 00 | INVOLUNTARY |
| 03/09/1967 | | | | | 01-Merger, Closure | 05-Fail to Meet Health/Safety |
| (L24) | (L41) | | (L25) | | 02-Dissatisfaction W/ Reimburseme | ent 06-Fail to Meet Agreement |
| 25. LTC EXTENSION DATE: | 27. ALTERNATI | VE SANCTIONS | (-/ | | 03-Risk of Involuntary Termination | OTHER |
| 23. ETC EXTENSION DATE. | | of Admissions: | | | 04-Other Reason for Withdrawal | 07-Provider Status Change |
| | 1 | | (L44) | | | 00-Active |
| (L27) | B. Rescind Sus | pension Date: | | | | |
| | | | (L45) | | | |
| 28. TERMINATION DATE: | 29 | . INTERMEDIARY/ | CARRIER NO. | | 30. REMARKS | |
| | | 03001 | | | | |
| | (L28) | | | (L31) | | |
| 31. RO RECEIPT OF CMS-1539 | 20 | . DETERMINATION | | DATE | | |
| 51. KO KECEH I OF CM5-1559 | | . DETERMINATION | OF ALL KOVAL I | | | |
| | (L32) | | | (L33) | DETERMINATION APPR | OVAL |



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 6, 2017

Ms. Michelle Hanneken, Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, MN 56431

RE: Project Number S5119025

Dear Ms. Hanneken:

On September 21, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor St. Cloud A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: brenda.fischer@state.mn.us Phone: (320) 223-7338 Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 31, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 21, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 21, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

> Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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

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

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>mark.meath@state.mn.us</u> Phone: (651) 201-4118 Fax: (651) 215-9697

| | | AND HUMAN SERVICES | | FORM | APPROVED |
|--------------------------|---|--|---------------------|---|----------------------------|
| | | & MEDICAID SERVICES | | | . 0938-0391 |
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E SURVEY IPLETED |
| | | 245119 | B. WING _ | | 21/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| AITKIN H | EALTH SERVICES | | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENT | ſS | F 00 | 0 | |
| | was completed by s Department of Hea compliance with the | /17, a recertification survey surveyors from the Minnesota Ith (MDH) to determine e regulations at 42 CFR Part uirements for Long Term Care | | | |
| | as your allegation o Department's accept enrolled in ePOC, y at the bottom of the | f correction (POC) will serve f compliance upon the otance. Because you are rour signature is not required first page of the CMS-2567 nic submission of the POC will tion of compliance. | | | |
| F 176 SS=D | on-site revisit of you validate that substa regulations has bee your verification. 483.10(c)(7) RESID | acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with DENT SELF-ADMINISTER D SAFE | F 17 | 6 | 10/27/17 |
| | the interdisciplinary §483.21(b)(2)(ii), hapractice is clinically | elf-administer medications if team, as defined by as determined that this appropriate. NT is not met as evidenced | | | |
| | Based on observat review, the facility fa had been conducte medications for 1 o | ion, interview and document ailed to ensure an assessment d for self-administration of f 1 residents (R29) who's unattended at the table in the | | AHS ensures that an assessment is conducted by the IDT team for self-administration of medications for those individuals who wish to self-administer medications to determine if clinically appropriate. | |
| | Findings include: | | | R29 had a medication self-administration | |
| LABORATORY | DIRECTOR'S OR PROVID | ER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | TITLE | (X6) DATE |
| Electron | ically Signed | | | | 10/16/2017 |

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.

PRINTED: 10/23/2017

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 10/23/2017 APPROVED 0938-0391 |
|--------------------------|---|---|--------------------|-----|---|---|-------------------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245119 | B. WING | | | 09/2 | 21/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| AITKIN H | EALTH SERVICES | | | | 01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 176 | dated 7/17/17, india intact. R29's Face Sheet, diagnosis of atrial fi heart's two upper cl coordination with th heart). R29's Physician Ora included orders for treat atrial fibrillation Thursday and Cour days of the week so start date of 8/30/17 During observation registered nurse (R paper cup, with one side of R29's place room. RN-A told R2 out of the dining roo The medication car dinning room to the threshold. The medi table was not visible seated with three of | imum Data Set assessment, cated R29's cognition was printed 9/19/17, included a brillation (condition when the hambers beat out of e two lower chambers of the der sheet, printed 9/19/17, Coumadin (blood thinner to n) 2.5 milligrams (mg) daily on nadin 5 mg daily on all other cheduled for 5:00 p.m. with a 7. on 9/18/17, at 5:18 p.m. N)-A placed a small white e oval peach pill, on the right mat on the table in the dining 29 here's your pill and walked om back to medication cart. t was located outside the right of the dinning room e from the cart. R29 was ther male residents at this | F 1 | 176 | assessment completed on 4/14/20 noted resident does not wish to self-administer medications. Nursin to store, document, and administer medications. Re-assessment comp on 10/9/17 which indicates that resi does not wish to self-administer. R educated on 9/18/17 regarding proc medication administration and proc and procedure for self-administration medications. All residents who are not able to self-administer medications have the potential to be affected by this defice practice. The Self-Administration of Medication Aides regarding medication administ process and self-administration of medication policy and procedure. The include education on staying with residents who are not able to self-administer until medication is ingested. | ng staff oleted ident N-A cess of ess on of ne cient on ed. ed in stration | |
| | table in the dining re closed. The medica the cup until 5:22 p. room, woke up R29 from the cup which room table. When interviewed of | R29 remained seated at the born, however, his eyes were ation remained on the table in .m. when RN-A entered dining and administered the pill had been left on the dining on 9/18/17, at 6:54 p.m. RN-A | | | All residents who wish to self-admir medications have been assessed for safety to do so. Assessment findings are document EMR and implemented on care plan charts have been reviewed and are compliance. SAM assessments are reviewed quarterly for continued appropriateness. | or ted in n. All e in | |
| | stated medications | were only to be left with | | | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 10/23/2017 APPROVED 0938-0391 |
|--------------------------|---|---|---------------------|----|--|--------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
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| NAME OF | PROVIDER OR SUPPLIER | - | | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | IEALTH SERVICES | | | | 01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | ĸ | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 176 | administer medicat stated R29 shouldn medication and req with the resident un consumed. When interviewed of licensed practical n those residents with self-administer medi unattended with medication During an interview registered nurse (R assessed to safely RN-D stated R29 s to self-administer h During an interview 3:00 p.m. LPN-A loc Administration Rec of the pill and time of LPN-A stated R29's unattended at the d was Coumadin as t that was scheduled When interviewed of director of nursing s been left unattende should have stayed medication was cor The facilities undate Medication by Residuals | known to be able to ion independently. RN-A also ion independently. RN-A also i't have been left alone with the uired that the nurse to stay still the medication was on 9/19/17, at 1:25 p.m. urse (LPN)-A stated only in an assessment to dications can be left edications. on 9/19/17, at 2:10 p.m. N)-D stated R29 was not self- administer medication. is medication. on 9/19/17, at approximately oked at the Medication ord. Based on the description of scheduled administration, is oval peach pill that was left lining room table on 9/18/17 his was the only medication I during the supper hour. on 9/19/17, at 2:16 p.m. the stated R29 should not have bed with medication and staff with the resident until the | F1 | 76 | DON or Designee will complete aud medication administration 3 X week weeks, Weekly X 4 weeks, 2 X mod 2 months. Audit results will be brou Qapi for further review and recommendations. | kly X 4 nthly X | |

| | | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | | TIPLE CONSTRUCTION | 1 | 0938-039 SURVEY | |
|--------------------------|---|--|---------------------|--|---|---------------------------|--|
| | OF DEFICIENCIES OF CORRECTION | IDENTIFICATION NUMBER: | | NG | · · · | E SURVEY PLETED | |
| | | 245119 | B. WING _ | | 09/2 | 09/21/2017 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COL | DE | | |
| AITKIN H | IEALTH SERVICES | | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE | |
| F 241 SS=D | 483.10(a)(1) DIGNI INDIVIDUALITY | TY AND RESPECT OF | F 24 | 41 | | 10/27/17 | |
| | resident in a manner promotes maintena her quality of life re- individuality. The fa promote the rights of This REQUIREMEN by: Based on observat review, the facility fa privacy was mainta 1 residents (R66) o undergarments visi residents, visitors a Findings include: R66's admission M 9/4/17, identified R6 impairment, display and required extens activities of daily livi identified R66 had o | NT is not met as evidenced tion, interview and document ailed to ensure personal ined to promote dignity for 1 of bserved with bare skin and ble from the hallway to other nd staff. inimum Data Set (MDS) dated 66 had moderate cognitive red no disorganized thinking, sive assistance for most ing (ADLs). Further, the MDS boccasional urinary with depression, | | AHS ensures that all resident treated and cared for in a man promotes maintenance or en- her quality of life recognizing of resident's individuality. AHS p and protects the right of the re- includes ensuring personal pr maintained to promote dignity A privacy curtain has been ins R66's room to allow resident the hallway with the curtain pa so that he can lay in bed in will garments he chooses while si to see out in the hallway per h preference of door being open | nner that nances his or each promotes esident. This ivacy is stalled in to see out in artially pulled natever till being able ns n. R66 | | |
| | Pulmonary Disease Disease." During observation was laying in bed in wide open, and fully had a fan running a sheet on top of him pulled down past hi knees exposing his gray colored incont | "Asthma, Chronic Obstructive e [COPD], or Chronic Lung on 9/18/17, at 5:36 p.m. R66 his private room with the door y visible to the hallway. R66 long with a single white bed , however, the sheet was s waist going to almost his bare chest, upper legs and a inence brief. R66's room had lled on the ceiling which had | | cognition was reassessed on and R66 denies states he is r uncomfortable in room with do people looking at him, however willing to have curtain installer want to". All residents who request to h door left open and prefer to w clothing have the potential to by this deficient practice. If a noted to prefer to have the do refuses to wear clothing, the f | ot oor open and er was d "if you ave their ear minimal be affected resident is or open and | | |

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| | RS FOR MEDICARE | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTI | PLE CONSTRUCTION | MB NO. 0938-039 (X3) DATE SURVEY | |
|--------------------------|---|---|---------------------|--|--|--|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDIN | G | COMPLETED | |
| | | 245119 | B. WING | | 09/21/2017 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| AITKIN I | HEALTH SERVICES | | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETIC | |
| F 241 | metallic hooking de however, the room installed. At 5:39 p the facility, R21, wh door opened, howe quarterly MDS date severe cognitive im An additional obser (over one hour later in his room with the continued to have t past his waist, expo legs and gray color interviewed immedi observation, R66 st uncomfortable and "sometimes," has c by his room and sta elaborate further. F if anyone from the f him about his private During a subseque 1:35 p.m. R66 was doorway opened ar R66's eyes were cle down around his wa chest. At 1:38 p.m. was walking down t R66's room, then tu walking. When interviewed of nursing assistant (N observed R66 layin stated R66, doesn't time and declined h | evices to hang a curtain, had no privacy curtains , another resident living in heeled by his room with the ever, did not look inside. R21's ed 5/10/17, identified R21 had apairment. The second second second second second pairment. The second s | F 24 | address the need for a privacy cur be installed and/or offer different r placement to accommodate prefer resident while maintaining their per privacy. AHS dignity policy was reviewed a revised; staff education regarding personal privacy of residents will b completed. DON or Designee will complete au resident preference 3 X weekly X weeks, Weekly X 4 weeks, 2 X mo 2 months. Audit results will be bro Qapi for further review and recommendations. | oom rence of orsonal and be udits of 4 onthly X | |

| | | AND HUMAN SERVICES | | | FORM | : 10/23/2017 APPROVED : 0938-0391 |
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| STATEMENT | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG | (X3) DAT | E SURVEY IPLETED |
| | | 245119 | B. WING _ | | 09/ | 21/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | HEALTH SERVICES | | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 241 | felt R66 should be a not have to see him residents' home an too." Further, NA-E any other residents being exposed. During interview on registered nurse (R his room with his bas stated R66 will occa gown or clothing as stated R66 laying in and visible to others concern for him," a installing a privacy of discussed as an int When interviewed of director of nursing of seen R66 laying in however, added sh hallway. The DON with R66 about inst staff had approached questions pertaining denied being too ho a curtain to be insta no interventions, lik offering to change r portion of the hallway with R66 as she, "d During interview on registered nurse, di comment about R6 A facility Dignity Po | wearing a shirt so others did n exposed, as it was "other d they should be comfortable D stated she had not heard of making comments about R66 n 9/20/17, at 1:55 p.m. RN)-B observed R66 laying in are chest exposed. RN-B asionally refuse to wear a s it feels restrictive. RN-B n bed with bare skin exposed s, "definitely could be a dignity nd added she was unaware if curtain had ever been tervention for him. Dn 9/20/17, at 2:07 p.m. the (DON) stated she had never his bed exposed before, e didn't often make it down his stated she had just spoken talling a curtain as another ed her about the surveyors g to it. The DON stated R66 of in the room and would allow alled. Further, the DON stated te installing a curtain or rooms to a less traveled ay, had ever been discussed lidn't realize," it was a concern. | F 24 | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | F | ORM | 10/23/2017 APPROVED 0938-0391 |
|--------------------------|--|---|--------------------|---|--|---|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | 3) DATE | E SURVEY PLETED |
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| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| AITKIN H | IEALTH SERVICES | | | | 01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | (X5) COMPLETION DATE |
| F 241 F 250 SS=D | dignity, respect and procedure which ind maintain and protect bodily privacy during care and during treat 483.40(d) PROVISI RELATED SOCIAL (d) The facility must social services to at practicable physical well-being of each r This REQUIREMEN by: Based on observat review, the facility fa assistance with disc residents (R56) for Findings include: R56's 30-Day Minim 7/13/17, identified F impairment, require transfers, dressing a was independent wit the unit, and toiletin there was, "an activ R56 to return to the During observation was clean and well R56 stated he was nursing home. R56 recovery, however, | enhances quality of life, individuality," and listed a cluded, "Staff shall promote, et resident privacy, including g assistance with personal atment procedures." ON OF MEDICALLY SERVICE t provide medically-related ttain or maintain the highest d, mental and psychosocial esident. NT is not met as evidenced ion, interview and document ailed to provide ongoing charge planning for 1 of 1 discharge planning. num Data Set (MDS) dated 856 had moderate cognitive d only supervision with and personal hygiene, and ith locomotion, both on and off g. Further, the MDS identified e discharge plan" in place for community. on 9/18/17, at 6:46 p.m. R56 groomed. When interviewed, unsure why he still living in the 5 stated he admitted for no longer requires as much | F 2 | | AHS ensures that medically-related s services are provided to attain or mair the highest practicable physical, ment and psychosocial well- being of each resident by providing ongoing assistar with discharge planning from time of admission until discharge or decision long-term placement by resident and/or resident representative. On 9/13/17 R56 expressed the desire remain in the facility and not to be ask about discharge planning and he woul notify SSD if he decided he would like discharge. R56 re-assessed for dischar desires on 10/11/17 and resident woul like to remain at SNF, does not want A to pursue discharge. Senior Linkage he been involved along with resident cour caseworker, all of who support R56 decision for long term placement at facility. | social ntain tal nce for 'or e to ked ild e to harge ild AHS has | 10/27/17 |
| | recovery, however, care and felt able to | | | | | | |

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| | CALE AND A CONTRACT AND A CONTRACT AND A CONTRACT A CONTRACTACT A CONTRACTACTACTICA A CONTRACTACTACTACTICA A CONTRACTACTACTACTACTACTACTACTACT | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MI II T | | E CONSTRUCTION | | 0938-039 SURVEY |
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| F 250 | | - | F 25 | 50 | | | |
| | exclaimed, "They m holding a person!" | hands on his knees," and nust have some kind of law for | | | F-A re-interviewed on 10/10/17 and that resident is in appropriate envir and that resident has requested to SNF vs. ALF. F-A further states R | ronment stay at | |
| | practitioner (NP)-A was going to remain rehabilitation. This of | 9/19/17, at 9:09 a.m. nurse stated she understood R56 n in the nursing home after his decision was made at care | | | not understand less restricted environment. R56 believes that me home not in a facility. | | |
| | conference with R56, his responsible party and staff present. NP-A was unaware R56 still had a desire to discharge from the nursing home. | | | All residents admitted for short term with impaired cognition have the p to be affected by this deficient prac | otential | | |
| | a.m. R56 stated he living facility (ALF) would be a good liv facility had discusse however, did not wa to reside in Aitkin w | interview on 9/20/17, at 8:30 recently looked at an assisted with a friend (F)-A and felt it ing option for himself. The ed an ALF in another town, ant to move there and wanted here his friends live. R56 e facility about discharge but, nothing." | | | The facilities discharge policy has reviewed. AHS starts discharge p on admission until date of discharge Documentation of discharge plann conversations will be documented EMR. AHS holds a pre-discharge p conference within the first 10 days admission to plan the discharge ar provision of necessary home care services, discharge planning contin | lanning ge. ing in the olanning of nd | |
| | a.m. F-A stated he to move to a more i and had toured the him about his feelin the facilty. Before a independently living R56 and himself ha services (SS) about | g in his own home. F-A stated id talked with the facility social t moving but the facility stay there but (R56) would be | | | with a discharge planning conferent prior to discharge, including reside family and/or resident representati staff, community resource staff, and county case manager. AHS bases discharge potential on physiciant evaluation, anticipated level of independence, support personnel available, financial resources, anti- treatments/procedures required, availability of community resources resident and/or family expectations | nce nt, ve, SNF id s cipated s, and | |
| | completed 8/3/17, i cognitive deficits wi management of fina | therapy (OT) consultation dentified R56 exhibited some th medication set up, ances, looking up numbers in roblems with completing travel | | | wishes. Discharge planning is rev and revisited quarterly, with signific change and with resident inquiries All Short stay residents have been | iewed cant | |

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| | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | IPLE CONSTRUCTION | OMB NO. (X3) DAT | E SURVEY | |
|--------------------------|--|---|---------------------|--|---|---------------------------|--|
| | F CORRECTION | IDENTIFICATION NUMBER: | | NG | · · / | PLETED | |
| | | 245119 | B. WING _ | | | 21/2017 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | CODE | | |
| AITKIN H | EALTH SERVICES | | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | | |
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| F 250 | Continued From pa | age 8 | F 25 | 50 | | | |
| | | esidents double vision. At that 24 hour supervision. | | interviewed regarding their preferences | discharge | | |
| | 8/14/17, identified I | medical doctor (MD)-A on R56 was close to baseline from he encouraged R56 to try an | | Staff education regarding of planning process and docu the discharge planning pro completed. | umentation of | | |
| | (NP)-A identified Ra and had inquired if assisted living. NP- vision had resolved headaches followin subdural hematom considering moving returning home, an | 8/17/17, from nurse practioner 56 was alert to conversation he will be able to go to A identified R56's double d, but still had occasional ing his motor vehicle accident a. NP-A stated R56 was g to an assisted living versus d felt this would be in his best ed by MD-A progress note of | | DON or designee will com regarding residents discha facility planning process 22 weeks, 2 X month X 2 mon monthly thereafter. Audit of brought to Qapi for further recommendation. | rge wishes and K weekly X 4 nths, and then results will be | | |
| | director of nursing care conference ha assessed by occup needed 24 hour su | note dated 8/24/17, by the (DON) identified a resident ad been held. R56 was pational therapy (OT) and pervision. They were waiting r medical assistance prior to | | | | | |
| | R56 decided to sta time and had chose further identified the | ered nurse (RN)-D documented y at the facility for a period of en not to go to ALF. The note at R56 did not wish to be arging and would let the facility ned to discharge. | | | | | |
| | stated R56 required knew F-A had take | n 9/21/17, at 10:22 a.m. SS d 24 hour supervision and n R56 to tour a local ALF, ded to remain at the facility | | | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 10/23/2017 APPROVED |
|--------------------------|--|--|---------------------|----|---|-----------|----------------------------------|
| STATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | E CONSTRUCTION | (X3) DATE | 0938-0391 E SURVEY IPLETED |
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| F 250 | through the winter w F-A this morning (9, changed his mind fi both R56 and F-A s facility for the winter to the nursing home home to screen R5 was completed or w screen was, adding anything. She state his mind." SS state assessment and de supervised living sit was completed on 8 cognitive testing on had no cognitive im OT was notified to a since R56 showed she completed her During interview at stated F-A had bee brought some pape want to stay in the r and wanted to move During interview on R56 and SS, R56 s don't want to stay h she had placed a ca awaiting a return ca be best for him to n During interview on occupational therap been assessed on 8 /3/17. OT-A stated completed they rec | when she met with R56 and //21/17). SS stated R56 requently and this morning, spoke about R56 staying at the r, and would be bringing items e. The ALF was at the nursing 6 but was unsure when this what the outcome of the g she had not documented ed, "Tomorrow he may change ed OT completed an etermined a 24 hour tuation was indicated which 8/3/17. She completed a 9/12/17, and identified R56 opairment. SS was unsure if complete a new assessment no cognitive impairment when assessment on 9/12/17. 9/21/17, at 10:47 a.m. R56 in in this morning to visit and erwork to complete. He did not nursing home for the winter, re to the ALF. | F 2 | 50 | | | |

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| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | | FORM | 10/23/2017 APPROVED 0938-0391 |
|--------------------------|---|--|--------------------|-----|---|-----------|-------------------------------------|
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| | HEALTH SERVICES | | | | 01 MINNESOTA AVENUE SOUTH NTKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 250 | medications. OT-A displays an improve would be an opport done in August. The been informed of cl thought an ALF would During interview on SS, administrator, a stated R56 had a h from staying to beir administrator stated however, R56 was term care unit beca the facility. The add R56 with his finance decisions for R56. I decision making. Th had not toured any SS and RN-D clarif ALF. R56 was initia changed his mind a transfer to the ALF. BIMS (cognitive tes was addressed in a were unsure what co was present at the During telephone in a.m. the owner of th present for the tour transfer to the ALF. on 9/14/17 and the orders and an upda physical for (R56's) During telephone in a.m. F-A stated he | stated when someone ed cognitive assessment, it tunity to assess, which was e OT-A stated she had not hanges in R56's cognition and uld be appropriate for R56. n 9/21/17, at 11:22 a.m. with and RN-D, the administrator istory of changing his mind, ng transferred. The d R56 was a short term stay, recently moved to the long ause he wanted to remain in ministrator stated F-A assists es, but they do not make R56 was independent in his he administrator stated R56 ALF facilities in the area but fied R56 had toured the local ally interested, per RN-D but as he was proceeding with a . RN-D and SS stated his sting tool) had improved which a morning meeting but they date this occurred or whom | F 2 | 250 | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 10/23/2017 APPROVED 0938-0391 |
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| | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245119 | B. WING | | | 09/2 | 21/2017 |
| NAME OF PRO | OVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| AITKIN HE | ALTH SERVICES | | | | 01 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 278 S S F 278 S S S S S S C M ((M (A P () (((((((((((((((((| stay at the nursing h stay at the nursing h he ALF. F-A stated vork well for R56. A policy was requess but was not received nade for resident re- herapies. A blank ro- copy of completed r cognitive testing of 9 hot provided. 483.20(g)-(j) ASSES ACCURACY/COOF g) Accuracy of Ass- nust accurately refl h) Coordination A registered nurse r each assessment w participation of heal i) Certification 1) A registered nurse r each assessment w participation of heal i) Certification 2) Each individual w ssessment must s hat portion of the a j) Penalty for Falsif 1) Under Medicare vho willfully and know | the facility staff wanted him to nome, R56 had not agreed to nome, and wanted to move to he thought the ALF would ated for discharge planning d. A request for policies was beferral for evaluation by eferral for evaluation by eferral for R56 following 9/12/17 was requested and SSMENT RDINATION/CERTIFIED essments. The assessment lect the resident's status. must conduct or coordinate <i>v</i> ith the appropriate th professionals. se must sign and certify that completed. who completes a portion of the ign and certify the accuracy of ssessment. ication and Medicaid, an individual | | 250 | | | 10/27/17 |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 10/23/2017 APPROVED 0938-0391 |
|--------------------------|---|--|---------------------|----|---|--|-------------------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE | E SURVEY PLETED |
| | | 245119 | B. WING _ | | | 09/2 | 21/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| AITKIN H | EALTH SERVICES | | | | 1 MINNESOTA AVENUE SOUTH TKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 278 | penalty of not more assessment; or (ii) Causes another and false statement subject to a civil mot \$5,000 for each ass (2) Clinical disagree material and false statement is REQUIREMENT by: Based on observat review, the facility faurinary incontinence (MDS) for 1 of 3 resurinary elimination. Findings include: The Long-Term Car Assessment Instrum 10/2017, identified is Minimum Data Set The section labeled Bladder," identified "Each resident who developing incontin assessed, and provide the section instructions," to be an other and the section instructions, "to be a state of the section instructions," to be a state of the section instructions, "to be a state of the section instruction instruction instructions, "to be a state of the section instruction in | ht is subject to a civil money than \$1,000 for each individual to certify a material t in a resident assessment is oney penalty or not more than sessment. ement does not constitute a tatement. NT is not met as evidenced ion, interview and document ailed to accurately code e on the Minimum Data Set sidents (R53) reviewed for | F 27 | 78 | AHS ensures residents are assess using a comprehensive assessmen process, in order to identify care ner and to develop an interdisciplinary of plan and that all assessments accur reflect the resident's status during the assessment period. A modification MDS was completed R53's Quarterly assessment on 9/2 that changed urinary continence stat "frequently incontinent". This assess was submitted to QIES system on 1 and was an accepted submission. The assessment of the resident was accur along with the care plan and care plan interventions. All residents who are incontinent of bladder as determined by assessment have the potential to be affected by deficient practice with inaccurate con of the MDS. All incontinent resident | t eds care rately he on 5/17 atus to ssment 0/2/17 The curate, lan ent this oding | |
| | 7-day look-back pe | y incontinent: if during the riod, the resident was during seven or more | | | MDS's will be reviewed to ensure accurate coding of urinary incontine | | |

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| | | & MEDICAID SERVICES | <i>(112)</i> | | OMB NO. | |
|--------------------------|--|--|---------------------|--|--|---------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | () | E SURVEY PLETED |
| | | 245119 | B. WING _ | | | 21/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODI | | |
| AITKIN H | IEALTH SERVICES | | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETIC DATE |
| F 278 | episodes but had a This includes incon urine, daytime or ni - "Code 3, always ir look-back period, th voids." R53's most recent of (MDS) dated 8/15/1 cognitive impairme only with toileting. and Bowel," identifi appliances (i.e. cath program to manage "Always incontinent continent voiding. During observation was laying in bed ir uncombed hair, how suggestive of urina When interviewed of nursing assistant (N restroom on his ow stated R53 does ha the overnight hours day, he's pretty good During interview on stated R53 was, "va and staff often just most tasks. NA-D much the same" in continence adding during the waking h | t least one continent void. tinence of any amount of | F 27 | ⁷⁸ Clinical Nurse Managers/MDS educated on proper coding ins urinary incontinence and assur MDS selection matches the as DON or Designee will complete accurate coding of urinary com the MDS 2 records weekly X 4 record weekly X 4 weeks, 2 rec monthly X 2 months. Audit rest brought to Qapi for further revi recommendations. | tructions for ing the sessment. e audits for tinence on weeks, I cords ults will be | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 10/23/2017 APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245119 | B. WING _ | | | 09/2 | 21/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| AITKIN H | IEALTH SERVICES | | | | 01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 278 | sense," why R53 we incontinent on an as R53's Bowel & Blac Consolidated 7-Day MDS Assessment F identified R53 had however, three of th continent. When interviewed of registered nurse (R completed R53's qu reviewing his, "bow speaking with staff only counted, "one voiding on the sum always incontinent." current Resident As manual for instructi | ould be considered as always | F 2 | 78 | | | |
| F 282 SS=D | 5/11/15, identified a Minimum Data Set Discharge and Ree accurately and elect facility's MDS inform policy identified, "M accuracy as part of and performance in 483.21(b)(3)(ii) SEF PERSONS/PER CA (b)(3) Comprehens The services provid | | F 28 | 82 | | | 10/27/17 |

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| CENTER STATEMENT | | AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245119 | | TIPLE CONSTRUCTION NG | FORM MB NO. (X3) DATE COM | 10/23/2017 APPROVED 0938-0391 E SURVEY PLETED |
|--------------------------|---|---|---------------------|--|---|---|
| | PROVIDER OR SUPPLIER | 243119 | D. WING | STREET ADDRESS, CITY, STATE, ZIP CODE | 09/2 | 21/2017 |
| | EALTH SERVICES | | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 282 | Continued From pa must- (ii) Be provided by c | - | F 28 | 82 | | |
| | accordance with ea care. This REQUIREMEN by: | ch resident's written plan of NT is not met as evidenced ion, interview and document | | AHS ensures that interventions ar | 9 | |
| | review, the facility fa interventions as dire 2 residents (R2, R2 | | | implemented as directed by the ca for those who require nutritional interventions to promote independ and/or safe eating. | re plan ent | |
| | 6/13/17, identified F | imum Data Set (MDS) dated 32 had severe cognitive dependent with eating, and disorders. | | Staff caring for R2 on 9/18/17 were educated on care plan intervention meal ticket instructions were re-an to facilitate easier reading of care p interventions. Care plan interventi were re-assessed and Care plan u based on assessment. | s. R2's anged blan ons | |
| | dated 9/6/17, identii mechanical soft die assessment identifii therapy] in June [20 episode. Resident and eats very quick individual bowls in a | e's Observation assessment fied R2 consumed a t with puree vegetables. The ed, " was seen by [speech 17] [related to] a choking doesn't chew her food well, ly. She receives her food in an effort to reduce the speed | | Staff caring for R22 on 9/18/17 and 9/20/17 were educated on care pla interventions. R22's meal ticket instructions were re-arranged to fa easier reading of care plan interve Care plan updated to reflect use of spoon at meals. | n cilitate ntions. | |
| | required, "supervisi eating," and listed a in Individual Bowls During observation was seated in the G | d 9/13/17, identified R2 on and occasional assist for in intervention of, "Serve Food - Offer 1 at a time." on 9/18/17, at 5:02 p.m. R2 Garden Terrace dining room esidents. At 5:20 p.m. R2 was | | All residents who require adaptive equipment for eating have the pote be affected by this deficient practic residents will be provided the appr assistive devices per their plan of o The plan of care in relation to adapt equipment will be outlined on the r ticket. Meal ticket will be available each meal. | e. All opriate care. otive neal | |

Facility ID: 00002

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| CENTER STATEMENT | RS FOR MEDICARE | AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPLI | | FORM MB NO. (X3) DATE | 10/23/2017 APPROVED 0938-0391 E SURVEY |
|--------------------------|---|---|-------------------|-------|---|--|---|
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILC | ING _ | | COMI | PLETED |
| | | 245119 | B. WING | | | 09/2 | 21/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | EALTH SERVICES | | | | 01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 282 | served a regular pla and garlic bread. F menu slip placed or her which identified soft diet. Further, th had been highlighte "Separate bowls [sp meal was not serve care plan or menu s lasagna using a reg while attempting to from the lasagna us attempting to eat th Nursing assistant (f right side, assisting and asked R2, "Car did not verbally resp eating, often times cleared of food befor At 5:23 p.m. (three consumed all of the her fingers to run al fingers several time cc (cubic centimete and started to drink "slow down," while s an additional plate of consume them usin attempting to drink glass. At 5:26 p.m. (six mi finished consuming dish and attempted table mates bowl of "this mine[?]" while told R2 it was not, a | ge 16 ate of food with lasagna, peas 2 had a visible white colored in the table directly in front of she consumed a mechanical he slip had black text which ed in yellow which read, bacing] for all foods." The d in bowls as directed by her slip. R2 began to eat the gular fork in her right hand, pick up some cooked cheese sing her left hand and em both at the same time. NA)-E was seated on R2's another resident with eating, n you take a little drink?" R2 bond to NA-E and continued not waiting for her mouth to be ore taking additional bites. minutes later) R2 had e provided lasagna and used ong the plate, licking her es. R2 then picked up a 240 r) glass of red colored juice it. NA-E stated aloud to R2, she drank. R2 then picked up of mixed berries and began to ag a regular spoon, at times from the bowl like it was a | F2 | 282 | Dietary Staff will be educated on ac equipment and layout of meal ticke identify need of adaptive equipmen Nursing staff will be educated on ac equipment and process for assuring proper adaptive equipment is being All nursing and dietary staff will be educated on care plan interventions serving R2 and R22. Dietary Director or designee will co audits regarding proper use of adap equipment 3 X weekly X4 weeks, w X4 weeks, 2X monthly X 2 months. results will be brought to Qapi for fur review and recommendations | t to t. daptive g g used. s for mplete ptive veekly . Audit | |

| | | AND HUMAN SERVICES | | | | FORM | 10/23/2017 APPROVED 0938-0391 |
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| STATEMENT | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · / | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245119 | B. WING | | | 09/2 | 21/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| AITKIN H | HEALTH SERVICES | | | | 01 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 282 | Continued From pa 100% of the provide During interview on stated the white me communicate a res "additional informat for, "kitchen staff to assistants] to doubl are being served th R2 had been server regular plate adding and at risk of chokin NA-E stated she wa interventions being risk of choking besi questioned about th directing to give R2 NA-E stated they ar from, "what I've hea it was still a current When interviewed of registered nurse (R used to, "communio need," in order to, " Further, RN-C state quickly at times she staff should be follo her menu slip, and bowls to, "slow her choking risk." R22's quarterly Min 8/29/17, identified F required extensive a Further, R22's face identified R22 had e | age 17 ed meal. 9/18/17, at 6:22 p.m. NA-E enu slips are used to idents specific diet and also, tion," like special instructions o see and for [nursing le check," to ensure residents the correct diets. NA-E stated d the evening meal on a g R2 was, "a speedy eater," ng, "from eating so fast." | F 2 | 282 | DEFICIENCY) | | |

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| | | AND HUMAN SERVICES | | | | FORM | 10/23/2017 APPROVED 0938-0391 |
|--------------------------|--|--|--------------------|-----|--|-----------|-------------------------------------|
| STATEMENT | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245119 | B. WING | | | 09/; | 21/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | HEALTH SERVICES | | | | 01 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 282 | R22's care plan prir required frequent as with use of adaptive "2-handled cup with dycem [non-slip madirected staff to pro assistance as need During observation was seated at a tab was holding a spoo visible tremors in he of two to three inches served her meal on and used both hand up to her mouth usi several instances o the plate onto the ta- minutes later) nursi approached and off R22. When intervi NA-F stated R22 was eating when staff no due to her tremors. During interview on stated " I am tired a R22 stated it was b divided plate when presence of the trem During subsequent 12:06 p.m. R22 was a table, and had be half, along with mas was again served h non-lipped plate. R2 sandwich on her ow | nted 9/22/17, identified R22 ssistance with eating along e equipment which included a, n lids and straws, divided plate, aterial]." The care plan ovide this equipment and led. on 9/18/17, at 5:42 p.m. R22 ole for the evening meal. R22 on with both hands and had er lower arms with movements es back and forth. R22 was n a regular, non-lipped plate ds to bring food from the plate ing the regular spoons with of food falling over the edge of able. At 5:54 p.m. (12 ing assistant (NA)-F fered assistance with eating to iewed after the meal service, as provided assistance with otice she is having troubles | | 282 | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 10/23/2017 APPROVED 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|-----------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | LE CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245119 | B. WING | | | 09/2 | 21/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | IEALTH SERVICES | | | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 282 | staff to eat the mas | hed potatoes. | F 2 | 282 | 2 | | |
| | stated R22 was ablindependently, how when needed addin foods. NA-B stated equipment during mincluding a lipped p push food against ti utensil. During sub at 1:36 p.m. NA-B s used on 9/20/17, fo service, adding she lipped plate. NA-B | on 9/20/17, at 2:06 p.m. NA-B e to feed herself ever, would ask for assistance in g she did well with finger I R22 used some adaptive heals to help her with eating, late, which allowed R22 to he edge and scoop it on her osequent interview on 9/21/17, stated a regular plate was r R22 during the lunch meal did not notice it was not a stated if she had noticed the hould could have notified | | | | | |
| F 311 SS=D | dietary staff to have Further, during the registered nurse clii joined the conversa equipment, like a lip on the care plan an served her meal on the care plan. A policy on impleme provided. 483.24(a)(1) TREA IMPROVE/MAINTA (a)(1) A resident is a treatment and servi or her ability to carr living, including thos of this section. | e it addressed. interview with NA-B, nical coordinator (RN)-D tion and stated adaptive oped plate, should be outlined d R22 should have been a lipped plate as directed by enting the care plan was not | F | 311 | | | 10/27/17 |

Facility ID: 00002

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| STATEMENT | OF DEFICIENCIES | KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION (2 | IB NO. 0938-039 X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|---------------------|-----|---|--|
| | | IDENTIFICATION NUMBER: | A. BUILDI | ING | | GOIVIFLETED |
| | | 245119 | B. WING | | | 09/21/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | |
| AITKIN H | IEALTH SERVICES | | | | 01 MINNESOTA AVENUE SOUTH NTKIN, MN 56431 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY) | |
| F 311 | Continued From pa | ae 20 | F 3 | 811 | | |
| | Based on observat review, the facility f therapy interventior improve independe | tion, interview and document ailed to implement speech is to reduce risk factors and nt eating for 1 of 2 residents ating habits and abilities. | | | AHS ensures that all residents are g the appropriate treatment and servic maintain or improve their ability to ca out ADL's including implementation of speech therapy interventions to redu risk factors and improve independent eating. | es to arry of ice |
| | 6/13/17, identified F impairment, was inc had no swallowing R2's General Nurse dated 9/6/17, identi mechanical soft die | e's Observation assessment fied R2 consumed a t with puree vegetables. The | | | Staff caring for R2 on 9/18/17 were educated on care plan interventions based on speech therapy recommendations. R2's meal ticket instructions were re-arranged to facil easier reading of care plan intervent and updated to reflect speech therap recommendations. | litate ions |
| | therapy] in June [20 episode. Resident and eats very quick individual bowls in a of her eating." Furt 7/1/17, identified R2 and was eating her had her slow down eating her mixed ver | ed, " was seen by [speech 017] [related to] a choking doesn't chew her food well, dy. She receives her food in an effort to reduce the speed ther, R2's progress note dated 2 was, "eating supper tonight food to [sic] fast. The staff several times She started egetables and then was owing up and spitting phlegm." | | | All residents who have participated in Speech Therapy with discharge recommendations for adaptive equip or eating strategies have the potentia be affected by this deficient practice. current residents with speech therap recommendations for adaptive equip or eating strategies will be reviewed assure recommendations on the plan care and being implemented or appropriate documentation of refusa | oment al to . All by oment to n of |
| | 6/26/17, identified r safety and efficience included, "Caregive updated for giving p time [one presentat reduce the bolus siz period." R2's care | py Discharge Summary dated ecommendations to, "facilitate ey," for R2 while eating which er training provided; care plan batient small bowls of food at a tion of food at a time] to ze and increase meal time plan, dated 9/13/17, identified plan, and occasional assist | | | resident is present in EMR. All resid will be provided the appropriate assis devices per their plan of care. The p care in relation to adaptive equipmer be outlined on the meal ticket. Mea ticket will be available for each meal. Dietary Staff will be educated on ada | lents stive blan of nt will l aptive |
| | for eating," and liste | rvision and occasional assist ed an intervention of, "Serve Bowls - Offer 1 at a time." | | | equipment and layout of meal ticket identify need of adaptive equipment. Nursing staff will be educated on ada | |

Facility ID: 00002

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| DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03 | | | | | | | |
|---|--------|--|--|---|----------------------------|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | |
| | 245119 | B. WING | | 09/2 | 21/2017 | | |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | |
| AITKIN HEALTH SERVICES | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | F 311 | equipment and process for assurin proper adaptive equipment is being All nursing and dietary staff will be educated on specific process for se R2. Dietary Director or designee will co audits regarding proper use of ada equipment 3 X weekly X 4 weeks, y X 4 weeks, 2 X monthly X 2 month Audit results will be brought to Qap further review and recommendation | g used. erving mplete ptive weekly s. i for | | | |

If continuation sheet Page 22 of 30

| DEPARTMENT OF HEALT CENTERS FOR MEDICAR | FORM | : 10/23/2017 APPROVED : 0938-0391 | | | | |
|--|--|--|--|-------------------------------|----------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
| | 245119 | | B. WING | | 09/21/2017 | |
| NAME OF PROVIDER OR SUPPLIE | R | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| AITKIN HEALTH SERVICES | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | | | |
| (X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| F 311 Continued From | 11 Continued From page 22 | | 1 | | | |
| table mates bowl "this mine[?]" whi told R2 it was not dishes in a pile or 100% of the prov During interview of stated the white r communicate a re "additional inform for, "kitchen staff assistants] to dou are being served NA-E stated R2 r plate adding R2 v stated she was un being used to hell eating and chokin When questioned instructions direct separate bowls, N that was still a cu When interviewed registered nurse meals so quickly choke," and staff her in individual b During interview of language therapis evaluation complet quickly and havin stated due to R2's inability to remern cues, the only op "environmental choiling the states of the state | Continued From page 22 table mates bowl of mixed berries asking NA-E, "this mine[?]" while pulling it towards her. NA-E told R2 it was not, and R2 then stacked all of her dishes in a pile on the table; having consumed 100% of the provided meal. During interview on 9/18/17, at 6:22 p.m. NA-E stated the white menu slips are used to communicate a residents specific diet and also, "additional information," like special instructions for, "kitchen staff to see and for [nursing assistants] to double check," to ensure residents are being served the correct diets and meals. NA-E stated R2 had been served on a regular plate adding R2 was, "a speedy eater." NA-E stated she was unaware of any interventions being used to help R2 reduce the speed of her eating and choking besides, "a lot of cueing." When questioned about the menu slip instructions directing to give R2 her food in separate bowls, NA-E stated she was unsure if that was still a current intervention for R2 or not. When interviewed on 9/20/17, at 12:20 p.m. registered nurse (RN)-C stated R2 eats her meals so quickly at times she, "would almost choke," and staff should be providing her food to her in individual bowls to, "slow her down." During interview on 9/20/17, at 12:34 p.m. speech language therapist (SLP)-A stated R2 had an evaluation completed on 6/26/17, due to eating quickly and having a choking episode. SLP-A stated due to R2's cognitive impairment and inability to remember swallowing strategies or cues, the only options available were, "environmental changes," including placing R2's food in separate bowls, "to slow her rate down." | | | | | |

Facility ID: 00002

If continuation sheet Page 23 of 30

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 10/23/2017 APPROVED 0938-0391 | | | |
|--------------------------|---|---|--|-----|---|----------|-------------------------------------|--|--|--|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | X3) DATE | E SURVEY PLETED | | | |
| | | 245119 | B. WING | | | 09/2 | 21/2017 | | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | | | |
| AITKIN H | IEALTH SERVICES | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE | | | |
| F 311 F 323 SS=D | consumed the next staff, "should be," g separate bowls or re- therapy if they notic working. 483.25(d)(1)(2)(n)(1 HAZARDS/SUPER' (d) Accidents. The facility must en (1) The resident en- from accident hazar (2) Each resident near and assistance dev (n) - Bed Rails. The appropriate alternation bed rail. If a bed or must ensure correct maintenance of bect to the following eler (1) Assess the resident from bed rails prior (2) Review the risks the resident or reside informed consent p (3) Ensure that the appropriate for the following following for the following follo | time to swallow," before she bite. Further, SLP-A stated iving R2 her meals in efer R2 back to speech ed the intervention was not I)-(3) FREE OF ACCIDENT VISION/DEVICES sure that - vironment remains as free rds as is possible; and eceives adequate supervision ices to prevent accidents. e facility must attempt to use ives prior to installing a side or side rail is used, the facility t installation, use, and d rails, including but not limited nents. dent for risk of entrapment to installation. | | 311 | | | 10/27/17 | | | |
| | | ion, interview and document ailed to ensure smoking risks | | | AHS ensures that resident's environ remains as free from accident hazard | | | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 10/23/2017 APPROVED 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|---|-------------------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE | SURVEY PLETED |
| | | 245119 | B. WING | i | | 09/2 | 21/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | ç | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| AITKIN H | EALTH SERVICES | | | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 323 | residents (R46) who grounds. Findings include: R46's admission Mi 7/26/17, indicated F did not have any fur upper extremities. T of heart failure and R46's progress note - 7/23/17, at 1:25 p. outside smoking wit reminded of the nor he understood, and smoking outside. - 7/25/17, at 3:00 p. was spoken to about entrance of the faci the non- smoking p smoke on the grour he would think about would talk to a nurs smoking. A Smoking Contract R46 and the admini | nimum Data Set (MDS) dated A46 had intact cognition and actional limitations in the The MDS identified diagnoses manic depression. es indicated the following: m. indicated R46 was found th another resident. R46 was n-smoking policy and indicated then was found again m. indicated on 7/24/17, R46 at smoking in the front lity. R46 stated he understood olicy and stated he would "not ads of the facility." R46 stated at other smoking options and e if R46 chose to quit | F | 323 | is possible and that each resident receives adequate supervision and assistance devices to prevent accid by ensuring smoking risk are comprehensively assessed. A smoking assessment was complet R46. The assessment concludes the resident is safe to smoke off facility grounds when accompanied by visit who assists resident off property are returns resident to property. Care printerventions were updated based of smoking assessment. All residents with smoking tendence have the potential to be affected by deficient practice. All residents ide with smoking tendencies were comprehensively assessed for safe smoking off facility grounds with accompaniment, care plans were updated by 9/26/17. Smoking policy has been reviewed revised. Nursing staff will be provided education of the smoking tendencies to the smoking tendencies were completed by 9/26/17. | eted on hat tor hd lan on this htified ety with pdate d to as and | |
| | smoke off of facility During interview on stated he smoked a the street from the | 9/19/17, at 10:52 a.m. R46 a couple times a week, across facility when a friend of his stated his friend kept his | | | and safety interventions related to smoking. DON or designee will complete aud completion of a smoking assessmeresidents with smoking tendencies weekly X 4 weeks, weekly X 4 weeks monthly X2 months. Audit results weekly x 4 | ent on 3 X eks, 2 X | |

Facility ID: 00002

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| | - | AND HUMAN SERVICES | | | | FORM | APPROVED |
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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | E SURVEY PLETED |
| | | 245119 | B. WING _ | | | 09/: | 21/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | • | | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | IEALTH SERVICES | | | 30 | 01 MINNESOTA AVENUE SOUTH | | |
| ALIXINT | | | | Α | ITKIN, MN 56431 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | 1 | (X5) |
| PRÉFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | < | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | | COMPLETION DATE |
| IAG | | | iAd | | DEFICIENCY) | E | |
| | | | 1 | | | | |
| F 323 | Continued From pa | ae 25 | F 3 | 23 | | | |
| | | 5 | | | brought to Qapi for further review a | nd | |
| | R46's medical reco | rd did not include a | | | recommendation. | | |
| | comprehensive ass | essment for smoking. | | | | | |
| | | | | | | | |
| | | ed 7/31/17, did not include | | | | | |
| | any interventions re | elated to R46's smoking. | | | | | |
| | During observation | on 9/20/17, at 7:41 a.m. R46 | | | | | |
| | | eelchair eating breakfast | | | | | |
| | | e dining room. R46 had no | | | | | |
| | obvious burns or bu | urn holes in his clothing. | | | | | |
| | | on 9/20/17, at 10:02 a.m. | | | | | |
| | | NA)-C stated R46 went across Family Dollar to smoke, | | | | | |
| | | friend. To her knowledge R46 | | | | | |
| | | elf or had burn holes in his | | | | | |
| | | ed the nurses were aware R46 ing off facility property. | | | | | |
| | - | | | | | | |
| | | 9/20/17, at 10:22 a.m. NA-D | | | | | |
| | | rivate and independent person seen R46 smoking, however, | | | | | |
| | | itors and left the facility | | | | | |
| | frequently with then | | | | | | |
| | | | | | | | |
| | | on 9/20/17, at 10:24 a.m. N)-B stated R46 did not | | | | | |
| | | ounds, but suspected he | | | | | |
| | | as away from the facility on | | | | | |
| | | not sure if a smoking | | | | | |
| | assessment had be | en completed on R46. RN-B | | | | | |
| | | oking contract was completed | | | | | |
| | | he facility indicating R46 | | | | | |
| | ayreed not to siflok | e on facility grounds. | | | | | |
| | | 9/21/17, at 8:43 a.m. RN-C | | | | | |
| | | ounds were non-smoking. | | | | | |
| I | KIN-C STATED a SMO | king assessment had not | | | | | |

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PRINTED: 10/23/2017

| | | AND HUMAN SERVICES | | | | FORM | 10/23/2017 APPROVED 0938-0391 |
|--------------------------|--|--|---------|-----|--|-------------------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | | (X3) DATE SURVEY COMPLETED | |
| | | 245119 | B. WING | | | 09/2 | 21/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| AITKIN H | EALTH SERVICES | | | | 01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | IX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 323 | were non- smoking he [R46] does off of business." RN-C sta developed because facility grounds. On 9/21/17, at 10:2 director of quality (I responsible for wha grounds and a smo been completed as non-smoking. DQ a admission, they cou grounds. The facility Smoking indicated smoking of | age 26 R46 as the facility grounds . RN-C further stated " What f these premises is his ated a care plan was never e, R46 didn't smoke on the 24 a.m. registered nurse DQ) stated the facility was not at residents do off facility oking assessment had not the facility grounds were added residents were told on uldn't smoke on facility g policy dated 6/10/17, was forbidden anywhere on The policy directed staff to | F | 323 | | | |
| F 369 SS=D | notify residents that the property ground assessment would resident was not be or family member. 483.60(g) ASSISTIN EQUIPMENT/UTEN (g) Assistive device The facility must pro and utensils for resi appropriate assistant | t smoking was only allowed off ds. The policy also indicated an be completed only if the eing accompanied by a friend VE DEVICES - EATING NSILS | F | 369 | | | 10/27/17 |
| | This REQUIREMEN by: Based on observat | NT is not met as evidenced tion, interview and document ailed to provide a lipped plate | | | AHS ensures that special eating equipment and utensils are provided | l for | |

Facility ID: 00002

If continuation sheet Page 27 of 30

| | | | | IPLE CONSTRUCTION | OMB NO. | |
|---|---|--|--|---|---|---------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IG | | E SURVEY PLETED |
| | | 245119 | B. WING _ | | | 21/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COL | DE | |
| AITKIN H | IEALTH SERVICES | | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| F 369 | Continued From pa | - | F 36 | | | |
| | of 3 residents (R22 living (ADLs). | ility to eat independently for 1) reviewed for activities of daily | | resident who need them and a assistance is provided to ensu- resident can use the assistive when consuming meals and s | ure that the devices | |
| Findings include: R22's quarterly Minimum Data Set (MDS) da 8/29/17, identified R22 was cognitively intact required extensive assistance of one with ea Further, R22's face sheet printed 9/12/17, identified R22 had essential tremors (a nervo system disorder which causes rhythmic shak R22's physician progress note dated 8/4/17, identified "The patient has had more tremory making it harder for her to eat." Further, R22 nursing progress note dated 9/20/17, indicate that during a care conference for R22 on 9/1 it was identified that R22 required increased assistance with eating related to tremors. R22's progress note dated 8/31/17, identified completed nutrition assessment for R22 who consumed a regular diet using a two handled with lid, large straws, divided plate and dycer (non slip material) to promote independent e Further, the assessment identified R22 was sometimes independent with eating; howeve other times required extensive assist related her essential tremors. | R22 was cognitively intact and assistance of one with eating. sheet printed 9/12/17, essential tremors (a nervous | | Staff caring for R22 on 9/18/1 9/20/17 were educated on car interventions. R22's meal tick instructions were re-arranged easier reading of care plan in | re plan et to facilitate erventions. | | |
| | ogress note dated 8/4/17, ient has had more tremor, r her to eat." Further, R22's ote dated 9/20/17, indicated conference for R22 on 9/19/17, it R22 required increased | | All residents who require adal equipment for eating have the be affected by this deficient p residents will be provided the assistive devices per their pla The plan of care in relation to equipment will be outlined on ticket. Meal ticket will be ava each meal. | e potential to ractice. All appropriate n of care. adaptive the meal | | |
| | completed nutrition consumed a regula with lid, large straw (non slip material) t Further, the assess sometimes indeper other times required | assessment for R22 who in diet using a two handled cup is, divided plate and dycem to promote independent eating. sment identified R22 was indent with eating; however, at d extensive assist related to | | Dietary Staff will be educated equipment and layout of meal identify need of adaptive equi Nursing staff will be educated equipment and process for as proper adaptive equipment is Dietary Director or designee v audits regarding proper use o | ticket to pment. on adaptive ssuring being used. vill complete f adaptive | |
| | R22's care plan printed 9/22/17, identified R22 required frequent assistance with eating along with use of adaptive equipment which included a, "2-handled cup with lids and straws, divided plate, dycem." The care plan directed staff to provide this equipment and assistance as needed. Further, an undated dietary menu card identified R22's meal information and directed staff to use | | | equipment 3X weekly X 4 wee X4 weeks, 2 X monthly X 2 m results will be brought to Qap review and recommendations | onths. Audit for further | |

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| | | AND HUMAN SERVICES | | | | FORM | 10/23/2017 APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245119 | B. WING | i | | 09/: | 21/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| AITKIN H | HEALTH SERVICES | | | | 01 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 369 | two handled cups w plate. During observation was seated at a tab was holding a soup had visible tremors movements of two f R22 was served he non-lipped plate and food from the plate regular soup spoon falling over the edge At 5:54 p.m. (12 mi (NA)-F approached eating to R22. Whe meal service, NA-F assistance with eati having troubles due During interview on stated " I am tired a R22 stated it was b divided plate when presence of the tren During a subsequen 12:06 p.m. R22 was a table, and had be half, along with mas was served her me plate. R22 was able own after it was pla she requested assis mashed potatoes. When interviewed of stated R22 was able | with lids, dycem, and a divided on 9/18/17, at 5:42 p.m. R22 be for the evening meal. R22 o spoon with both hands and in her lower arms with to three inches back and forth. For meal on a regular, d used both hands to bring up to her mouth using the with several instances of food e of the plate onto the table. nutes later) nursing assistant and offered assistance with en interviewed following the 5 stated R22 was provided ing when staff notice she is e to her tremors. 9/19/17, at 1:47 p.m. R22 and wore out. It is every day." est to use a soup spoon and attempting to eat related to the mors. It observation on 9/20/17, at s seated in the dining room at een served a sandwich, cut in shed potatoes. Again, R22 al on a regular, non-lipped e to eat the sandwich on her iced in her hands, however, stance from staff to eat the on 9/20/17, at 2:06 p.m. NA-B | | 369 | | | |

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| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | FORM | 10/23/2017 APPROVED 0938-0391 |
|--------------------------|--|--|---------------------|--|-----------|-------------------------------------|
| STATEMENT | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245119 | B. WING | | 09/2 | 21/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | HEALTH SERVICES | | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 369 | when needed; addi foods. NA-B stated equipment during n including a lipped p push food against t utensil. During sut at 1:36 p.m. NA-B s used on 9/20/17, fo service, and that sh lipped plate. NA-B error at that time, s dietary staff to have the interview, regist (RN)-D joined the c adaptive equipment be outlined on the c During interview on manager (DM) revia and stated a divide served all meals. A | age 29 ing, she did well with finger d R22 used some adaptive neals to help her with eating, plate, which allowed R22 to the edge and scoop it on her bsequent interview on 9/21/17, stated a regular plate was or R22 during the lunch meal ne did not notice it was not a stated if she had noticed the hould could have notified e it addressed. Further, during tered nurse clinical coordinator conversation and stated t needed by residents would care plan and dietary slip. n 9/21/17, at 1:30 p.m. dietary ewed the dietary slip for R22 d plate should be used when and further stated that it should blemented when R22's meal is | F 369 | | | |

Facility ID: 00002

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 6, 2017

Ms. Michelle Hanneken, Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, MN 56431

Re: State Nursing Home Licensing Orders - Project Number S5119025

Dear Ms. Hanneken:

The above facility was surveyed on September 18, 2017 through September 21, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

An equal opportunity employer.

Aitkin Health Services October 6, 2017 Page 2

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer at: (320) 223-7338 or email: brenda.fischer@state.mn.us.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely, Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>mark.meath@state.mn.us</u> Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

| Minneso | ta Department of He | alth | | | | |
|--------------------------|--|--|-----------------------|--|-------------------|--------------------------|
| - | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 00002 | B. WING | | 09/2 | 1/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | TATE, ZIP CODE | | |
| | EALTH SERVICES | 301 MINN AITKIN, M | ESOTA AVEN N 56431 | NUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 000 | Initial Comments | | 2 000 | | | |
| | *****ATTEI | NTION***** | | | | |
| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess | nether a violation has been | | | | |
| | that may result from orders provided tha the Department with | hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance. | | | | |
| | receipt of State lice the Minnesota Depa Informational Bullet <http: www.health.<br="">fobul.htm> The St delineated on the a</http:> | participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/in ate licensing orders are | | | | |
| ABORATOR | epartment of Health Y DIRECTOR'S OR PROVIE ically Signed | DER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | TITLE | | (X6) DATE 10/16/17 |

Electronically Signed

STATE FORM

If continuation sheet 1 of 30

| STATEMENT OF | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
|--|---|--|-------------------------|--|----------------------------------|-------------------------|
| | | 00002 | B. WING | | 09/ | 21/2017 |
| NAME OF PROV | IDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| AITKIN HEAL | TH SERVICES | | NESOTA AVEN MN 56431 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 000 Cor Jeg you is n enta text Sta con corr Min On Deg the Plea corr anc Min the fedd ass Nur The colu stat "Su anc corr Min the Plea corr anc corr anc Plea corr anc corr find after Plea corr anc corr find after Plea corr anc corr find after Plea corr anc corr find after Plea corr find after PLE FO | electronically. ecessary for Sta er the word "cor t. You must then te licensure pro- npletion date, the rected prior to e unesota Departm 9/18/17-9/21/17 partment's staff, following correct ase indicate in y rection that you I identify the dat unesota Departm State Licensing eral software. Ta igned to Minnes rsing Homes. e assigned tag m umn entitled "ID tute/rule out of commary Statement dence by." Follo the Suggested are period for Con EASE DISREGA | Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 7, surveyors of this visited the above provider and totion orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed. The orders have been so a state statutes/rules for to prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and | 2 000 | DEFICIENC | Υ) | |

| STATEMEN | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVE COMPLETED | |
|--------------------------|--|---|------------------------|--|------------------------------|------------------------|
| | | 00002 | B. WING | | 09/21/20- | 17 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | |
| AITKIN H | IEALTH SERVICES | | IESOTA AVE IN 56431 | NUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE CON | (X5) MPLETE DATE |
| 2 000 | Continued From pa | ge 2 | 2 000 | | | |
| | PLAN OF CORREC | QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES. | | | | |
| 2 565 | MN Rule 4658.0405 Plan of Care; Use | 5 Subp. 3 Comprehensive | 2 565 | | 10/2 | 27/17 |
| | Subp. 3. Use. A comust be used by all care of the resident | omprehensive plan of care personnel involved in the | | | | |
| | by: Based on observation review, the facility fa | ent is not met as evidenced on, interview and document ailed to implement ected by the care plan for 2 of 2) reviewed who required ons to promote independent | | Corrected | | |
| | Findings include: | | | | | |
| | 6/13/17, identified F | imum Data Set (MDS) dated 32 had severe cognitive dependent with eating, and disorders. | | | | |
| | dated 9/6/17, identifi mechanical soft die assessment identifi therapy] in June [20 episode. Resident and eats very quick | I's Observation assessment fied R2 consumed a t with puree vegetables. The ed, " was seen by [speech 17] [related to] a choking doesn't chew her food well, ly. She receives her food in an effort to reduce the speed | | | | |

| STATEMEN | ta Department of He TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED 09/21/2017 | |
|--------------------------|--|---|-------------------------|--|---|-------------------------|
| | | 00002 | B. WING | | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | TATE, ZIP CODE | | |
| AITKIN H | IEALTH SERVICES | | NESOTA AVEN MN 56431 | IUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 565 | Continued From pa | age 3 | 2 565 | | | |
| | of her eating." | | | | | |
| | required, "supervisi eating," and listed a | ed 9/13/17, identified R2 ion and occasional assist for an intervention of, "Serve Food - Offer 1 at a time." | | | | |
| | in Individual Bowls - Offer 1 at a time." During observation on 9/18/17, at 5:02 p.m. R2 was seated in the Garden Terrace dining room with several other residents. At 5:20 p.m. R2 was served a regular plate of food with lasagna, peas and garlic bread. R2 had a visible white colored menu slip placed on the table directly in front of her which identified she consumed a mechanical soft diet. Further, the slip had black text which had been highlighted in yellow which read, "Separate bowls [spacing] for all foods." The meal was not served in bowls as directed by her care plan or menu slip. R2 began to eat the lasagna using a regular fork in her right hand, while attempting to pick up some cooked cheese from the lasagna using her left hand and attempting to eat them both at the same time. Nursing assistant (NA)-E was seated on R2's right side, assisting another resident with eating, and asked R2, "Can you take a little drink?" R2 did not verbally respond to NA-E and continued eating, often times not waiting for her mouth to be cleared of food before taking additional bites. | | | | | |
| | consumed all of the her fingers to run a fingers several time cc (cubic centimete and started to drink "slow down," while | minutes later) R2 had e provided lasagna and used long the plate, licking her es. R2 then picked up a 240 er) glass of red colored juice k it. NA-E stated aloud to R2, she drank. R2 then picked up of mixed berries and began to | | | | |
| | consume them usir | from the bowl like it was a | | | | |

| STATEMEN | Dta Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|-----------------------|--|-------------------------------|-------------------------|
| | | 00002 | B. WING | | 09// | 21/2017 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, S | TATE, ZIP CODE | | |
| AITKIN H | HEALTH SERVICES | 301 MINNI AITKIN, M | ESOTA AVEN N 56431 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE |
| 2 565 | Continued From pa | ge 4 | 2 565 | | | |
| | glass. | | | | | |
| | finished consuming dish and attempted table mates bowl of "this mine[?]" while told R2 it was not, a dishes in a pile on t 100% of the provide During interview on stated the white me communicate a res "additional informat for, "kitchen staff to assistants] to doubl are being served th R2 had been server regular plate adding and at risk of chokin NA-E stated she wa interventions being risk of choking besi questioned about th directing to give R2 NA-E stated they an from, "what I've hea it was still a current When interviewed of registered nurse (R used to, "communio need," in order to, " Further, RN-C state quickly at times she staff should be follo her menu slip, and | 9/18/17, at 6:22 p.m. NA-E enu slips are used to idents specific diet and also, ion," like special instructions see and for [nursing e check," to ensure residents e correct diets. NA-E stated d the evening meal on a g R2 was, "a speedy eater," ng, "from eating so fast." | | | | |

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED |
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| | | 00002 | B. WING | | 09/21/2017 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | TATE, ZIP CODE | - | |
| AITKIN H | IEALTH SERVICES | 301 MINN AITKIN, M | IESOTA AVEN IN 56431 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 565 | Continued From pa | age 5 | 2 565 | | | |
| | 8/29/17, identified F required extensive Further, R22's face identified R22 had system disorder wh R22's care plan print required frequent at with use of adaptive "2-handled cup with dycem [non-slip mathing] | himum Data Set (MDS) dated R22 was cognitively intact and assistance of one with eating. e sheet printed 9/12/17, essential tremors (a nervous hich causes rhythmic shaking). Inted 9/22/17, identified R22 assistance with eating along e equipment which included a, h lids and straws, divided plate, aterial]." The care plan ovide this equipment and fed. | | | | |
| | was seated at a tak was holding a spoo visible tremors in h of two to three inch served her meal or and used both hand up to her mouth us several instances of the plate onto the tak minutes later) nursi approached and of R22. When intervit NA-F stated R22 w | on 9/18/17, at 5:42 p.m. R22 ble for the evening meal. R22 on with both hands and had er lower arms with movements les back and forth. R22 was n a regular, non-lipped plate ds to bring food from the plate ing the regular spoons with of food falling over the edge of able. At 5:54 p.m. (12 ing assistant (NA)-F fered assistance with eating to iewed after the meal service, vas provided assistance with otice she is having troubles | | | | |
| | stated " I am tired a R22 stated it was b | a 9/19/17, at 1:47 p.m. R22 and wore out. It is every day." best to use a soup spoon and attempting to eat related to the mors. | | | | |
| | During subsequent | observation on 9/20/17, at | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | • • | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 00002 | B. WING | | 09/21/2017 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| AITKIN I | HEALTH SERVICES | | NESOTA AVEN MN 56431 | IUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE |
| 2 565 | Continued From pa | age 6 | 2 565 | | | |
| | a table, and had be half, along with mar- was again served h non-lipped plate. Ri- sandwich on her ow hands, however, sh staff to eat the mass When interviewed of stated R22 was abl independently, how when needed addir foods. NA-B stated equipment during n including a lipped p push food against t utensil. During sul at 1:36 p.m. NA-B s used on 9/20/17, fo service, adding she lipped plate. NA-B error at that time, s dietary staff to have Further, during the registered nurse cli joined the conversa equipment, like a lip on the care plan an served her meal on the care plan. A policy on implement provided. | on 9/20/17, at 2:06 p.m. NA-B le to feed herself vever, would ask for assistance ong she did well with finger d R22 used some adaptive neals to help her with eating, plate, which allowed R22 to the edge and scoop it on her bsequent interview on 9/21/17, stated a regular plate was or R22 during the lunch meal e did not notice it was not a stated if she had noticed the hould could have notified e it addressed. interview with NA-B, nical coordinator (RN)-D ation and stated adaptive pped plate, should be outlined and R22 should have been in a lipped plate as directed by enting the care plan was not | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED 09/21/2017 | |
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| | | 00002 | B. WING | | | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | |
| AITKIN H | IEALTH SERVICES | | NESOTA AVE MN 56431 | NUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 2 565 | Continued From pa | ige 7 | 2 565 | | | |
| | care plans, then au | dit to ensure compliance. | | | | |
| | TIME PERIOD FOR days. | R CORRECTION: Seven (7) | | | | |
| 2 830 | MN Rule 4658.0520 Proper Nursing Car | 0 Subp. 1 Adequate and re; General | 2 830 | | | 10/27/17 |
| | receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t | general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be our possible unless there is a he attending physician that the in in bed or the resident bed. | d t | | | |
| | by: Based on observati review, the facility f were comprehensiv | ent is not met as evidenced ion, interview and document ailed to ensure smoking risks vely assessed for 1 of 1 o currently smoked off facility | | Corrected | | |
| | Findings include: | | | | | |
| | 7/26/17, indicated F did not have any fu | inimum Data Set (MDS) dated R46 had intact cognition and nctional limitations in the The MDS identified diagnoses manic depression. | | | | |

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED |
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| | | 00002 | B. WING | | 09/21/2017 | |
| IAME OF F | PROVIDER OR SUPPLIER | | DDRESS, CITY, S | | | |
| AITKIN H | IEALTH SERVICES | | NESOTA AVEN MN 56431 | IUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | ION SHOULD BE | (X5) COMPLET DATE |
| 2 830 | Continued From pa | age 8 | 2 830 | | | |
| | R46's progress not | tes indicated the following: | | | | |
| | - 7/23/17, at 1:25 p.m. indicated R46 was found outside smoking with another resident. R46 was reminded of the non-smoking policy and indicated he understood, and then was found again smoking outside. | | Ł | | | |
| | was spoken to abo entrance of the fac the non- smoking p smoke on the grou he would think abo | b.m. indicated on 7/24/17, R46 out smoking in the front ility. R46 stated he understood policy and stated he would "not nds of the facility." R46 stated ut other smoking options and se if R46 chose to quit | | | | |
| | R46 and the admin | ct dated 7/31/17, signed by histrator, indicated R46 agreed cility grounds and would only y grounds. | | | | |
| | stated he smoked a the street from the | n 9/19/17, at 10:52 a.m. R46 a couple times a week, across facility when a friend of his r stated his friend kept his ter for him. | | | | |
| | | ord did not include a sessment for smoking. | | | | |
| | | ted 7/31/17, did not include elated to R46's smoking. | | | | |
| | was seated in a wh independently in th | on 9/20/17, at 7:41 a.m. R46 neelchair eating breakfast e dining room. R46 had no urn holes in his clothing. | | | | |
| | During an interview | v on 9/20/17, at 10:02 a.m. | | | | |

| | Dta Department of He NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED |
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| | | 00002 | B. WING | | 09/ | 21/2017 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | TATE, ZIP CODE | | |
| AITKIN H | HEALTH SERVICES | | IESOTA AVEN MN 56431 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 2 830 | nursing assistant (N the street to the old accompanied by a f never burned himse clothing. NA-C state was currently smok During interview on stated R46 was a p and she had never R46 had a lot of vis frequently with then When interviewed of registered nurse (R smoke on facility gr smoked when he w outings. RN-B was assessment had be further stated a smo between R46 and th agreed not to smok During interview on stated the facility gr RN-C stated a smo been completed on were non- smoking he [R46] does off o business." RN-C sta developed because facility grounds. On 9/21/17, at 10:2 director of quality (I responsible for wha grounds and a smo been completed as | NA)-C stated R46 went across Family Dollar to smoke, friend. To her knowledge R46 elf or had burn holes in his ed the nurses were aware R46 ing off facility property. 9/20/17, at 10:22 a.m. NA-D rivate and independent persor seen R46 smoking, however, itors and left the facility | | | | |

| STATEMEN | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00002 | B. WING | | 09/21/2017 | |
| NAME OF | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | | | |
| AITKIN H | HEALTH SERVICES | | NESOTA AVEN MN 56431 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹ | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 2 830 | Continued From pa grounds. | ige 10 | 2 830 | | | |
| | indicated smoking y property grounds. notify residents that the property ground assessment would resident was not be or family member. SUGGESTED MET director of nursing of inservice staff to as smoking assessme safety for any resid | g policy dated 6/10/17, was forbidden anywhere on The policy directed staff to t smoking was only allowed off ds. The policy also indicated ar be completed only if the sing accompanied by a friend THOD OF CORRECTION: The (DON) or designee could a ensuring comprehensive ents are completed to ensure ent identified to be smoking | 1 | | | |
| | while admitted to th TIME PERIOD FOR (10) days. | R CORRECTION: Ten days | | | | |
| 2 915 | Subp. 6. Activities comprehensive res home must ensure A. a resident is treatments and ser abilities in activities deterioration is a not the resident's cond part, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech | given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of ition. For purposes of this ally living includes the ss, and groom; id ambulate; | 2 915 | | | 10/27/17 |

Minnesota Department of Health STATE FORM

6899

16M811

If continuation sheet 11 of 30

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION (| X3) DATE SURVEY COMPLETED | |
|---------------|---|---|-------------------------|--|------------------------------|--|
| | | 00002 | B. WING | | 09/21/2017 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | |
| AITKIN H | IEALTH SERVICES | | IESOTA AVE /IN 56431 | NUE SOUTH | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | | |
| 2 915 | Continued From pa | ge 11 | 2 915 | | | |
| | | | | | | |
| | This MN Requireme by: | ent is not met as evidenced | | | | |
| | Based on observati review, the facility fa therapy intervention improve independe | on, interview and document ailed to implement speech is to reduce risk factors and nt eating for 1 of 2 residents ating habits and abilities. | | Corrected | | |
| | Findings include: | | | | | |
| | 6/13/17, identified F | imum Data Set (MDS) dated R2 had severe cognitive dependent with eating, and disorders. | | | | |
| | dated 9/6/17, identi mechanical soft die assessment identifi therapy] in June [20 episode. Resident and eats very quick individual bowls in a of her eating." Furt 7/1/17, identified R2 and was eating her had her slow down eating her mixed ver | e's Observation assessment fied R2 consumed a t with puree vegetables. The ed, " was seen by [speech 017] [related to] a choking doesn't chew her food well, ly. She receives her food in an effort to reduce the speed her, R2's progress note dated 2 was, "eating supper tonight food to [sic] fast. The staff several times She started egetables and then was wing up and spitting phlegm." | | | | |
| | 6/26/17, identified r safety and efficienc included, "Caregive | py Discharge Summary dated ecommendations to, "facilitate y," for R2 while eating which er training provided; care plan patient small bowls of food at a | | | | |

| STATEME | Dta Department of He NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00002 | B. WING | B. WING | | 21/2017 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AI | DRESS, CITY, ST | ATE, ZIP CODE | | |
| | HEALTH SERVICES | | NESOTA AVEN MN 56431 | UE SOUTH | | |
| (X4) ID PREFIX TAG | IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED | | ION SHOULD BE | (X5) COMPLET DATE |
| 2 915 | time [one presentat reduce the bolus si: period." R2's care R2 required, "super for eating," and liste Food in Individual E During observation was seated in the G with several other r served a regular pla and garlic bread. F menu slip placed of her which identified soft diet. Further, t had been highlighte bowls [spacing] for served in bowls as menu slip. R2 bega regular fork in her r pick up some cooke using her left hand both at the same tir was seated on R2's resident with eating take a little drink?" to NA-E and contine waiting for her mou taking additional bit At 5:23 p.m. (three consumed all of the her fingers to run a fingers several time cc (cubic centimete and started to drink "slow down," while an additional plate of | tion of food at a time] to ze and increase meal time plan, dated 9/13/17, identified rvision and occasional assist ed an intervention of, "Serve Bowls - Offer 1 at a time." on 9/18/17, at 5:02 p.m. R2 Garden Terrace dining room esidents. At 5:20 p.m. R2 was ate of food with lasagna, peas R2 had a visible white colored in the table directly in front of she consumed a mechanical he slip had black text which ed in yellow reading, "Separate all foods." The meal was not directed by her care plan or an to eat the lasagna using a ight hand, while attempting to ed cheese from the lasagna and attempting to eat them me. Nursing assistant (NA)-E s right side, assisting another I, and asked R2, "Can you R2 did not verbally respond ued eating, often times not th to be cleared of food before | | DEFICIENC | | |

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00002 | B. WING | | 09/21/2017 | |
| NAME OF F | PROVIDER OR SUPPLIER | | DRESS, CITY, S | | | |
| AITKIN H | IEALTH SERVICES | | NESOTA AVEN MN 56431 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE |
| 2 915 | Continued From pa | age 13 | 2 915 | | | |
| | glass. | | | | | |
| | finished consuming dish and attempted table mates bowl o "this mine[?]" while told R2 it was not, dishes in a pile on 100% of the provid | | | | | |
| | stated the white me communicate a res "additional informat for, "kitchen staff to assistants] to doub are being served th NA-E stated R2 ha plate adding R2 was stated she was una being used to help eating and choking When questioned a instructions directin separate bowls, NA | n 9/18/17, at 6:22 p.m. NA-E enu slips are used to sidents specific diet and also, tion," like special instructions o see and for [nursing le check," to ensure residents ne correct diets and meals. d been served on a regular as, "a speedy eater." NA-E aware of any interventions R2 reduce the speed of her besides, "a lot of cueing." about the menu slip ng to give R2 her food in A-E stated she was unsure if ent intervention for R2 or not. | | | | |
| | registered nurse (F meals so quickly at choke," and staff s | on 9/20/17, at 12:20 p.m. RN)-C stated R2 eats her t times she, "would almost hould be providing her food to wls to, "slow her down." | | | | |
| | language therapist evaluation complet quickly and having stated due to R2's | n 9/20/17, at 12:34 p.m. speech (SLP)-A stated R2 had an red on 6/26/17, due to eating a choking episode. SLP-A cognitive impairment and per swallowing strategies or | | | | |

| STATEMEN | Dta Department of He NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00002 | B. WING | | 09/21/2017 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | HEALTH SERVICES | | NESOTA AVEN MN 56431 | IUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| 2 915 | cues, the only optio "environmental cha food in separate bo SLP-A stated imple would allow, "some consumed the next staff, "should be," g separate bowls or r | - | 2 915 | | | |
| | director of nursing (regarding ensuring to safe eating are c audit to ensure com | THOD OF CORRECTION: The (DON) could inservice staff resident interventions related onsistenly implemented, then npliance. R CORRECTION: Seven (7) | | | | |
| 2 945 | MN Rule 4658.0530 Eating - Nursing Per Subpart 1. Nursing personnel must det served diets as pre help in eating must receipt of the meals unhurried and in a r enhances each res Adaptive self-help of contribute to the res eating. Food and fl be observed and de reported to the nurs resident's care duri | 0 Subp. 1 Assistance with ersonnel g personnel. Nursing termine that residents are scribed. Residents needing be promptly assisted upon a and the assistance must be manner that maintains or ident's dignity and respect. devices must be provided to sident's independence in luid intake of residents must eviations from normal se responsible for the ng the work period the viation was made. Persistent | 2 945 | | | 10/27/17 |

| | IT OF DEFICIENCIES OF CORRECTION | Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | LE CONSTRUCTION | | E SURVEY PLETED |
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| | | 00002 | B. WING | | 09/21/2017 | |
| IAME OF I | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, | STATE, ZIP CODE | | |
| | IEALTH SERVICES | | NESOTA AVE MN 56431 | NUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY) | SHOULD BE | (X5) COMPLET DATE |
| 2 945 | Continued From pa | age 15 | 2 945 | | | |
| | unresolved probler attending physicia | ns must be reported to the n. | | | | |
| | by: Based on observat review, the facility to maximize the ab | tion, interview and document failed to provide a lipped plate pility to eat independently for 1 2) reviewed for activities of daily | , | Corrected | | |
| | Findings include: | | | | | |
| | 8/29/17, identified required extensive Further, R22's face identified R22 had | nimum Data Set (MDS) dated R22 was cognitively intact and assistance of one with eating. e sheet printed 9/12/17, essential tremors (a nervous nich causes rhythmic shaking). | | | | |
| | identified "The pat making it harder fo nursing progress n that during a care o it was identified that | ogress note dated 8/4/17, ient has had more tremor, ir her to eat." Further, R22's ote dated 9/20/17, indicated conference for R22 on 9/19/17, at R22 required increased ting related to tremors. | | | | |
| | completed nutrition consumed a regula with lid, large straw (non slip material) Further, the assess sometimes indepe | te dated 8/31/17, identified a n assessment for R22 who ar diet using a two handled cup vs, divided plate and dycem to promote independent eating sment identified R22 was ndent with eating; however, at ed extensive assist related to | | | | |

| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00002 | B. WING | | 09/21/2017 | |
| NAME OF I | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | | | |
| AITKIN H | IEALTH SERVICES | | NESOTA AVEN MN 56431 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 2 945 | Continued From pa | age 16 | 2 945 | | | |
| | her essential tremo | rs. | | | | |
| | required frequent a with use of adaptive "2-handled cup with dycem." The care this equipment and Further, an undated R22's meal information | nted 9/22/17, identified R22 assistance with eating along e equipment which included a, n lids and straws, divided plate plan directed staff to provide assistance as needed. d dietary menu card identified ation and directed staff to use with lids, dycem, and a divided | | | | |
| | was seated at a tak was holding a soup had visible tremors movements of two R22 was served he non-lipped plate an food from the plate regular soup spoon falling over the edg At 5:54 p.m. (12 mi (NA)-F approached eating to R22. Wh meal service, NA-F | on 9/18/17, at 5:42 p.m. R22 ble for the evening meal. R22 o spoon with both hands and in her lower arms with to three inches back and forth. er meal on a regular, id used both hands to bring up to her mouth using the with several instances of food e of the plate onto the table. inutes later) nursing assistant and offered assistance with en interviewed following the stated R22 was provided ing when staff notice she is e to her tremors. | | | | |
| | stated " I am tired a R22 stated it was b | 9/19/17, at 1:47 p.m. R22 and wore out. It is every day." test to use a soup spoon and attempting to eat related to the mors. | 9 | | | |
| | 12:06 p.m. R22 wa a table, and had be | nt observation on 9/20/17, at s seated in the dining room at een served a sandwich, cut in shed potatoes. Again, R22 | | | | |

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | E SURVEY PLETED | |
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| | | 00002 | B. WING | | 09/ | 09/21/2017 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | | |
| AITKIN F | IEALTH SERVICES | | NESOTA AVEN MN 56431 | IUE SOUTH | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 2 945 | Continued From pa | age 17 | 2 945 | | | | |
| | plate. R22 was able own after it was pla | al on a regular, non-lipped e to eat the sandwich on her aced in her hands, however, stance from staff to eat the | | | | | |
| | stated R22 was abl independently, how when needed; addi foods. NA-B stated equipment during n including a lipped p push food against t utensil. During sul at 1:36 p.m. NA-B used on 9/20/17, for service, and that sh lipped plate. NA-B error at that time, s dietary staff to have the interview, regist (RN)-D joined the o adaptive equipment be outlined on the o During interview on manager (DM) revia and stated a divide served all meals. A | on 9/20/17, at 2:06 p.m. NA-B le to feed herself vever, would ask for assistance ng, she did well with finger d R22 used some adaptive neals to help her with eating, blate, which allowed R22 to the edge and scoop it on her bsequent interview on 9/21/17, stated a regular plate was or R22 during the lunch meal ne did not notice it was not a stated if she had noticed the hould could have notified e it addressed. Further, during tered nurse clinical coordinator conversation and stated t needed by residents would care plan and dietary slip. | , I r | | | | |
| | dietary manager (D (DON) could inserv for ensuring adaptiv | THOD OF CORRECTION: The M) and/or director of nursing rice staff regarding the process ve equipment is consistently sident care needs with eating; e compliance. | 3 | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION (| X3) DATE SURVEY COMPLETED |
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| | | 00002 | B. WING | | 09/21/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | |
| AITKIN H | IEALTH SERVICES | | IESOTA AVE IN 56431 | NUE SOUTH | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETI |
| 2 945 | Continued From pa | ge 18 | 2 945 | | |
| | TIME PERIOD FOF days. | R CORRECTION: Seven (7) | | | |
| 21495 | MN Rule 4658.1009 Providing Social Se | 5 Subp. 5 Social Services; rvices | 21495 | | 10/27/17 |
| | Subp. 5. Providing social services. Social services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405. | | | | |
| | by: Based on observati review, the facility fa assistance with disc | ent is not met as evidenced on, interview and document ailed to provide ongoing charge planning for 1 of 1 iewed for discharge planning. | | Corrected | |
| | Findings include: | | | | |
| | 7/13/17, identified F impairment, require transfers, dressing was independent w the unit, and toiletin | num Data Set (MDS) dated R56 had moderate cognitive ed only supervision with and personal hygiene, and ith locomotion, both on and off g. Further, the MDS identified re discharge plan" in place for community. | | | |
| | was clean and well R56 stated he was nursing home. R56 recovery, however, | on 9/18/17, at 6:46 p.m. R56 groomed. When interviewed, unsure why he still living in the stated he admitted for no longer requires as much o discharge from the nursing | | | |

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00002 | B. WING | | 09/ | 21/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | |
| AITKIN H | IEALTH SERVICES | | NESOTA AVEN MN 56431 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE | (X5) COMPLET DATE |
| 21495 | Continued From pa | age 19 | 21495 | | | |
| | here," slapping his | e's no reason why I should be hands on his knees," and nust have some kind of law for | | | | |
| | practitioner (NP)-A was going to remai rehabilitation. This conference with R5 staff present. NP-A | 9/19/17, at 9:09 a.m. nurse stated she understood R56 n in the nursing home after his decision was made at care 56, his responsible party and A was unaware R56 still had a from the nursing home. | | | | |
| | a.m. R56 stated he living facility (ALF) would be a good liv facility had discuss however, did not w to reside in Aitkin w | interview on 9/20/17, at 8:30 e recently looked at an assisted with a friend (F)-A and felt it ring option for himself. The ed an ALF in another town, ant to move there and wanted where his friends live. R56 e facility about discharge but, nothing." | | | | |
| | a.m. F-A stated he to move to a more and had toured the him about his feelin the facilty. Before a independently living R56 and himself ha services (SS) about | nterview on 9/20/17, at 11:31 was aware that (R56) desired independent living situation ALF with R56. R56 had told ngs of being held a prisoner at admission, R56 was g in his own home. F-A stated ad talked with the facility social it moving but the facility stay there but (R56) would be e ALF. | | | | |
| | completed 8/3/17, i cognitive deficits w management of fin | therapy (OT) consultation identified R56 exhibited some ith medication set up, ances, looking up numbers in roblems with completing travel | | | | |

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED | | |
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| | | 00002 | B. WING | | 09/ | 21/2017 | | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | | | | |
| | IEALTH SERVICES | | NESOTA AVEN | IUE SOUTH | | | | |
| | | | MN 56431 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLE DATE | | |
| 21495 | Continued From pa | age 20 | 21495 | | | | | |
| | | esidents double vision. At that 24 hour supervision. | | | | | | |
| | 8/14/17, identified I | medical doctor (MD)-A on R56 was close to baseline from he encouraged R56 to try an | ו | | | | | |
| | (NP)-A identified R and had inquired if assisted living. NP- vision had resolved headaches followir subdural hematom considering moving returning home, an | 8/17/17, from nurse practione 56 was alert to conversation he will be able to go to -A identified R56's double d, but still had occasional ng his motor vehicle accident a. NP-A stated R56 was g to an assisted living versus ad felt this would be in his best ed by MD-A progress note of | r | | | | | |
| | director of nursing care conference has assessed by occup needed 24 hour su | note dated 8/24/17, by the (DON) identified a resident ad been held. R56 was bational therapy (OT) and pervision. They were waiting r medical assistance prior to | | | | | | |
| | R56 decided to sta time and had chose further identified th | ered nurse (RN)-D documented by at the facility for a period of en not to go to ALF. The note at R56 did not wish to be arging and would let the facility hed to discharge. | | | | | | |
| | stated R56 require knew F-A had take however, R56 deci | n 9/21/17, at 10:22 a.m. SS d 24 hour supervision and n R56 to tour a local ALF, ded to remain at the facility when she met with R56 and | | | | | | |

| STATEME | Dta Department of He NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00002 | B. WING | | 09/ | 21/2017 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | TATE, ZIP CODE | | |
| | HEALTH SERVICES | | IESOTA AVEN MN 56431 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE |
| 21495 | F-A this morning (9 changed his mind f both R56 and F-A s facility for the winter to the nursing home home to screen R5 was completed or w screen was, adding anything. She state his mind." SS state assessment and de supervised living si was completed on a cognitive testing on had no cognitive im OT was notified to since R56 showed she completed her During interview at stated F-A had bee brought some pape want to stay in the n and wanted to mov During interview on R56 and SS, R56 s don't want to stay h she had placed a c awaiting a return ca be best for him to n During interview on occupational therap been assessed on 8/3/17. OT-A stated completed they rec supervision and rec medications. OT-A | /21/17). SS stated R56 requently and this morning, spoke about R56 staying at the r, and would be bringing items e. The ALF was at the nursing 6 but was unsure when this what the outcome of the g she had not documented d, "Tomorrow he may change ed OT completed an etermined a 24 hour tuation was indicated which 8/3/17. She completed a 9/12/17, and identified R56 spairment. SS was unsure if complete a new assessment no cognitive impairment when assessment on 9/12/17. 9/21/17, at 10:47 a.m. R56 n in this morning to visit and erwork to complete. He did not nursing home for the winter, e to the ALF. 9/21/17, at 10:52 a.m. with tated "On this winter stuff, I ere this winter." SS stated all to the ALF and was all. R56 stated he felt it would | | | | |

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| AITKIN H | EALTH SERVICES | | IESOTA AVEN IN 56431 | IUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21495 | Continued From pa | age 22 | 21495 | | | |
| | done in August. Th been informed of c | would be an opportunity to assess, which was done in August. The OT-A stated she had not been informed of changes in R56's cognition and thought an ALF would be appropriate for R56. | | | | |
| | SS, administrator, a stated R56 had a h from staying to bein administrator stated however, R56 was term care unit beca the facility. The ad R56 with his financ decisions for R56. decision making. T had not toured any SS and RN-D clarif ALF. R56 was initia changed his mind a transfer to the ALF. BIMS (cognitive tes was addressed in a | d R56 was a short term stay, recently moved to the long ause he wanted to remain in ministrator stated F-A assists es, but they do not make R56 was independent in his he administrator stated R56 ALF facilities in the area but fied R56 had toured the local ally interested, per RN-D but as he was proceeding with a . RN-D and SS stated his sting tool) had improved which a morning meeting but they date this occurred or whom | | | | |
| | a.m. the owner of the present for the tour transfer to the ALF on 9/14/17 and the orders and an update orders and an update orders. | nterview on 9/22/17, at 10:51 he local ALF stated he was and screening of R56 for his The resident was screened y were awaiting medication ated admission history and admission to the ALF. | | | | |
| | a.m. F-A stated he 9/21/17 and discus F-A stated although stay at the nursing | nterview on 9/22/17, at 10:56 met with SS and R56 on sed R56's plan for housing. In the facility staff wanted him to home, R56 had not agreed to home, and wanted to move to | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | (X3) DATE SURVEY COMPLETED 09/21/2017 | |
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| | | 00002 | B. WING | | | |
| JAME OF F | PROVIDER OR SUPPLIER | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| AITKIN F | EALTH SERVICES | | ESOTA AVE | NUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLE ⁻ DATE |
| 21495 | Continued From pa | age 23 | 21495 | | | |
| | the ALF. F-A stated work well for R56. | d he thought the ALF would | | | | |
| | but was not receive made for resident therapies. A blank copy of completed | sted for discharge planning ed. A request for policies was referral for evaluation by referral form was provided. A referral for R56 following 9/12/17 was requested and | | | | |
| | administrator or de social services sta who seek a discha needs, along with actions in the med | THOD OF CORRECTION: The esignee could inservice the ff regarding helping residents rge plan with their wishes and documenting these steps and ical record. The administrator ensure compliance. | | | | |
| | TIME PERIOD FO (21) days. | R CORRECTION: Twenty-one | | | | |
| 21565 | MN Rule 4658.132 Medications Self A | 5 Subp. 4 Administration of dmin | 21565 | | | 10/27/1 |
| | self-administer me resident assessme care as required in 4658.0405 indicate | ninistration. A resident may dications if the comprehensive ent and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician. | | | | |
| | by: Based on observat review, the facility had been conducted | ient is not met as evidenced tion, interview and document failed to ensure an assessment ed for self-administration of of 1 residents (R29) who's | | Corrected | | |

| STATEMEN | ta Department of He TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | E SURVEY PLETED | |
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| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | | |
| AITKIN H | IEALTH SERVICES | 301 MINN AITKIN, M | ESOTA AVEN IN 56431 | IUE SOUTH | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE | |
| 21565 | Continued From pa | ige 24 | 21565 | | | | |
| | medication was left dining room. | unattended at the table in the | | | | | |
| | Findings include: | | | | | | |
| | | imum Data Set assessment, cated R29's cognition was | | | | | |
| | diagnosis of atrial fi heart's two upper c | printed 9/19/17, included a ibrillation (condition when the hambers beat out of he two lower chambers of the | | | | | |
| | included orders for treat atrial fibrillation Thursday and Cour | der sheet, printed 9/19/17, Coumadin (blood thinner to n) 2.5 milligrams (mg) daily on madin 5 mg daily on all other cheduled for 5:00 p.m. with a 7. | | | | | |
| | registered nurse (R paper cup, with one side of R29's place room. RN-A told R2 out of the dining roo The medication car dinning room to the threshold. The medicable was not visible | on 9/18/17, at 5:18 p.m. N)-A placed a small white oval peach pill, on the right mat on the table in the dining 9 here's your pill and walked om back to medication cart. t was located outside the e right of the dinning room dication left on the dining room e from the cart. R29 was | | | | | |
| | table. At 5:21 p.m. table in the dining r closed. The medic the cup until 5:22 p room, woke up R29 | ther male residents at this R29 remained seated at the oom, however, his eyes were ation remained on the table in .m. when RN-A entered dining and administered the pill had been left on the dining | | | | | |

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED |
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| AITKIN H | IEALTH SERVICES | | NESOTA AVEN MN 56431 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ^Y | ON SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 21565 | Continued From pa | ige 25 | 21565 | | | |
| | When interviewed on 9/18/17, at 6:54 p.m. RN-A stated medications were only to be left with residents who were known to be able to administer medication independently. RN-A also stated R29 shouldn't have been left alone with the medication and required that the nurse to stay with the resident until the medication was consumed. | | • | | | |
| | licensed practical n those residents wit | on 9/19/17, at 1:25 p.m. urse (LPN)-A stated only h an assessment to dications can be left edications. | | | | |
| | registered nurse (F assessed to safely | on 9/19/17, at 2:10 p.m. N)-D stated R29 was not self- administer medication. hould not have been left alone is medication. | | | | |
| | 3:00 p.m. LPN-A lo Administration Rec of the pill and time LPN-A stated R29's unattended at the c was Coumadin as t | on 9/19/17, at approximately oked at the Medication ord. Based on the description of scheduled administration, s oval peach pill that was left lining room table on 9/18/17 this was the only medication I during the supper hour. | | | | |
| | director of nursing been left unattende | on 9/19/17, at 2:16 p.m. the stated R29 should not have d with medication and staff with the resident until the nsumed. | | | | |
| | Medication by Resi | ed Self Administration of dents policy, directed staff to f resident's wishing to self | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE S COMPL | |
|--------------------------|---|---|------------------------|---|----------------------|--------------------------|
| | | 00002 | B. WING | | 09/2 1 | /2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| AITKIN H | HEALTH SERVICES | | NESOTA AVE MN 56431 | NUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21565 | Continued From pa | ge 26 | 21565 | | | |
| | administer for cogn abilities. | itive, physical and visual | | | | |
| | director of nursing (regarding ensuring comprehensively as | ssessed for safety with ninistration, then audit to | • | | | |
| | TIME PERIOD FOF days. | R CORRECTION: Seven (7) | | | | |
| 21805 | MN St. Statute 144 Residents of HC Fa | .651 Subd. 5 Patients & ac.Bill of Rights | 21805 | | | 10/27/17 |
| | residents have the courtesy and respe | us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a | | | | |
| | by: | ent is not met as evidenced | | | | |
| | review, the facility f privacy was mainta 1 residents (R66) o | ion, interview and document ailed to ensure personal ined to promote dignity for 1 o bserved with bare skin and ble from the hallway to other and staff. | f | Corrected | | |
| | Findings include: | | | | | |
| | 9/4/17, identified Re impairment, display | inimum Data Set (MDS) dated 66 had moderate cognitive ved no disorganized thinking, sive assistance for most | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE SURVEY COMPLETED 09/21/2017 | |
|--------------------------|--|--|-------------------------|--|---|-------------------------|
| | | 00002 | B. WING | | | |
| IAME OF F | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, S | TATE, ZIP CODE | | |
| | EALTH SERVICES | | NESOTA AVEN MN 56431 | IUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 21805 | identified R66 had incontinence along schizophrenia and, Pulmonary Disease Disease." During observation was laying in bed ir wide open, and full had a fan running a sheet on top of him pulled down past h knees exposing his gray colored incont a visible track insta metallic hooking de however, the room installed. At 5:39 p the facility, R21, wh door opened, howe quarterly MDS date severe cognitive im An additional obser (over one hour late in his room with the continued to have t past his waist, expo legs and gray color interviewed immed observation, R66 s uncomfortable and "sometimes," has c | ing (ADLs). Further, the MDS occasional urinary with depression, "Asthma, Chronic Obstructive e [COPD], or Chronic Lung on 9/18/17, at 5:36 p.m. R66 h is private room with the doo y visible to the hallway. R66 along with a single white bed h, however, the sheet was is waist going to almost his bare chest, upper legs and a inence brief. R66's room had lled on the ceiling which had evices to hang a curtain, had no privacy curtains 0.m., another resident living in heeled by his room with the ever, did not look inside. R21's ed 5/10/17, identified R21 had ipairment. evation on 9/18/17, at 6:37 p.m r) found R66 remained in bed e doorway opened. R66 he white linen pulled down osing his bare chest, upper ed incontinence brief. When | r | | | |
| | | - | | | | |

| | Dta Department of He NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED | |
|--------------------------|--|---|-------------------------|--|-----------------------------------|-------------------------|--|
| | | 00002 | B. WING | | 09/ | 09/21/2017 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | TATE, ZIP CODE | | | |
| AITKIN I | HEALTH SERVICES | | NESOTA AVEN MN 56431 | UE SOUTH | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 21805 | 1:35 p.m. R66 was doorway opened ar R66's eyes were cle down around his wa chest. At 1:38 p.m. was walking down t R66's room, then tu walking. When interviewed of nursing assistant (N observed R66 layin stated R66, doesn't time and declined h the morning when s felt R66 should be v not have to see him residents' home an too." Further, NA-E any other residents being exposed. During interview on registered nurse (R his room with his bas stated R66 will occa gown or clothing as stated R66 laying ir and visible to others concern for him," al installing a privacy of discussed as an int When interviewed of director of nursing (seen R66 laying in however, added sh hallway. The DON | again laying in bed with his nd visible from the hallway. osed, and his bedding was aist which exposed his bare an unidentified male visitor the hallway and looked into urned his head away and kept on 9/20/17, at 1:39 p.m. NA)-D and this surveyor, g in bed in his room. NA-D twear clothing most of the naving a shirt put on earlier in staff offered. NA-D stated she wearing a shirt so others did n exposed, as it was "other d they should be comfortable D stated she had not heard of making comments about R66 9/20/17, at 1:55 p.m. N)-B observed R66 laying in are chest exposed. RN-B asionally refuse to wear a ti feels restrictive. RN-B n bed with bare skin exposed s, "definitely could be a dignity nd added she was unaware if curtain had ever been | | DEFICIENC | ΥΥ) | | |

| STATEMENT OF DEFICIENCIES(X1) PROVIDER/SUPPLIER/CLIAAND PLAN OF CORRECTIONIDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---------------------------------|--|-----------------------------------|-------------------------|
| | | | | | | |
| | | 00002 | B. WING | | 09/ | 21/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST NESOTA AVEN | | | |
| AITKIN H | IEALTH SERVICES | | MN 56431 | 0E 300 m | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21805 | Continued From pa | age 29 | 21805 | | | |
| | questions pertaining to it. The DON stated R66 denied being too hot in the room and would allow a curtain to be installed. Further, the DON stated no interventions, like installing a curtain or offering to change rooms to a less traveled portion of the hallway, had ever been discussed with R66 as she, "didn't realize," it was a concern. During interview on 9/20/17, at 2:15 p.m. registered nurse, director of quality declined to comment about R66's privacy. A facility Dignity Policy dated 9/2013, identified each resident, "shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality," and listed a procedure which included, "Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." | | ł | | | |
| | The director of nurs inservice staff rega | THOD OF CORRECTION: sing (DON) or designee could rding ensuring patients are not r visible to others and audit to e. | t | | | |
| | TIME PERIOD FOI days. | R CORRECTION: Seven (7) | | | | |
| | | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | Ŧ | (LUAD) | FORM | 10/17/2017 APPROVED 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION 01 - MAIN BUILDING 01 | | E SURVEY PLETED |
| T | | 245119 | B. WING | | | 09/1 | 9/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| AITKIN H | EALTH SERVICES | | | | 01 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| K 000 | INITIAL COMMENT | ſS | КO | 000 | | | |
| | FIRE SAFETY | | | | | | |
| | ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH | OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE. | | | | | |
| | ON-SITE REVISIT CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA | F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. | | | | | |
| | Minnesota Departm Marshal Division. A Aitkin Health Servic compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F | Survey was conducted by the nent of Public Safety, Fire At the time of this survey, see was found not in a requirements for participation hid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), g Health Care. | | | | | |
| | PLEASE RETURN CORRECTION FO DEFICIENCIES (K- | R THE FIRE SAFETY | | | | | |
| | HEALTH CARE FIR STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 5510 | SHAL DIVISION STREET, SUITE 145 | | | | | |
| | By e-mail to both; | | | | | | |
| | director's or provid | DER/SUPPLIER REPRESENTATIVE'S SIG | NATURE | | TITLE | | (X6) DATE 10/16/2017 |

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.

| | | AND HUMAN SERVICES | | | | FORM / | 10/17/2017 APPROVED 0938-0391 |
|-----------------------------------|--|---|---------------------|----|---|-------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION 1 - MAIN BUILDING 01 | (X3) DATE COMF | SURVEY PLETED |
| | | 245119 | B. WING | | | 09/1 | 9/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | 1 | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| | AITKIN HEALTH SERVICES | | | | 1 MINNESOTA AVENUE SOUTH TKIN, MN 56431 | | |
| (X4) ID PREFIX T A G | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| K 000 | Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. | | К 00 | 00 | | | |
| | 3. The name and/o responsible for corr | oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. | | | | | |
| | a full basement. The constructed in 1958 dining room main e the existing building II(111) construction was added that was | ces is a one story building with the original building was 5 with additions in 1962, and a entry was added in 2002. Both g and the addition are type . In 2009-2010 an addition is a one story addition with a was determined to be of Type hs. | | | | | |
| | facility has a compl smoke detection in | e sprinkler protected. The ete fire alarm system with the corridors and spaces r, that is monitored for artment notification. | | | | | |
| | The facility has a lic | censed capacity of 44 beds | | | | | |

If continuation sheet Page 2 of 5

| | | & MEDICAID SERVICES | | | OMB NO. | |
|--------------------------|---|--|---------------------|--|------------|---------------------------|
| | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING | | (X3) DATE SURVEY COMPLETED | | |
| 245119 | | | | 09/1 | 09/19/2017 | |
| NAME OF | PROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| AITKIN I | HEALTH SERVICES | | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETIO DATE |
| K 000 | Continued From pa and had a census o | ige 2 of 40 at the time of the survey, | K 00 | ס | | |
| | 483.70(a) is NOT M | | K 35 | | | 10/6/17 |
| K 351 SS=D | Spinkler System - I 2012 EXISTING Nursing homes, an construction type, a approved automatic accordance with NI Installation of Sprin In Type I and II con measures are perm sprinkler protection or local regulations In hospitals, sprinkl closets of patient sl of the closet does r sprinkler coverage required by NFPA 1 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, 9 This STANDARD is Based on observat system is not instal accordance with NI Installation of Sprin The failure to maint compliance with NI being place out of s the fire protection s of an emergency th | d hospitals where required by are protected throughout by an c sprinkler system in FPA 13, Standard for the kler Systems. struction, alternative protection nitted to be substituted for in specific areas where state prohibit sprinklers. lers are not required in clothes eeping rooms where the area not exceed 6 square feet and covers the closet footprint as 3, Standard for Installation of 19.3.5.3, 19.3.5.4, 19.3.5.5, | | All residents and staff could pote affected by this if an emergency were to occur. The ESD replace ceiling tiles. | event | |

| | OF DEFICIENCIES | & MEDICAID SERVICES | | | | 0938-039 E SURVEY |
|--------------------------|--|---|---|---|---|----------------------------|
| | | | | G 01 - MAIN BUILDING 01 | COMPLETED | |
| 245119 | | B. WING | | 09/19/2017 | | |
| NAME OF F | PROVIDER OR SUPPLIER | n | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| AITKIN H | IEALTH SERVICES | | | 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOL | | JLD BE | (X5) COMPLETION DATE |
| K 351 | Continued From pa | age 3 | K 35 | 1 | | |
| | Findings include: | | | | | |
| | on 09/19/2017, obs mechanical pump r lower level had ope ceiling tiles that are heads. This condit | ween 9:00 a.m. and 1:00 p.m. servations revealed in the room that is located in the enings created from missing a located next to two sprinkler tion would allow the heat and prinkler head and delay it | | | | |
| | Maintenance Supe | ition was verified by the rvisor. eentals - Building System | K 90 | 1 | | 10/27/17 |
| | Building systems a 1 through 4 require Categories are det | | | | | |
| | Based on observa facility has failed to current facility Risk with the NFPA 99 " 2012 edition sectio could affect 40 of 4 | is not met as evidenced by: tion and staff interview, the provide a complete and Assessment in accordance Health Care Facilities Code" n 4.1. This deficient practice O residents, as well as an ber of staff, and visitors. | | K 901 Complete and current fac Assessment in Accordance with It was found that the document incomplete. The current risk ass did not account for all of the roo are located within the building to storage and other support room | NFPA 99. was sessment ms that include | |

Event ID: 16M821

Facility ID: 00002

If continuation sheet Page 4 of 5

| | TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIP | | (X3) DATE SURVEY COMPLETED | |
|-----------------------------------|--|---|---------------------|--|---|---------------------------|
| | | | A: BUILDING | | | |
| | | 245119 | B. WING | | 09/ | 19/2017 |
| AME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 301 MINNESOTA AVENUE SOUTH | | |
| | IEALTH SERVICES | | | AITKIN, MN 56431 | | |
| (X4) ID PREFIX T A G | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETIO DATE |
| K 901 | Continued From pa | ige 4 | K 901 | | | |
| | Findings include: On facility tour between 9:00 a.m. to 1:00 p.m. on 09/19/2017, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility has a risk assessment document but upon reviewing the document it was found that the assessment was incomplete. The current risk assessment did not account for all of the rooms that are located within the building to include storage and other support rooms and it also did not account for all of the systems that are identified in chapters 6, 9, 10, and 11 of the NFPA 99 "Health Care Facilities Code" 2012 edition. | | | also did not account for all of the that are identified in chapters 6, 11 of the NFPA 99 "Health Care Code" 2012 edition. | 9, 10, and | |
| | | | | The risk assessment was modified include much greater detail through each smoke compartment separated by grouping "like" rooms toget separated by dissimilar rooms. Not currently identified were rem Categories were added according chapters 6, 9, 10, and 11 of NFR | ugh listing irately and her, Categories noved. ng to | |
| | This deficient cond Maintenance Supe | ition was verified by the rvisor. | | | | * |
| | | | | | | |

Facility ID: 00002

If continuation sheet Page 5 of 5