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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 16M8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00002

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245119**

2.STATE VENDOR OR MEDICAID NO.
(L2) **231247600**

3. NAME AND ADDRESS OF FACILITY
(L3) **AITKIN HEALTH SERVICES**
(L4) **301 MINNESOTA AVENUE SOUTH**
(L5) **AITKIN, MN** (L6) **56431**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2006**

6. DATE OF SURVEY **11/06/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 12/13/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Peterson, Enforcement Specialist — 01/18/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/09/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 01/24/2018 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/16/2017
(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 Peterson

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 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 Peterson

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

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).

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 16M8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00002

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245119**

2.STATE VENDOR OR MEDICAID NO.
(L2) **231247600**

3. NAME AND ADDRESS OF FACILITY
(L3) **AITKIN HEALTH SERVICES**
(L4) **301 MINNESOTA AVENUE SOUTH**
(L5) **AITKIN, MN** (L6) **56431**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2006**

6. DATE OF SURVEY **09/21/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Austin Fry, HFE-NE II 10/23/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 11/13/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/09/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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:

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

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

Remedies - 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;

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

Informal Dispute Resolution - 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/18/17 to 9/21/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an assessment had been conducted for self-administration of medications for 1 of 1 residents (R29) who's medication was left unattended at the table in the dining room. Findings include:	F 176	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. R29 had a medication self-administration	10/27/17

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

Electronically Signed | 10/16/2017

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F 176	Continued From page 1 R29's quarterly Minimum Data Set assessment, dated 7/17/17, indicated R29's cognition was intact. R29's Face Sheet, printed 9/19/17, included a diagnosis of atrial fibrillation (condition when the heart's two upper chambers beat out of coordination with the two lower chambers of the heart). R29's Physician Order sheet, printed 9/19/17, included orders for Coumadin (blood thinner to treat atrial fibrillation) 2.5 milligrams (mg) daily on Thursday and Coumadin 5 mg daily on all other days of the week scheduled for 5:00 p.m. with a start date of 8/30/17. During observation on 9/18/17, at 5:18 p.m. registered nurse (RN)-A placed a small white paper cup, with one oval peach pill, on the right side of R29's placemat on the table in the dining room. RN-A told R29 here's your pill and walked out of the dining room back to medication cart. The medication cart was located outside the dinning room to the right of the dinning room threshold. The medication left on the dining room table was not visible from the cart. R29 was seated with three other male residents at this table. At 5:21 p.m. R29 remained seated at the table in the dining room, however, his eyes were closed. The medication remained on the table in the cup until 5:22 p.m. when RN-A entered dining room, woke up R29 and administered the pill from the cup which had been left on the dining room table. When interviewed on 9/18/17, at 6:54 p.m. RN-A stated medications were only to be left with	F 176	assessment completed on 4/14/2017 that noted resident does not wish to self-administer medications. Nursing staff to store, document, and administer medications. Re-assessment completed on 10/9/17 which indicates that resident does not wish to self-administer. RN-A educated on 9/18/17 regarding process of medication administration and process and procedure for self-administration of medications. All residents who are not able to self-administer medications have the potential to be affected by this deficient practice. The Self-Administration of Medication policy has been reviewed and revised. Education will be provided to licensed nursing staff and Trained Medication Aides regarding medication administration process and self-administration of medication policy and procedure.This will include education on staying with residents who are not able to self-administer until medication is ingested. All residents who wish to self-administer medications have been assessed for safety to do so. Assessment findings are documented in EMR and implemented on care plan. All charts have been reviewed and are in compliance. SAM assessments are reviewed quarterly for continued appropriateness.	

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F 176	Continued From page 2 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. When interviewed on 9/19/17, at 1:25 p.m. licensed practical nurse (LPN)-A stated only those residents with an assessment to self-administer medications can be left unattended with medications. During an interview on 9/19/17, at 2:10 p.m. registered nurse (RN)-D stated R29 was not assessed to safely self- administer medication. RN-D stated R29 should not have been left alone to self-administer his medication. During an interview on 9/19/17, at approximately 3:00 p.m. LPN-A looked at the Medication Administration Record. Based on the description of the pill and time of scheduled administration, LPN-A stated R29's oval peach pill that was left unattended at the dining room table on 9/18/17 was Coumadin as this was the only medication that was scheduled during the supper hour. When interviewed on 9/19/17, at 2:16 p.m. the director of nursing stated R29 should not have been left unattended with medication and staff should have stayed with the resident until the medication was consumed. The facilities undated Self Administration of Medication by Residents policy, directed staff to assess the ability of resident's wishing to self administer for cognitive, physical and visual abilities.	F 176	DON or Designee will complete audits of medication administration 3 X weekly X 4 weeks, Weekly X 4 weeks, 2 X monthly X 2 months. Audit results will be brought to Qapi for further review and recommendations.	

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F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained to promote dignity for 1 of 1 residents (R66) observed with bare skin and undergarments visible from the hallway to other residents, visitors and staff. Findings include: R66's admission Minimum Data Set (MDS) dated 9/4/17, identified R66 had moderate cognitive impairment, displayed no disorganized thinking, and required extensive assistance for most activities of daily living (ADLs). Further, the MDS identified R66 had occasional urinary incontinence along with depression, schizophrenia and, "Asthma, Chronic Obstructive Pulmonary Disease [COPD], or Chronic Lung Disease." During observation on 9/18/17, at 5:36 p.m. R66 was laying in bed in his private room with the door wide open, and fully visible to the hallway. R66 had a fan running along with a single white bed sheet on top of him, however, the sheet was pulled down past his waist going to almost his knees exposing his bare chest, upper legs and a gray colored incontinence brief. R66's room had a visible track installed on the ceiling which had	F 241	AHS ensures that all residents are treated and cared for in a manner that promotes maintenance or enhances his or her quality of life recognizing each resident's individuality. AHS promotes and protects the right of the resident. This includes ensuring personal privacy is maintained to promote dignity. A privacy curtain has been installed in R66's room to allow resident to see out in the hallway with the curtain partially pulled so that he can lay in bed in whatever garments he chooses while still being able to see out in the hallway per his preference of door being open. R66 cognition was reassessed on 10/10/17 and R66 denies states he is not uncomfortable in room with door open and people looking at him, however was willing to have curtain installed "if you want to". All residents who request to have their door left open and prefer to wear minimal clothing have the potential to be affected by this deficient practice. If a resident is noted to prefer to have the door open and refuses to wear clothing, the facility will	10/27/17

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F 241	Continued From page 4 metallic hooking devices to hang a curtain, however, the room had no privacy curtains installed. At 5:39 p.m., another resident living in the facility, R21, wheeled by his room with the door opened, however, did not look inside. R21's quarterly MDS dated 5/10/17, identified R21 had severe cognitive impairment. An additional observation on 9/18/17, at 6:37 p.m. (over one hour later) found R66 remained in bed in his room with the doorway opened. R66 continued to have the white linen pulled down past his waist, exposing his bare chest, upper legs and gray colored incontinence brief. When interviewed immediately following the observation, R66 stated he was, "a little" uncomfortable and in pain. R66 stated he, "sometimes," has concerns with people walking by his room and staring at him, however, did not elaborate further. R66 stated he could not recall if anyone from the facility had ever visited with him about his privacy. During a subsequent observation on 9/20/17, at 1:35 p.m. R66 was again laying in bed with his doorway opened and visible from the hallway. R66's eyes were closed, and his bedding was down around his waist which exposed his bare chest. At 1:38 p.m. an unidentified male visitor was walking down the hallway and looked into R66's room, then turned his head away and kept walking. When interviewed on 9/20/17, at 1:39 p.m. nursing assistant (NA)-D and this surveyor, observed R66 laying in bed in his room. NA-D stated R66, doesn't wear clothing most of the time and declined having a shirt put on earlier in the morning when staff offered. NA-D stated she	F 241	address the need for a privacy curtain to be installed and/or offer different room placement to accommodate preference of resident while maintaining their personal privacy. AHS dignity policy was reviewed and revised; staff education regarding personal privacy of residents will be completed. DON or Designee will complete audits of resident preference 3 X weekly X 4 weeks, Weekly X 4 weeks, 2 X monthly X 2 months. Audit results will be brought to Qapi for further review and recommendations.	

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F 241	Continued From page 5	F 241		

felt R66 should be wearing a shirt so others did not have to see him exposed, as it was "other residents' home and they should be comfortable too." Further, NA-D stated she had not heard of any other residents making comments about R66 being exposed.

During interview on 9/20/17, at 1:55 p.m. registered nurse (RN)-B observed R66 laying in his room with his bare chest exposed. RN-B stated R66 will occasionally refuse to wear a gown or clothing as it feels restrictive. RN-B stated R66 laying in bed with bare skin exposed and visible to others, "definitely could be a dignity concern for him," and added she was unaware if installing a privacy curtain had ever been discussed as an intervention for him.

When interviewed on 9/20/17, at 2:07 p.m. the director of nursing (DON) stated she had never seen R66 laying in his bed exposed before, however, added she didn't often make it down his hallway. The DON stated she had just spoken with R66 about installing a curtain as another staff had approached her about the surveyors 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

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F 241	Continued From page 6 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."	F 241		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ongoing assistance with discharge planning for 1 of 1 residents (R56) for discharge planning. Findings include: R56's 30-Day Minimum Data Set (MDS) dated 7/13/17, identified R56 had moderate cognitive impairment, required only supervision with transfers, dressing and personal hygiene, and was independent with locomotion, both on and off the unit, and toileting. Further, the MDS identified there was, "an active discharge plan" in place for R56 to return to the community. During observation on 9/18/17, at 6:46 p.m. R56 was clean and well groomed. When interviewed, R56 stated he was unsure why he still living in the nursing home. R56 stated he admitted for recovery, however, no longer requires as much care and felt able to discharge from the nursing home adding, "there's no reason why I should be	F 250	AHS ensures that medically-related social services are provided to attain or maintain the highest practicable physical, mental and psychosocial well- being of each resident by providing ongoing assistance with discharge planning from time of admission until discharge or decision for long-term placement by resident and/or resident representative. On 9/13/17 R56 expressed the desire to remain in the facility and not to be asked about discharge planning and he would notify SSD if he decided he would like to discharge. R56 re-assessed for discharge desires on 10/11/17 and resident would like to remain at SNF, does not want AHS to pursue discharge. Senior Linkage has been involved along with resident county caseworker, all of who support R56 decision for long term placement at facility.	10/27/17

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F 250	Continued From page 7 here," slapping his hands on his knees," and exclaimed, "They must have some kind of law for holding a person!" During interview on 9/19/17, at 9:09 a.m. nurse practitioner (NP)-A stated she understood R56 was going to remain in the nursing home after his rehabilitation. This decision was made at care conference with R56, his responsible party and staff present. NP-A was unaware R56 still had a desire to discharge from the nursing home. During subsequent interview on 9/20/17, at 8:30 a.m. R56 stated he recently looked at an assisted living facility (ALF) with a friend (F)-A and felt it would be a good living option for himself. The facility had discussed an ALF in another town, however, did not want to move there and wanted to reside in Aitkin where his friends live. R56 stated he asked the facility about discharge but, "They don't tell me nothing." During telephone interview on 9/20/17, at 11:31 a.m. F-A stated he was aware that (R56) desired to move to a more independent living situation and had toured the ALF with R56. R56 had told him about his feelings of being held a prisoner at the facilty. Before admission, R56 was independently living in his own home. F-A stated R56 and himself had talked with the facility social services (SS) about moving but the facility thought he should stay there but (R56) would be happier living at the ALF. R56's occupational therapy (OT) consultation completed 8/3/17, identified R56 exhibited some cognitive deficits with medication set up, management of finances, looking up numbers in phone book, and problems with completing travel	F 250	F-A re-interviewed on 10/10/17 and stated that resident is in appropriate environment and that resident has requested to stay at SNF vs. ALF. F-A further states R56 does not understand less restricted environment. R56 believes that means home not in a facility. All residents admitted for short term rehab with impaired cognition have the potential to be affected by this deficient practice. The facilities discharge policy has been reviewed. AHS starts discharge planning on admission until date of discharge. Documentation of discharge planning conversations will be documented in the EMR. AHS holds a pre-discharge planning conference within the first 10 days of admission to plan the discharge and provision of necessary home care services, discharge planning continues with a discharge planning conference prior to discharge, including resident, family and/or resident representative, SNF staff, community resource staff, and county case manager. AHS bases discharge potential on physician evaluation, anticipated level of independence, support personnel available, financial resources, anticipated treatments/procedures required, availability of community resources, and resident and/or family expectations and wishes. Discharge planning is reviewed and revisited quarterly, with significant change and with resident inquiries. All Short stay residents have been	

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F 250	Continued From page 8 subtest related to residents double vision. At that time, R56 needed 24 hour supervision. A narrative note of medical doctor (MD)-A on 8/14/17, identified R56 was close to baseline from two prior visits and he encouraged R56 to try an assisted living. A provider notes of 8/17/17, from nurse practioner (NP)-A identified R56 was alert to conversation and had inquired if he will be able to go to assisted living. NP-A identified R56's double vision had resolved, but still had occasional headaches following his motor vehicle accident subdural hematoma. NP-A stated R56 was considering moving to an assisted living versus returning home, and felt this would be in his best interest, as identified by MD-A progress note of 8/14/17. A nursing progress note dated 8/24/17, by the director of nursing (DON) identified a resident care conference had been held. R56 was assessed by occupational therapy (OT) and needed 24 hour supervision. They were waiting for authorization for medical assistance prior to going to an ALF. On 9/13/17, registered nurse (RN)-D documented R56 decided to stay at the facility for a period of time and had chosen not to go to ALF. The note further identified that R56 did not wish to be asked about discharging and would let the facility know when he wished to discharge. During interview on 9/21/17, at 10:22 a.m. SS stated R56 required 24 hour supervision and knew F-A had taken R56 to tour a local ALF, however, R56 decided to remain at the facility	F 250	interviewed regarding their discharge preferences Staff education regarding discharge planning process and documentation of the discharge planning process will be completed. DON or designee will complete audits regarding residents discharge wishes and facility planning process 2X weekly X 4 weeks, 2 X month X 2 months, and then monthly thereafter. Audit results will be brought to Qapi for further review and recommendation.	

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F 250	Continued From page 9	F 250		

through the winter when she met with R56 and F-A this morning (9/21/17). SS stated R56 changed his mind frequently and this morning, both R56 and F-A spoke about R56 staying at the facility for the winter, and would be bringing items to the nursing home. The ALF was at the nursing home to screen R56 but was unsure when this was completed or what the outcome of the screen was, adding she had not documented anything. She stated, "Tomorrow he may change his mind." SS stated OT completed an assessment and determined a 24 hour supervised living situation was indicated which was completed on 8/3/17. She completed a cognitive testing on 9/12/17, and identified R56 had no cognitive impairment. SS was unsure if OT was notified to complete a new assessment since R56 showed no cognitive impairment when she completed her assessment on 9/12/17.

During interview at 9/21/17, at 10:47 a.m. R56 stated F-A had been in this morning to visit and brought some paperwork to complete. He did not want to stay in the nursing home for the winter, and wanted to move to the ALF.

During interview on 9/21/17, at 10:52 a.m. with R56 and SS, R56 stated "On this winter stuff, I don't want to stay here this winter." SS stated she had placed a call to the ALF and was awaiting a return call. R56 stated he felt it would be best for him to move to the ALF.

During interview on 9/21/17, at 11:00 a.m. occupational therapist (OT)-A stated R56 had been assessed on two occasions, 7/5/17 and 8/3/17. OT-A stated based on the assessments completed they recommended R56 have 24 hour supervision and receive assistance with new

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F 250	Continued From page 10	F 250		

medications. OT-A stated when someone displays an improved cognitive assessment, it 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.

During interview on 9/21/17, at 11:22 a.m. with SS, administrator, and RN-D, the administrator stated R56 had a history of changing his mind, from staying to being transferred. The administrator stated R56 was a short term stay, however, R56 was recently moved to the long term care unit because he wanted to remain in the facility. The administrator stated F-A assists R56 with his finances, but they do not make decisions for R56. R56 was independent in his decision making. The administrator stated R56 had not toured any ALF facilities in the area but SS and RN-D clarified R56 had toured the local ALF. R56 was initially interested, per RN-D but changed his mind as he was proceeding with a transfer to the ALF. RN-D and SS stated his BIMS (cognitive testing tool) had improved which was addressed in a morning meeting but they were unsure what date this occurred or whom was present at the meeting.

During telephone interview on 9/22/17, at 10:51 a.m. the owner of the local ALF stated he was present for the tour and screening of R56 for his transfer to the ALF. The resident was screened on 9/14/17 and they were awaiting medication orders and an updated admission history and physical for (R56's) admission to the ALF.

During telephone interview on 9/22/17, at 10:56 a.m. F-A stated he met with SS and R56 on 9/21/17 and discussed R56's plan for housing.

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F 250	Continued From page 11 F-A stated although the facility staff wanted him to stay at the nursing home, R56 had not agreed to stay at the nursing home, and wanted to move to the ALF. F-A stated he thought the ALF would work well for R56. A policy was requested for discharge planning but was not received. A request for policies was made for resident referral for evaluation by therapies. A blank referral form was provided. A copy of completed referral for R56 following cognitive testing of 9/12/17 was requested and not provided.	F 250		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (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 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. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a	F 278		10/27/17

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	245119	A. BUILDING _____ B. WING _____	09/21/2017

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F 278	Continued From page 12 resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code urinary incontinence on the Minimum Data Set (MDS) for 1 of 3 residents (R53) reviewed for urinary elimination. Findings include: The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/2017, identified instructions for completing the Minimum Data Set (MDS) used in nursing homes. The section labeled, "Section H: Bowel and Bladder," identified an intent which included, "Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment ... and services to achieve or maintain as normal elimination function as possible." Further, the section listed several, "Coding Instructions," to be followed for coding a residents' urinary incontinence, which included: - "Code 2, frequently incontinent: if during the 7-day look-back period, the resident was incontinent of urine during seven or more	F 278	AHS ensures residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan and that all assessments accurately reflect the resident's status during the assessment period. A modification MDS was completed on R53's Quarterly assessment on 9/25/17 that changed urinary continence status to "frequently incontinent". This assessment was submitted to QIES system on 10/2/17 and was an accepted submission. The assessment of the resident was accurate, 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 this deficient practice with inaccurate coding of the MDS. All incontinent resident MDS's will be reviewed to ensure accurate coding of urinary incontinence.	

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F 278	Continued From page 13 episodes but had at least one continent void. This includes incontinence of any amount of urine, daytime or nighttime," and; - "Code 3, always incontinent: if during the 7-day look-back period, the resident had no continent voids." R53's most recent quarterly Minimum Data Set (MDS) dated 8/15/17, identified R53 had severe cognitive impairment and required supervision only with toileting. Further, "Section H - Bladder and Bowel," identified R53 used no urinary appliances (i.e. catheter), was on a toileting program to manage his continence and was, "Always incontinent," with no episodes of continent voiding. During observation on 9/18/17, at 4:02 p.m. R53 was laying in bed in his room. R53 had uncombed hair, however, had no obvious odor suggestive of urinary incontinence present. When interviewed on 9/20/17, at 10:28 a.m. nursing assistant (NA)-C stated R53 will use the restroom on his own, "but not always." NA-C stated R53 does have urinary incontinence during the overnight hours, however added, "during the day, he's pretty good," and is, "mostly continent." During interview on 9/20/17, at 10:38 a.m. NA-D stated R53 was, "very independent," with cares and staff often just provide set-up assistance for most tasks. NA-D stated R53 has been, "pretty much the same" in the past months with continence adding he typically was continent during the waking hours, only having incontinence during the overnights and first void in the morning. Further, NA-D stated it, "doesn't make	F 278	Clinical Nurse Managers/MDS will be educated on proper coding instructions for urinary incontinence and assuring the MDS selection matches the assessment. DON or Designee will complete audits for accurate coding of urinary continence on the MDS 2 records weekly X 4 weeks, I record weekly X 4 weeks, 2 records monthly X 2 months. Audit results will be brought to Qapi for further review and recommendations.	

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F 278	Continued From page 14 sense," why R53 would be considered as always incontinent on an assessment. R53's Bowel & Bladder Summary Report - Consolidated 7-Day dated 8/9/17 to 8/15/17 (the MDS Assessment Reference Date [ARD]), identified R53 had 16 documented urinary voids, however, three of the voids were recorded as continent. When interviewed on 9/20/17, at 10:49 a.m. registered nurse (RN)-C stated she had completed R53's quarterly MDS dated 8/15/17, by reviewing his, "bowel and bladder summary," and speaking with staff on the floor. RN-C stated she only counted, "one time," he was continent with voiding on the summary and she, "would call that always incontinent." Further, RN-C reviewed the current Resident Assessment Instrument (RAI) manual for instructions on coding section H of the MDS with the surveyor and stated, "then I did it wrong." A facility MDS 3.0 Assessment policy dated 5/11/15, identified a procedure which dictated, "All Minimum Data Set [MDS] Assessments and Discharge and Reentry records will be completed accurately and electronically encoded into the facility's MDS information system. Further, the policy identified, "MDS's may be reviewed for accuracy as part of the QAPI [quality assessment and performance improvement] review process."	F 278		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 282		10/27/17

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F 282	Continued From page 15 must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions as directed by the care plan for 2 of 2 residents (R2, R22) reviewed who required nutritional interventions to promote independent and/or safe eating. Findings include: R2's admission Minimum Data Set (MDS) dated 6/13/17, identified R2 had severe cognitive impairment, was independent with eating, and had no swallowing disorders. R2's General Nurse's Observation assessment dated 9/6/17, identified R2 consumed a mechanical soft diet with puree vegetables. The assessment identified, " ... was seen by [speech therapy] in June [2017] [related to] a choking episode. Resident doesn't chew her food well, and eats very quickly. She receives her food in individual bowls in an effort to reduce the speed of her eating." R2's care plan dated 9/13/17, identified R2 required, "supervision and occasional assist for eating," and listed an intervention of, "Serve Food 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	F 282	AHS ensures that interventions are implemented as directed by the care plan for those who require nutritional interventions to promote independent and/or safe eating. Staff caring for R2 on 9/18/17 were educated on care plan interventions. R2's meal ticket instructions were re-arranged to facilitate easier reading of care plan interventions. Care plan interventions were re-assessed and Care plan updated based on assessment. Staff caring for R22 on 9/18/17 and 9/20/17 were educated on care plan interventions. R22's meal ticket instructions were re-arranged to facilitate easier reading of care plan interventions. Care plan updated to reflect use of soup spoon at meals. All residents who require adaptive equipment for eating have the potential to be affected by this deficient practice. All residents will be provided the appropriate assistive devices per their plan of care. The plan of care in relation to adaptive equipment will be outlined on the meal ticket. Meal ticket will be available for each meal.	

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F 282	Continued From page 16 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. At 5:23 p.m. (three minutes later) R2 had consumed all of the provided lasagna and used her fingers to run along the plate, licking her fingers several times. R2 then picked up a 240 cc (cubic centimeter) glass of red colored juice and started to drink it. NA-E stated aloud to R2, "slow down," while she drank. R2 then picked up an additional plate of mixed berries and began to consume them using a regular spoon, at times attempting to drink from the bowl like it was a glass. At 5:26 p.m. (six minutes after being served) R2 finished consuming all of the mixed berries in the dish and attempted to reach over and take her 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	F 282	Dietary Staff will be educated on adaptive equipment and layout of meal ticket to identify need of adaptive equipment. Nursing staff will be educated on adaptive equipment and process for assuring proper adaptive equipment is being used. All nursing and dietary staff will be educated on care plan interventions for serving R2 and R22. Dietary Director or designee will complete audits regarding proper use of adaptive equipment 3 X weekly X4 weeks, weekly X4 weeks, 2X monthly X 2 months. Audit results will be brought to Qapi for further review and recommendations	

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F 282	Continued From page 17 100% 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. NA-E stated R2 had been served the evening meal on a regular plate adding R2 was, "a speedy eater," and at risk of choking, "from eating so fast." NA-E stated she was unaware of any interventions being used to help R2 reduce her risk of 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 they are, "not making a difference," from, "what I've heard," adding she wasn't sure if it 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 a care plan was used to, "communicate what they [residents] need," in order to, "meet all of their needs." Further, RN-C stated R2 eats her meals so quickly at times she, "would almost choke," and staff should be following her care plan accordingly her menu slip, and provide the food in separate bowls to, "slow her down," as it, "decreases her choking risk." R22's quarterly Minimum Data Set (MDS) dated 8/29/17, identified R22 was cognitively intact and required extensive assistance of one with eating. Further, R22's face sheet printed 9/12/17, identified R22 had essential tremors (a nervous system disorder which causes rhythmic shaking).	F 282		

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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 [non-slip material]." The care plan directed staff to provide this equipment and assistance as needed.

During observation on 9/18/17, at 5:42 p.m. R22 was seated at a table for the evening meal. R22 was holding a spoon with both hands and had visible tremors in her lower arms with movements of two to three inches back and forth. R22 was served her meal on a regular, non-lipped plate and used both hands to bring food from the plate up to her mouth using the regular spoons with several instances of food falling over the edge of the plate onto the table. At 5:54 p.m. (12 minutes later) nursing assistant (NA)-F approached and offered assistance with eating to R22. When interviewed after the meal service, NA-F stated R22 was provided assistance with eating when staff notice she is having troubles due to her tremors.

During interview on 9/19/17, at 1:47 p.m. R22 stated " I am tired and wore out. It is every day." R22 stated it was best to use a soup spoon and divided plate when attempting to eat related to the presence of the tremors.

During subsequent observation on 9/20/17, at 12:06 p.m. R22 was seated in the dining room at a table, and had been served a sandwich, cut in half, along with mashed potatoes. However, R22 was again served her meal on a regular, non-lipped plate. R22 was able to eat the sandwich on her own after it was placed in her hands, however, she requested assistance from

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F 282	Continued From page 19 staff to eat the mashed potatoes. When interviewed on 9/20/17, at 2:06 p.m. NA-B stated R22 was able to feed herself independently, however, would ask for assistance when needed adding she did well with finger foods. NA-B stated R22 used some adaptive equipment during meals to help her with eating, including a lipped plate, which allowed R22 to push food against the edge and scoop it on her utensil. During subsequent interview on 9/21/17, at 1:36 p.m. NA-B stated a regular plate was used on 9/20/17, for R22 during the lunch meal service, adding she did not notice it was not a lipped plate. NA-B stated if she had noticed the error at that time, should could have notified dietary staff to have it addressed. Further, during the interview with NA-B, registered nurse clinical coordinator (RN)-D joined the conversation and stated adaptive equipment, like a lipped plate, should be outlined on the care plan and R22 should have been served her meal on a lipped plate as directed by the care plan. A policy on implementing the care plan was not provided.	F 282		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by:	F 311		10/27/17

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F 311	Continued From page 20 Based on observation, interview and document review, the facility failed to implement speech therapy interventions to reduce risk factors and improve independent eating for 1 of 2 residents (R2) reviewed for eating habits and abilities. Findings include: R2's admission Minimum Data Set (MDS) dated 6/13/17, identified R2 had severe cognitive impairment, was independent with eating, and had no swallowing disorders. R2's General Nurse's Observation assessment dated 9/6/17, identified R2 consumed a mechanical soft diet with puree vegetables. The assessment identified, " ... was seen by [speech therapy] in June [2017] [related to] a choking episode. Resident doesn't chew her food well, and eats very quickly. She receives her food in individual bowls in an effort to reduce the speed of her eating." Further, R2's progress note dated 7/1/17, identified R2 was, "eating supper tonight and was eating her food to [sic] fast. The staff had her slow down several times ... She started eating her mixed vegetables and then was choking ... was throwing up and spitting phlegm." R2's Speech Therapy Discharge Summary dated 6/26/17, identified recommendations to, "facilitate safety and efficiency," for R2 while eating which included, "Caregiver training provided; care plan updated for giving patient small bowls of food at a time [one presentation of food at a time] to reduce the bolus size and increase meal time period." R2's care plan, dated 9/13/17, identified R2 required, "supervision and occasional assist for eating," and listed an intervention of, "Serve Food in Individual Bowls - Offer 1 at a time."	F 311	AHS ensures that all residents are given the appropriate treatment and services to maintain or improve their ability to carry out ADL's including implementation of speech therapy interventions to reduce risk factors and improve independent eating. 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 facilitate easier reading of care plan interventions and updated to reflect speech therapy recommendations. All residents who have participated in Speech Therapy with discharge recommendations for adaptive equipment or eating strategies have the potential to be affected by this deficient practice. All current residents with speech therapy recommendations for adaptive equipment or eating strategies will be reviewed to assure recommendations on the plan of care and being implemented or appropriate documentation of refusal of resident is present in EMR. All residents will be provided the appropriate assistive devices per their plan of care. The plan of care in relation to adaptive equipment will be outlined on the meal ticket. Meal ticket will be available for each meal. Dietary Staff will be educated on adaptive equipment and layout of meal ticket to identify need of adaptive equipment. Nursing staff will be educated on adaptive	

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F 311	Continued From page 21 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 reading, "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. At 5:23 p.m. (three minutes later) R2 had consumed all of the provided lasagna and used her fingers to run along the plate, licking her fingers several times. R2 then picked up a 240 cc (cubic centimeter) glass of red colored juice and started to drink it. NA-E stated aloud to R2, "slow down," while she drank. R2 then picked up an additional plate of mixed berries and began to consume them using a regular spoon, at times attempting to drink from the bowl like it was a glass. At 5:26 p.m. (six minutes after being served) R2 finished consuming all of the mixed berries in the dish and attempted to reach over and take her	F 311	equipment and process for assuring proper adaptive equipment is being used. All nursing and dietary staff will be educated on specific process for serving R2. Dietary Director or designee will complete audits regarding proper use of adaptive equipment 3 X weekly X 4 weeks, weekly X 4 weeks, 2 X monthly X 2 months. Audit results will be brought to Qapi for further review and recommendations.	

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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." SLP-A stated implementing that strategy for R2

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	245119	A. BUILDING _____ B. WING _____	09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 23 would allow, "some time to swallow," before she consumed the next bite. Further, SLP-A stated staff, "should be," giving R2 her meals in separate bowls or refer R2 back to speech therapy if they noticed the intervention was not working.	F 311		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure smoking risks	F 323	AHS ensures that resident's environment remains as free from accident hazards as	10/27/17

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F 323	Continued From page 24 were comprehensively assessed for 1 of 1 residents (R46) who currently smoked off facility grounds. Findings include: R46's admission Minimum Data Set (MDS) dated 7/26/17, indicated R46 had intact cognition and did not have any functional limitations in the upper extremities. The MDS identified diagnoses of heart failure and manic depression. R46's progress notes 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. - 7/25/17, at 3:00 p.m. indicated on 7/24/17, R46 was spoken to about smoking in the front entrance of the facility. R46 stated he understood the non- smoking policy and stated he would "not smoke on the grounds of the facility." R46 stated he would think about other smoking options and would talk to a nurse if R46 chose to quit smoking. A Smoking Contract dated 7/31/17, signed by R46 and the administrator, indicated R46 agreed not to smoke on facility grounds and would only smoke off of facility grounds. During interview on 9/19/17, at 10:52 a.m. R46 stated he smoked a couple times a week, across the street from the facility when a friend of his visited. R46 further stated his friend kept his cigarettes and lighter for him.	F 323	is possible and that each resident receives adequate supervision and assistance devices to prevent accidents by ensuring smoking risk are comprehensively assessed. A smoking assessment was completed on R46. The assessment concludes that resident is safe to smoke off facility grounds when accompanied by visitor who assists resident off property and returns resident to property. Care plan interventions were updated based on smoking assessment. All residents with smoking tendencies have the potential to be affected by this deficient practice. All residents identified with smoking tendencies were comprehensively assessed for safety with smoking off facility grounds with accompaniment, care plans were update and interventions were implemented to monitor safety of smoking. This was completed by 9/26/17. Smoking policy has been reviewed and revised. Nursing staff will be provided education regarding changes to the smoking policy and safety interventions related to smoking. DON or designee will complete audits on completion of a smoking assessment on residents with smoking tendencies 3 X weekly X 4 weeks, weekly X 4 weeks, 2 X monthly X2 months. Audit results will be	

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F 323	Continued From page 25 R46's medical record did not include a comprehensive assessment for smoking. R46's care plan dated 7/31/17, did not include any interventions related to R46's smoking. During observation on 9/20/17, at 7:41 a.m. R46 was seated in a wheelchair eating breakfast independently in the dining room. R46 had no obvious burns or burn holes in his clothing. During an interview on 9/20/17, at 10:02 a.m. nursing assistant (NA)-C stated R46 went across the street to the old Family Dollar to smoke, accompanied by a friend. To her knowledge R46 never burned himself or had burn holes in his clothing. NA-C stated the nurses were aware R46 was currently smoking off facility property. During interview on 9/20/17, at 10:22 a.m. NA-D stated R46 was a private and independent person and she had never seen R46 smoking, however, R46 had a lot of visitors and left the facility frequently with them. When interviewed on 9/20/17, at 10:24 a.m. registered nurse (RN)-B stated R46 did not smoke on facility grounds, but suspected he smoked when he was away from the facility on outings. RN-B was not sure if a smoking assessment had been completed on R46. RN-B further stated a smoking contract was completed between R46 and the facility indicating R46 agreed not to smoke on facility grounds. During interview on 9/21/17, at 8:43 a.m. RN-C stated the facility grounds were non-smoking. RN-C stated a smoking assessment had not	F 323	brought to Qapi for further review and recommendation.	

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F 323	Continued From page 26 been completed on R46 as the facility grounds were non- smoking. RN-C further stated " What he [R46] does off of these premises is his business." RN-C stated a care plan was never developed because, R46 didn't smoke on the facility grounds. On 9/21/17, at 10:24 a.m. registered nurse director of quality (DQ) stated the facility was not responsible for what residents do off facility grounds and a smoking assessment had not been completed as the facility grounds were non-smoking. DQ added residents were told on admission, they couldn't smoke on facility grounds. The facility Smoking policy dated 6/10/17, indicated smoking was forbidden anywhere on property grounds. The policy directed staff to notify residents that smoking was only allowed off the property grounds. The policy also indicated an assessment would be completed only if the resident was not being accompanied by a friend or family member.	F 323		
F 369 SS=D	483.60(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS (g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a lipped plate	F 369	AHS ensures that special eating equipment and utensils are provided for	10/27/17

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F 369	Continued From page 27 to maximize the ability to eat independently for 1 of 3 residents (R22) reviewed for activities of daily living (ADLs). Findings include: R22's quarterly Minimum Data Set (MDS) dated 8/29/17, identified R22 was cognitively intact and required extensive assistance of one with eating. Further, R22's face sheet printed 9/12/17, identified R22 had essential tremors (a nervous system disorder which causes rhythmic shaking). R22's physician progress note dated 8/4/17, identified "The patient has had more tremor, making it harder for her to eat." Further, R22's nursing progress note dated 9/20/17, indicated that during a care conference for R22 on 9/19/17, it was identified that R22 required increased assistance with eating related to tremors. R22's progress note dated 8/31/17, identified a completed nutrition assessment for R22 who consumed a regular diet using a two handled cup with lid, large straws, divided plate and dycem (non slip material) to promote independent eating. Further, the assessment identified R22 was sometimes independent with eating; however, at other times required extensive assist related to her essential tremors. 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	F 369	resident who need them and appropriate assistance is provided to ensure that the resident can use the assistive devices when consuming meals and snacks. Staff caring for R22 on 9/18/17 and 9/20/17 were educated on care plan interventions. R22's meal ticket instructions were re-arranged to facilitate easier reading of care plan interventions. All residents who require adaptive equipment for eating have the potential to be affected by this deficient practice. All residents will be provided the appropriate assistive devices per their plan of care. The plan of care in relation to adaptive equipment will be outlined on the meal ticket. Meal ticket will be available for each meal. Dietary Staff will be educated on adaptive equipment and layout of meal ticket to identify need of adaptive equipment. Nursing staff will be educated on adaptive equipment and process for assuring proper adaptive equipment is being used. Dietary Director or designee will complete audits regarding proper use of adaptive equipment 3X weekly X 4 weeks, weekly X4 weeks, 2 X monthly X 2 months. Audit results will be brought to Qapi for further review and recommendations.	

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F 369	Continued From page 28	F 369		

two handled cups with lids, dycem, and a divided plate.

During observation on 9/18/17, at 5:42 p.m. R22 was seated at a table for the evening meal. R22 was holding a soup spoon with both hands and had visible tremors in her lower arms with movements of two to three inches back and forth. R22 was served her meal on a regular, non-lipped plate and used both hands to bring food from the plate up to her mouth using the regular soup spoon with several instances of food falling over the edge of the plate onto the table. At 5:54 p.m. (12 minutes later) nursing assistant (NA)-F approached and offered assistance with eating to R22. When interviewed following the meal service, NA-F stated R22 was provided assistance with eating when staff notice she is having troubles due to her tremors.

During interview on 9/19/17, at 1:47 p.m. R22 stated " I am tired and wore out. It is every day." R22 stated it was best to use a soup spoon and divided plate when attempting to eat related to the presence of the tremors.

During a subsequent observation on 9/20/17, at 12:06 p.m. R22 was seated in the dining room at a table, and had been served a sandwich, cut in half, along with mashed potatoes. Again, R22 was served her meal on a regular, non-lipped plate. R22 was able to eat the sandwich on her own after it was placed in her hands, however, she requested assistance from staff to eat the mashed potatoes.

When interviewed on 9/20/17, at 2:06 p.m. NA-B stated R22 was able to feed herself independently, however, would ask for assistance

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F 369	Continued From page 29 when needed; adding, she did well with finger foods. NA-B stated R22 used some adaptive equipment during meals to help her with eating, including a lipped plate, which allowed R22 to push food against the edge and scoop it on her utensil. During subsequent interview on 9/21/17, at 1:36 p.m. NA-B stated a regular plate was used on 9/20/17, for R22 during the lunch meal service, and that she did not notice it was not a lipped plate. NA-B stated if she had noticed the error at that time, should could have notified dietary staff to have it addressed. Further, during the interview, registered nurse clinical coordinator (RN)-D joined the conversation and stated adaptive equipment needed by residents would be outlined on the care plan and dietary slip. During interview on 9/21/17, at 1:30 p.m. dietary manager (DM) reviewed the dietary slip for R22 and stated a divided plate should be used when served all meals. And further stated that it should be noticed and implemented when R22's meal is plated.	F 369		

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00002	A. BUILDING: _____ B. WING _____	09/21/2017

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 9/18/17-9/21/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions as directed by the care plan for 2 of 2 residents (R2, R22) reviewed who required nutritional interventions to promote independent and/or safe eating. Findings include: R2's admission Minimum Data Set (MDS) dated 6/13/17, identified R2 had severe cognitive impairment, was independent with eating, and had no swallowing disorders. R2's General Nurse's Observation assessment dated 9/6/17, identified R2 consumed a mechanical soft diet with puree vegetables. The assessment identified, " ... was seen by [speech therapy] in June [2017] [related to] a choking episode. Resident doesn't chew her food well, and eats very quickly. She receives her food in individual bowls in an effort to reduce the speed	2 565	Corrected	10/27/17

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2 565	Continued From page 3 of her eating." R2's care plan dated 9/13/17, identified R2 required, "supervision and occasional assist for eating," and listed an intervention of, "Serve Food 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. At 5:23 p.m. (three minutes later) R2 had consumed all of the provided lasagna and used her fingers to run along the plate, licking her fingers several times. R2 then picked up a 240 cc (cubic centimeter) glass of red colored juice and started to drink it. NA-E stated aloud to R2, "slow down," while she drank. R2 then picked up an additional plate of mixed berries and began to consume them using a regular spoon, at times attempting to drink from the bowl like it was a	2 565		

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2 565	Continued From page 4 glass. At 5:26 p.m. (six minutes after being served) R2 finished consuming all of the mixed berries in the dish and attempted to reach over and take her 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. NA-E stated R2 had been served the evening meal on a regular plate adding R2 was, "a speedy eater," and at risk of choking, "from eating so fast." NA-E stated she was unaware of any interventions being used to help R2 reduce her risk of 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 they are, "not making a difference," from, "what I've heard," adding she wasn't sure if it 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 a care plan was used to, "communicate what they [residents] need," in order to, "meet all of their needs." Further, RN-C stated R2 eats her meals so quickly at times she, "would almost choke," and staff should be following her care plan accordingly her menu slip, and provide the food in separate bowls to, "slow her down," as it, "decreases her choking risk."	2 565		

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2 565	Continued From page 5 R22's quarterly Minimum Data Set (MDS) dated 8/29/17, identified R22 was cognitively intact and required extensive assistance of one with eating. Further, R22's face sheet printed 9/12/17, identified R22 had essential tremors (a nervous system disorder which causes rhythmic shaking). 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 [non-slip material]." The care plan directed staff to provide this equipment and assistance as needed. During observation on 9/18/17, at 5:42 p.m. R22 was seated at a table for the evening meal. R22 was holding a spoon with both hands and had visible tremors in her lower arms with movements of two to three inches back and forth. R22 was served her meal on a regular, non-lipped plate and used both hands to bring food from the plate up to her mouth using the regular spoons with several instances of food falling over the edge of the plate onto the table. At 5:54 p.m. (12 minutes later) nursing assistant (NA)-F approached and offered assistance with eating to R22. When interviewed after the meal service, NA-F stated R22 was provided assistance with eating when staff notice she is having troubles due to her tremors. During interview on 9/19/17, at 1:47 p.m. R22 stated " I am tired and wore out. It is every day." R22 stated it was best to use a soup spoon and divided plate when attempting to eat related to the presence of the tremors. During subsequent observation on 9/20/17, at	2 565		

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2 565	Continued From page 6 12:06 p.m. R22 was seated in the dining room at a table, and had been served a sandwich, cut in half, along with mashed potatoes. However, R22 was again served her meal on a regular, non-lipped plate. R22 was able to eat the sandwich on her own after it was placed in her hands, however, she requested assistance from staff to eat the mashed potatoes. When interviewed on 9/20/17, at 2:06 p.m. NA-B stated R22 was able to feed herself independently, however, would ask for assistance when needed adding she did well with finger foods. NA-B stated R22 used some adaptive equipment during meals to help her with eating, including a lipped plate, which allowed R22 to push food against the edge and scoop it on her utensil. During subsequent interview on 9/21/17, at 1:36 p.m. NA-B stated a regular plate was used on 9/20/17, for R22 during the lunch meal service, adding she did not notice it was not a lipped plate. NA-B stated if she had noticed the error at that time, should could have notified dietary staff to have it addressed. Further, during the interview with NA-B, registered nurse clinical coordinator (RN)-D joined the conversation and stated adaptive equipment, like a lipped plate, should be outlined on the care plan and R22 should have been served her meal on a lipped plate as directed by the care plan. A policy on implementing the care plan was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding implementing resident	2 565		

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2 565	Continued From page 7 care plans, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure smoking risks were comprehensively assessed for 1 of 1 residents (R46) who currently smoked off facility grounds. Findings include: R46's admission Minimum Data Set (MDS) dated 7/26/17, indicated R46 had intact cognition and did not have any functional limitations in the upper extremities. The MDS identified diagnoses of heart failure and manic depression.	2 830	Corrected	10/27/17

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2 830	Continued From page 8 R46's progress notes 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. - 7/25/17, at 3:00 p.m. indicated on 7/24/17, R46 was spoken to about smoking in the front entrance of the facility. R46 stated he understood the non- smoking policy and stated he would "not smoke on the grounds of the facility." R46 stated he would think about other smoking options and would talk to a nurse if R46 chose to quit smoking. A Smoking Contract dated 7/31/17, signed by R46 and the administrator, indicated R46 agreed not to smoke on facility grounds and would only smoke off of facility grounds. During interview on 9/19/17, at 10:52 a.m. R46 stated he smoked a couple times a week, across the street from the facility when a friend of his visited. R46 further stated his friend kept his cigarettes and lighter for him. R46's medical record did not include a comprehensive assessment for smoking. R46's care plan dated 7/31/17, did not include any interventions related to R46's smoking. During observation on 9/20/17, at 7:41 a.m. R46 was seated in a wheelchair eating breakfast independently in the dining room. R46 had no obvious burns or burn holes in his clothing. During an interview on 9/20/17, at 10:02 a.m.	2 830		

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2 830	Continued From page 9 nursing assistant (NA)-C stated R46 went across the street to the old Family Dollar to smoke, accompanied by a friend. To her knowledge R46 never burned himself or had burn holes in his clothing. NA-C stated the nurses were aware R46 was currently smoking off facility property. During interview on 9/20/17, at 10:22 a.m. NA-D stated R46 was a private and independent person and she had never seen R46 smoking, however, R46 had a lot of visitors and left the facility frequently with them. When interviewed on 9/20/17, at 10:24 a.m. registered nurse (RN)-B stated R46 did not smoke on facility grounds, but suspected he smoked when he was away from the facility on outings. RN-B was not sure if a smoking assessment had been completed on R46. RN-B further stated a smoking contract was completed between R46 and the facility indicating R46 agreed not to smoke on facility grounds. During interview on 9/21/17, at 8:43 a.m. RN-C stated the facility grounds were non-smoking. RN-C stated a smoking assessment had not been completed on R46 as the facility grounds were non- smoking. RN-C further stated " What he [R46] does off of these premises is his business." RN-C stated a care plan was never developed because, R46 didn't smoke on the facility grounds. On 9/21/17, at 10:24 a.m. registered nurse director of quality (DQ) stated the facility was not responsible for what residents do off facility grounds and a smoking assessment had not been completed as the facility grounds were non-smoking. DQ added residents were told on admission, they couldn't smoke on facility	2 830		

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2 830	Continued From page 10 grounds. The facility Smoking policy dated 6/10/17, indicated smoking was forbidden anywhere on property grounds. The policy directed staff to notify residents that smoking was only allowed off the property grounds. The policy also indicated an assessment would be completed only if the resident was not being accompanied by a friend or family member. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff to as ensuring comprehensive smoking assessments are completed to ensure safety for any resident identified to be smoking while admitted to the facility. TIME PERIOD FOR CORRECTION: Ten days (10) days.	2 830		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and	2 915		10/27/17

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2 915	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement speech therapy interventions to reduce risk factors and improve independent eating for 1 of 2 residents (R2) reviewed for eating habits and abilities. Findings include: R2's admission Minimum Data Set (MDS) dated 6/13/17, identified R2 had severe cognitive impairment, was independent with eating, and had no swallowing disorders. R2's General Nurse's Observation assessment dated 9/6/17, identified R2 consumed a mechanical soft diet with puree vegetables. The assessment identified, " ... was seen by [speech therapy] in June [2017] [related to] a choking episode. Resident doesn't chew her food well, and eats very quickly. She receives her food in individual bowls in an effort to reduce the speed of her eating." Further, R2's progress note dated 7/1/17, identified R2 was, "eating supper tonight and was eating her food to [sic] fast. The staff had her slow down several times ... She started eating her mixed vegetables and then was choking ... was throwing up and spitting phlegm." R2's Speech Therapy Discharge Summary dated 6/26/17, identified recommendations to, "facilitate safety and efficiency," for R2 while eating which included, "Caregiver training provided; care plan updated for giving patient small bowls of food at a	2 915	Corrected	

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2 915	Continued From page 12	2 915		

time [one presentation of food at a time] to reduce the bolus size and increase meal time period." R2's care plan, dated 9/13/17, identified R2 required, "supervision and occasional assist for eating," and listed an intervention of, "Serve Food 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 reading, "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.

At 5:23 p.m. (three minutes later) R2 had consumed all of the provided lasagna and used her fingers to run along the plate, licking her fingers several times. R2 then picked up a 240 cc (cubic centimeter) glass of red colored juice and started to drink it. NA-E stated aloud to R2, "slow down," while she drank. R2 then picked up an additional plate of mixed berries and began to consume them using a regular spoon, at times attempting to drink from the bowl like it was a

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2 915	Continued From page 13 glass. At 5:26 p.m. (six minutes after being served) R2 finished consuming all of the mixed berries in the dish and attempted to reach over and take her 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	2 915		

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2 915	Continued From page 14 cues, the only options available were, "environmental changes," including placing R2's food in separate bowls, "to slow her rate down." SLP-A stated implementing that strategy for R2 would allow, "some time to swallow," before she consumed the next bite. Further, SLP-A stated staff, "should be," giving R2 her meals in separate bowls or refer R2 back to speech therapy if they noticed the intervention was not working. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could inservice staff regarding ensuring resident interventions related to safe eating are consistenly implemented, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	2 915		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent	2 945		10/27/17

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2 945	Continued From page 15 unresolved problems must be reported to the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a lipped plate to maximize the ability to eat independently for 1 of 3 residents (R22) reviewed for activities of daily living (ADLs). Findings include: R22's quarterly Minimum Data Set (MDS) dated 8/29/17, identified R22 was cognitively intact and required extensive assistance of one with eating. Further, R22's face sheet printed 9/12/17, identified R22 had essential tremors (a nervous system disorder which causes rhythmic shaking). R22's physician progress note dated 8/4/17, identified "The patient has had more tremor, making it harder for her to eat." Further, R22's nursing progress note dated 9/20/17, indicated that during a care conference for R22 on 9/19/17, it was identified that R22 required increased assistance with eating related to tremors. R22's progress note dated 8/31/17, identified a completed nutrition assessment for R22 who consumed a regular diet using a two handled cup with lid, large straws, divided plate and dycem (non slip material) to promote independent eating. Further, the assessment identified R22 was sometimes independent with eating; however, at other times required extensive assist related to	2 945	Corrected	

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2 945	Continued From page 16 her essential tremors. 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 two handled cups with lids, dycem, and a divided plate. During observation on 9/18/17, at 5:42 p.m. R22 was seated at a table for the evening meal. R22 was holding a soup spoon with both hands and had visible tremors in her lower arms with movements of two to three inches back and forth. R22 was served her meal on a regular, non-lipped plate and used both hands to bring food from the plate up to her mouth using the regular soup spoon with several instances of food falling over the edge of the plate onto the table. At 5:54 p.m. (12 minutes later) nursing assistant (NA)-F approached and offered assistance with eating to R22. When interviewed following the meal service, NA-F stated R22 was provided assistance with eating when staff notice she is having troubles due to her tremors. During interview on 9/19/17, at 1:47 p.m. R22 stated " I am tired and wore out. It is every day." R22 stated it was best to use a soup spoon and divided plate when attempting to eat related to the presence of the tremors. During a subsequent observation on 9/20/17, at 12:06 p.m. R22 was seated in the dining room at a table, and had been served a sandwich, cut in half, along with mashed potatoes. Again, R22	2 945		

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2 945	Continued From page 17 was served her meal on a regular, non-lipped plate. R22 was able to eat the sandwich on her own after it was placed in her hands, however, she requested assistance from staff to eat the mashed potatoes. When interviewed on 9/20/17, at 2:06 p.m. NA-B stated R22 was able to feed herself independently, however, would ask for assistance when needed; adding, she did well with finger foods. NA-B stated R22 used some adaptive equipment during meals to help her with eating, including a lipped plate, which allowed R22 to push food against the edge and scoop it on her utensil. During subsequent interview on 9/21/17, at 1:36 p.m. NA-B stated a regular plate was used on 9/20/17, for R22 during the lunch meal service, and that she did not notice it was not a lipped plate. NA-B stated if she had noticed the error at that time, should could have notified dietary staff to have it addressed. Further, during the interview, registered nurse clinical coordinator (RN)-D joined the conversation and stated adaptive equipment needed by residents would be outlined on the care plan and dietary slip. During interview on 9/21/17, at 1:30 p.m. dietary manager (DM) reviewed the dietary slip for R22 and stated a divided plate should be used when served all meals. And further stated that it should be noticed and implemented when R22's meal is plated. SUGGESTED METHOD OF CORRECTION: The dietary manager (DM) and/or director of nursing (DON) could inservice staff regarding the process for ensuring adaptive equipment is consistently implemented for resident care needs with eating; then audit to ensure compliance.	2 945		

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2 945	Continued From page 18 TIME PERIOD FOR CORRECTION: Seven (7) days.	2 945		
21495	MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ongoing assistance with discharge planning for 1 of 1 residents (R56) reviewed for discharge planning. Findings include: R56's 30-Day Minimum Data Set (MDS) dated 7/13/17, identified R56 had moderate cognitive impairment, required only supervision with transfers, dressing and personal hygiene, and was independent with locomotion, both on and off the unit, and toileting. Further, the MDS identified there was, "an active discharge plan" in place for R56 to return to the community. During observation on 9/18/17, at 6:46 p.m. R56 was clean and well groomed. When interviewed, R56 stated he was unsure why he still living in the nursing home. R56 stated he admitted for recovery, however, no longer requires as much care and felt able to discharge from the nursing	21495	Corrected	10/27/17

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home adding, "there's no reason why I should be here," slapping his hands on his knees," and exclaimed, "They must have some kind of law for holding a person!"

During interview on 9/19/17, at 9:09 a.m. nurse practitioner (NP)-A stated she understood R56 was going to remain in the nursing home after his rehabilitation. This decision was made at care conference with R56, his responsible party and staff present. NP-A was unaware R56 still had a desire to discharge from the nursing home.

During subsequent interview on 9/20/17, at 8:30 a.m. R56 stated he recently looked at an assisted living facility (ALF) with a friend (F)-A and felt it would be a good living option for himself. The facility had discussed an ALF in another town, however, did not want to move there and wanted to reside in Aitkin where his friends live. R56 stated he asked the facility about discharge but, "They don't tell me nothing."

During telephone interview on 9/20/17, at 11:31 a.m. F-A stated he was aware that (R56) desired to move to a more independent living situation and had toured the ALF with R56. R56 had told him about his feelings of being held a prisoner at the facilty. Before admission, R56 was independently living in his own home. F-A stated R56 and himself had talked with the facility social services (SS) about moving but the facility thought he should stay there but (R56) would be happier living at the ALF.

R56's occupational therapy (OT) consultation completed 8/3/17, identified R56 exhibited some cognitive deficits with medication set up, management of finances, looking up numbers in phone book, and problems with completing travel

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subtest related to residents double vision. At that time, R56 needed 24 hour supervision.

A narrative note of medical doctor (MD)-A on 8/14/17, identified R56 was close to baseline from two prior visits and he encouraged R56 to try an assisted living.

A provider notes of 8/17/17, from nurse practioner (NP)-A identified R56 was alert to conversation and had inquired if he will be able to go to assisted living. NP-A identified R56's double vision had resolved, but still had occasional headaches following his motor vehicle accident subdural hematoma. NP-A stated R56 was considering moving to an assisted living versus returning home, and felt this would be in his best interest, as identified by MD-A progress note of 8/14/17.

A nursing progress note dated 8/24/17, by the director of nursing (DON) identified a resident care conference had been held. R56 was assessed by occupational therapy (OT) and needed 24 hour supervision. They were waiting for authorization for medical assistance prior to going to an ALF.

On 9/13/17, registered nurse (RN)-D documented R56 decided to stay at the facility for a period of time and had chosen not to go to ALF. The note further identified that R56 did not wish to be asked about discharging and would let the facility know when he wished to discharge.

During interview on 9/21/17, at 10:22 a.m. SS stated R56 required 24 hour supervision and knew F-A had taken R56 to tour a local ALF, however, R56 decided to remain at the facility through the winter when she met with R56 and

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21495	Continued From page 21 F-A this morning (9/21/17). SS stated R56 changed his mind frequently and this morning, both R56 and F-A spoke about R56 staying at the facility for the winter, and would be bringing items to the nursing home. The ALF was at the nursing home to screen R56 but was unsure when this was completed or what the outcome of the screen was, adding she had not documented anything. She stated, "Tomorrow he may change his mind." SS stated OT completed an assessment and determined a 24 hour supervised living situation was indicated which was completed on 8/3/17. She completed a cognitive testing on 9/12/17, and identified R56 had no cognitive impairment. SS was unsure if OT was notified to complete a new assessment since R56 showed no cognitive impairment when she completed her assessment on 9/12/17. During interview at 9/21/17, at 10:47 a.m. R56 stated F-A had been in this morning to visit and brought some paperwork to complete. He did not want to stay in the nursing home for the winter, and wanted to move to the ALF. During interview on 9/21/17, at 10:52 a.m. with R56 and SS, R56 stated "On this winter stuff, I don't want to stay here this winter." SS stated she had placed a call to the ALF and was awaiting a return call. R56 stated he felt it would be best for him to move to the ALF. During interview on 9/21/17, at 11:00 a.m. occupational therapist (OT)-A stated R56 had been assessed on two occasions, 7/5/17 and 8/3/17. OT-A stated based on the assessments completed they recommended R56 have 24 hour supervision and receive assistance with new medications. OT-A stated when someone displays an improved cognitive assessment, it	21495		

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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.

During interview on 9/21/17, at 11:22 a.m. with SS, administrator, and RN-D, the administrator stated R56 had a history of changing his mind, from staying to being transferred. The administrator stated R56 was a short term stay, however, R56 was recently moved to the long term care unit because he wanted to remain in the facility. The administrator stated F-A assists R56 with his finances, but they do not make decisions for R56. R56 was independent in his decision making. The administrator stated R56 had not toured any ALF facilities in the area but SS and RN-D clarified R56 had toured the local ALF. R56 was initially interested, per RN-D but changed his mind as he was proceeding with a transfer to the ALF. RN-D and SS stated his BIMS (cognitive testing tool) had improved which was addressed in a morning meeting but they were unsure what date this occurred or whom was present at the meeting.

During telephone interview on 9/22/17, at 10:51 a.m. the owner of the local ALF stated he was present for the tour and screening of R56 for his transfer to the ALF. The resident was screened on 9/14/17 and they were awaiting medication orders and an updated admission history and physical for (R56's) admission to the ALF.

During telephone interview on 9/22/17, at 10:56 a.m. F-A stated he met with SS and R56 on 9/21/17 and discussed R56's plan for housing. F-A stated although the facility staff wanted him to stay at the nursing home, R56 had not agreed to stay at the nursing home, and wanted to move to

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21495	Continued From page 23 the ALF. F-A stated he thought the ALF would work well for R56. A policy was requested for discharge planning but was not received. A request for policies was made for resident referral for evaluation by therapies. A blank referral form was provided. A copy of completed referral for R56 following cognitive testing of 9/12/17 was requested and not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could inservice the social services staff regarding helping residents who seek a discharge plan with their wishes and needs, along with documenting these steps and actions in the medical record. The administrator could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21495		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an assessment had been conducted for self-administration of medications for 1 of 1 residents (R29) who's	21565	Corrected	10/27/17

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21565	Continued From page 24 medication was left unattended at the table in the dining room. Findings include: R29's quarterly Minimum Data Set assessment, dated 7/17/17, indicated R29's cognition was intact. R29's Face Sheet, printed 9/19/17, included a diagnosis of atrial fibrillation (condition when the heart's two upper chambers beat out of coordination with the two lower chambers of the heart). R29's Physician Order sheet, printed 9/19/17, included orders for Coumadin (blood thinner to treat atrial fibrillation) 2.5 milligrams (mg) daily on Thursday and Coumadin 5 mg daily on all other days of the week scheduled for 5:00 p.m. with a start date of 8/30/17. During observation on 9/18/17, at 5:18 p.m. registered nurse (RN)-A placed a small white paper cup, with one oval peach pill, on the right side of R29's placemat on the table in the dining room. RN-A told R29 here's your pill and walked out of the dining room back to medication cart. The medication cart was located outside the dinning room to the right of the dinning room threshold. The medication left on the dining room table was not visible from the cart. R29 was seated with three other male residents at this table. At 5:21 p.m. R29 remained seated at the table in the dining room, however, his eyes were closed. The medication remained on the table in the cup until 5:22 p.m. when RN-A entered dining room, woke up R29 and administered the pill from the cup which had been left on the dining room table.	21565		

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21565	Continued From page 25 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. When interviewed on 9/19/17, at 1:25 p.m. licensed practical nurse (LPN)-A stated only those residents with an assessment to self-administer medications can be left unattended with medications. During an interview on 9/19/17, at 2:10 p.m. registered nurse (RN)-D stated R29 was not assessed to safely self- administer medication. RN-D stated R29 should not have been left alone to self-administer his medication. During an interview on 9/19/17, at approximately 3:00 p.m. LPN-A looked at the Medication Administration Record. Based on the description of the pill and time of scheduled administration, LPN-A stated R29's oval peach pill that was left unattended at the dining room table on 9/18/17 was Coumadin as this was the only medication that was scheduled during the supper hour. When interviewed on 9/19/17, at 2:16 p.m. the director of nursing stated R29 should not have been left unattended with medication and staff should have stayed with the resident until the medication was consumed. The facilities undated Self Administration of Medication by Residents policy, directed staff to assess the ability of resident's wishing to self	21565		

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21565	Continued From page 26 administer for cognitive, physical and visual abilities. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could inservice staff regarding ensuring residents are comprehensively assessed for safety with medication self administration, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21565		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained to promote dignity for 1 of 1 residents (R66) observed with bare skin and undergarments visible from the hallway to other residents, visitors and staff. Findings include: R66's admission Minimum Data Set (MDS) dated 9/4/17, identified R66 had moderate cognitive impairment, displayed no disorganized thinking, and required extensive assistance for most	21805	Corrected	10/27/17

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activities of daily living (ADLs). Further, the MDS identified R66 had occasional urinary incontinence along with depression, schizophrenia and, "Asthma, Chronic Obstructive Pulmonary Disease [COPD], or Chronic Lung Disease."

During observation on 9/18/17, at 5:36 p.m. R66 was laying in bed in his private room with the door wide open, and fully visible to the hallway. R66 had a fan running along with a single white bed sheet on top of him, however, the sheet was pulled down past his waist going to almost his knees exposing his bare chest, upper legs and a gray colored incontinence brief. R66's room had a visible track installed on the ceiling which had metallic hooking devices to hang a curtain, however, the room had no privacy curtains installed. At 5:39 p.m., another resident living in the facility, R21, wheeled by his room with the door opened, however, did not look inside. R21's quarterly MDS dated 5/10/17, identified R21 had severe cognitive impairment.

An additional observation on 9/18/17, at 6:37 p.m. (over one hour later) found R66 remained in bed in his room with the doorway opened. R66 continued to have the white linen pulled down past his waist, exposing his bare chest, upper legs and gray colored incontinence brief. When interviewed immediately following the observation, R66 stated he was, "a little" uncomfortable and in pain. R66 stated he, "sometimes," has concerns with people walking by his room and staring at him, however, did not elaborate further. R66 stated he could not recall if anyone from the facility had ever visited with him about his privacy.

During a subsequent observation on 9/20/17, at

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1:35 p.m. R66 was again laying in bed with his doorway opened and visible from the hallway. R66's eyes were closed, and his bedding was down around his waist which exposed his bare chest. At 1:38 p.m. an unidentified male visitor was walking down the hallway and looked into R66's room, then turned his head away and kept walking.

When interviewed on 9/20/17, at 1:39 p.m. nursing assistant (NA)-D and this surveyor, observed R66 laying in bed in his room. NA-D stated R66, doesn't wear clothing most of the time and declined having a shirt put on earlier in the morning when staff offered. NA-D stated she felt R66 should be wearing a shirt so others did not have to see him exposed, as it was "other residents' home and they should be comfortable too." Further, NA-D stated she had not heard of any other residents making comments about R66 being exposed.

During interview on 9/20/17, at 1:55 p.m. registered nurse (RN)-B observed R66 laying in his room with his bare chest exposed. RN-B stated R66 will occasionally refuse to wear a gown or clothing as it feels restrictive. RN-B stated R66 laying in bed with bare skin exposed and visible to others, "definitely could be a dignity concern for him," and added she was unaware if installing a privacy curtain had ever been discussed as an intervention for him.

When interviewed on 9/20/17, at 2:07 p.m. the director of nursing (DON) stated she had never seen R66 laying in his bed exposed before, however, added she didn't often make it down his hallway. The DON stated she had just spoken with R66 about installing a curtain as another staff had approached her about the surveyors

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 29 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." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding ensuring patients are not left exposed and/or visible to others and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/19/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Aitkin Health Services was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both:	K 000		

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

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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. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Aitkin Health Services is a one story building with a full basement. The original building was constructed in 1955 with additions in 1962, and a dining room main entry was added in 2002. Both the existing building and the addition are type II(111) construction. In 2009-2010 an addition was added that was a one story addition with a full basement that was determined to be of Type II(111) Constructions. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 44 beds	K 000		

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K 000	Continued From page 2 and had a census of 40 at the time of the survey. At this time, the conditions of 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 351 SS=D	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (10) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect residents, as well as an undetermined number of staff, and visitors.	K 351	All residents and staff could potentially be affected by this if an emergency event were to occur. The ESD replaced the ceiling tiles.	10/6/17

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K 351	Continued From page 3 Findings include: On facility tour between 9:00 a.m. and 1:00 p.m. on 09/19/2017, observations revealed in the mechanical pump room that is located in the lower level had openings created from missing ceiling tiles that are located next to two sprinkler heads. This condition would allow the heat and fire to bypass the sprinkler head and delay it activation. This deficient condition was verified by the Maintenance Supervisor.	K 351		
K 901 SS=D	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 40 of 40 residents, as well as an undetermined number of staff, and visitors.	K 901	K 901 Complete and current facility Risk Assessment in Accordance with NFPA 99. It was found that the document 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	10/27/17

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K 901	Continued From page 4 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. This deficient condition was verified by the Maintenance Supervisor.	K 901	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. The risk assessment was modified to include much greater detail through listing each smoke compartment separately and only grouping "like" rooms together, separated by dissimilar rooms. Categories not currently identified were removed. Categories were added according to chapters 6, 9, 10, and 11 of NFPA 99.	