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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1SI3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00848

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245363**

2.STATE VENDOR OR MEDICAID NO.
(L2) **908540800**

3. NAME AND ADDRESS OF FACILITY
(L3) **AICOTA HEALTH CARE CENTER**
(L4) **850 SECOND STREET NORTHWEST**
(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)

6. DATE OF SURVEY **06/20/2018** (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)
09/30

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

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (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
	75			
(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:
Teresa Ament, Unit Supervisor 07/12/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 07/12/2018 (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
11/17/1986
(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
06/06/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245363 July 12, 2018

Ms. Alison Matalamaki, Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

Dear Ms. Matalamaki:

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 June 6, 2018 the above facility is certified for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

Electronically delivered
July 12, 2018

Ms. Alison Matalamaki, Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

RE: Project Number S5363027

Dear Ms. Matalamaki:

On May 17, 2018, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 3, 2018. (42 CFR 488.417 (b))

Also, we notified you in our letter of May 17, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 3, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on May 3, 2018, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our May 17, 2018 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 20, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 11, 2018, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 3, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 6, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 3, 2018, as of June 25, 2018.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of May 17, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 3, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective August 3, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 3, 2018, is to be rescinded.

In our letter of May 17, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 3, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 25, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure

cc: Licensing and Certification File

Electronically delivered
July 11, 2018

Ms. Alison Matalamaki, Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

RE: Project Number S5363027

Dear Ms. Matalamaki:

On May 17, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 3, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 20, 2018, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 3, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of . Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on May 3, 2018.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the May 3, 2018 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard extended survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 3, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 3, 2018. They will also notify the State Medicaid Agency that they must

also deny payment for new Medicaid admissions effective August 3, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Aicota Health Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 3, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

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 November 3, 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 electronic 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.

Sincerely,

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 1SI3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00848

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245363**
2.STATE VENDOR OR MEDICAID NO.
(L2) **908540800**

3. NAME AND ADDRESS OF FACILITY
(L3) **AICOTA HEALTH CARE CENTER**
(L4) **850 SECOND STREET NORTHWEST**
(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)

6. DATE OF SURVEY **05/03/2018** (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)
09/30

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

12.Total Facility Beds **75** (L18)
13.Total Certified Beds **75** (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
	75			
(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 :
Kathie Siemsen, HFE NE II 05/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 06/06/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
11/17/1986
(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

Electronically delivered
May 17, 2018

Ms. Alison Matalamaki, Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

RE: Project Number S5363027

Dear Ms. Matalamaki:

On May 3, 2018, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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 June 12, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 12, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

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.

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 August 3, 2018 (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 November 3, 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 electronic 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.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure

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
	245363	A. BUILDING _____ B. WING _____	05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST 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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/30/18, through 5/3/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 4/30/18, through 5/3/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and 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 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes	F 583		6/6/18

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

Electronically Signed | 05/25/2018

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F 583	Continued From page 1 accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure privacy was maintained during blood glucose monitoring for 1 of 2 residents (R107) observed during blood glucose monitoring. Findings include: R107's Diagnoses List dated 4/16/18, indicated diagnosis of type two diabetes, insulin	F 583	It is the policy of Aicota Health Care Center to develop and implement policies and procedures regarding personal privacy/confidentiality of records in regards to obtaining blood glucose reading. The blood glucose monitoring policy was reviewed and revised to address personal privacy/confidentiality of records. All	

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F 583	Continued From page 2 dependence. R107's admission Minimum Data Set (MDS) dated 4/25/18, indicated R107 was cognitively intact, and received insulin injections on seven of seven days during the assessment period. R107's Physician's Orders sheet dated 5/2/18, indicated orders for Accucheck (blood glucose checks) four times a day with Novolog insulin coverage per sliding scale. On 5/01/18, at 10:44 a.m. licensed practical nurse (LPN)-B was observed obtaining R107's blood glucose in the hall outside the multipurpose room. R107 stopped next to the medication cart and LPN-B donned gloves, set up the blood glucose machine, cleansed R107's finger with an alcohol wipe, poked R107's finger with a lancet, and obtained the blood specimen. Several residents were in the hall and multipurpose room area. On 5/01/18, at 11:36 a.m. LPN-B stated she usually did not check the blood glucose in the hall, but did not want R107 to be late for lunch, and she was waiting for R107 to come out of the activity. LPN-B further stated R107 has just recently been coming out of her room, and she did not want to take her back to her room. On 05/01/18, at 12:20 p.m. R107 stated this was not the first time her blood glucose was checked in the hall. R107 stated sometimes staff did it in her room, and sometimes they did it in the hall. "It depends on where they catch me." On 5/4/18, at approximately 10:00 a.m. the director of nursing (DON) stated she would expect blood glucose checks to be done in a	F 583	nurses will review this policy and will be educated on 05/30/18 about the importance of personal privacy/confidentiality when doing blood glucose monitoring. R107 discharged from the facility on 05/11/18, with no noted issues in regards to privacy or blood glucose monitoring. All residents with blood glucose monitoring will be assessed and reviewed to determine resident preference. Their care plans will be updated for their choice of private care location not in view of others in regards to their blood glucose monitoring. These areas are reassessed with every care conference and any changes are made as they arise to provide residents' personalized care. DON will monitor for compliance by completing at least three times weekly audits for one month and then monthly thereafter. Results will be reported to the QA/QAPI committee quarterly until compliance is sustained.	

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F 583	Continued From page 3 private area. The facility's Blood Glucose policy dated 5/18/11, lacked direction to provide privacy when obtaining a blood glucose.	F 583		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care planned interventions were implemented to prevent the development or worsening of pressure ulcers for 2 of 4 residents (R33, R32) reviewed for pressure ulcers. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis	F 686	It is the policy of Aicota Health Care Center to develop and implement policies and procedures regarding pressure ulcer prevention and healing. The pressure ulcer prevention and resident risk assessment policies were reviewed. All nursing staff will review this policy and will be educated on 06/06/18 about the importance of off-loading interventions. R32 uses a Heel Manager device. Staff education was completed for all shifts and	6/6/18

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F 686	Continued From page 4 Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough (yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed) and eschar (black, dry and leathery dead tissue and may form a thick covering) are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.	F 686	a laminated sign showing proper use of the Heel Manager device was placed in room on 05/03/18. R33 has a diagnosis of DM II and PVD which impact skin integrity to lower extremities. On 5/24/18, R33□s care plan was adjusted to reflect the every two hour off-loading schedule which also flows to the kardex. Staff involved in R33□s cares was educated on the importance of following the resident care plan, complete and accurate wound documentation and the necessary follow-up documentation. All residents with current pressure ulcers will be assessed to ensure all standards of care practices are in place and being implemented by staff. All other residents will be monitored every week and PRN for any new skin breakdown. DON and Wound Care Specialist will meet monthly to review any skin issues and any needed interventions and will conduct staff education on proper staging of pressure ulcers. DON will monitor for compliance by completing daily audits on alternating shifts for one week and then three times weekly until compliance is sustained and then monthly thereafter. Results will be reported to the QA/QAPI committee quarterly until compliance is sustained.	

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F 686	Continued From page 5 Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. R33's Face Sheet printed 5/2/18, indicated R33's diagnoses included a left leg amputation below the knee, diabetes mellitus type 2, peripheral vascular disease (PVD), anemia, and Alzheimer's disease. R33's quarterly Minimum Data Set (MDS) indicated R33 had a moderate to severe cognitive impairment, required extensive assistance for bed mobility and transfers, and was frequently incontinent of bowel and bladder. R33's MDS further indicated R33 was at risk for pressure ulcers and had one unstageable pressure ulcer measuring 0.5 centimeters (cm) x 0.4 cm with eschar (dark, dead tissue) present at that time. R33's MDS also indicated R33 had a pressure reducing device in chair and bed, a turning and repositioning program, and nutrition and pressure ulcer care interventions in place. R33's care plan initiated 12/8/17, indicated R33 had a potential for alteration in skin and had an unstageable pressure ulcer on the left lower extremity, and a red area on the coccyx (tailbone). R33's care plan indicated R33 required total assistance of staff for bed mobility, and directed staff to turn and reposition R33 every two hours, float heels, ensure a pressure reducing mattress was in the wheelchair and a pressure reducing mattress in bed, and was revised on 4/9/18, to include an alternating air mattress. R33's care plan further directed staff to check R33 for toileting needs or incontinence every two hours and change as indicated.	F 686		

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F 686	Continued From page 6	F 686		

R33's Kardex (nursing assistant care guide sheets) printed 5/2/18, directed staff to toilet R33 with morning and bedtime cares, before and after meals, and check R33 every two hours and change as indicated at night time. R33's Kardex lacked direction for repositioning.

R33's Tissue Tolerance (tool used to assist in determining the ability of the skin and its supporting structures to endure the effects of pressure, without adverse effects) dated 12/8/17, indicated R33 tolerated sitting in one position for two hours, and laying in one position for two hours without adverse effects.

R33's Braden Scale (tool used to assist in determining the risk for pressure ulcer development) dated 12/8/17, indicated R33 was at moderate risk for pressure ulcer development.

On 5/2/18, at 7:56 a.m. R33 was observed to be brought into his room for toileting needs. During continuous observations from 8:53 a.m. when R33 was up in the wheelchair next to the nurse's station, until 11:52 a.m. when R33 finished lunch (2 hours and 59 minutes), R33 was not offered repositioning or toilet use. R33 did not reposition himself during that time. Nursing assistant (NA)-B stated she was not aware of R33's positioning needs, and stated he would tell her when he needed to use the bathroom.

R33's Wound Flow Sheet dated 1/12/18, indicated a new vascular wound (associated with impaired circulation/blood flow) on the left lower leg considered to be unstageable.

R33's Wound Flow Sheet dated 1/31/18,

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F 686	Continued From page 7	F 686		

indicated R33 had a new pressure ulcer on the left buttock, measuring 1.0 cm x 0.5 cm, and was identified as a Stage 2 pressure ulcer.

R33's Wound Flow Sheet dated 2/3/18, indicated R33's left buttock pressure ulcer measured 1.0 cm x 1.0 cm, and was identified as a Stage 3 pressure ulcer.

R33's nurse practitioner (NP) progress notes dated 2/6/18, indicated R33's stump (amputated left lower extremity) was wrapped and intact.

R33's NP progress note dated 2/7/18, indicated R33's stump was wrapped, but had a small 1.5 cm eschar area. Wound care nursing was requested to look at R33's pressure ulcer, and R33 was directed to return to a physician for follow-up if no improvement.

R33's Wound Flow Sheet dated 2/9/18, indicated R33 had a newly identified pressure ulcer on the anterior left lower leg measuring 4.0 cm x 5.2 cm x 0.01 cm and was identified as a Stage 2 pressure ulcer, caused by an abrasion related to rubbing of the wraps on the skin with R33's leg movements in bed.

R33's NP progress note dated 2/9/18, indicated R33 was seen for concerns of a friction rub, which caused an open area on the medial aspect of the left stump, in addition to the previously identified small eschar area on R33's stump.

R33's physician orders dated 2/9/18, directed nursing to have the in house wound care to assess wounds on R33's stump and make treatment recommendations.

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F 686	Continued From page 8	F 686		

R33's progress notes dated 2/12/18, indicated a physical therapist (PT) saw R33 for wound care management to the left lower extremity. R33's progress note indicated R33 had a thick scab of necrotic (dead) tissue measuring 1.0 cm x 0.8 cm and was 75% yellow slough covered after 75% of the scab was removed. The wound edges were not well defined. R33 was noted to have a second area on the back medial portion of the left calf measuring 1.9 cm x 5.0 cm x more than 0.1 cm depth. The wound was 50% yellow slough and 50% pink granulation (new tissue) with irregular edges. Both areas were covered and wrapped and the splint was re-applied to the left lower extremity.

R33's Physician Orders dated 2/15/18, directed a nutritional supplement twice daily for nutrition and wound healing.

R33's Wound Flow Sheet dated 2/17/18, indicated R33's left lower inner leg abrasion measuring 3.2 cm x 1.5 cm was unstageable with 100% slough. R33's medical record lacked further documentation of this area.

R33's Braden Scale dated 3/9/18, indicated R33 remained at moderate risk for pressure ulcer development.

R33's Wound Flow Sheet dated 3/25/18, identified a new Stage 2 open blister on the left knee measuring 1.4 cm x 1.6 cm, related to the stump brace.

R33's Wound Flow sheet dated 4/10/18, indicated R33 had a newly identified unstageable pressure ulcer of the sacrum measuring 4.0 cm x 2.5 cm, and barrier cream was applied.

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F 686	Continued From page 9	F 686		

R33's NP progress note and nursing progress note dated 4/20/18, indicated R33's skin was intact.

A review of R33's progress notes dated 2/6/18 through 4/25/18, indicated R33 lacked any documentation regarding resistiveness to repositioning or toileting cares.

On 5/2/18, at 12:07 p.m. NA-B and NA-A brought R33 into the bedroom and transferred R33 to the bed with the Hoyer (mechanical) lift. R33's skin on the buttocks and coccyx were a medium red and appeared to blanch (loses all redness when pressed) on the edges, but was questionable over the coccyx. R33's incontinent brief was dry.

On 5/2/18, at 12:16 p.m. NA-B reviewed the Kardex in R33's closet and stated it said to toilet R33 every two hours at night, and before and after meals during the day.

On 5/2/18, at 12:20 p.m. licensed practical nurse (LPN)-A observed R33's skin on the buttocks and coccyx, and the skin blanched easily, and was intact. LPN-A measured R33's left medial lower leg at 3.2 cm x 0.5 cm, and described it as a red scarred, healed area with new tissue underneath. LPN-A measured the left front upper shin area at 2.0 cm x 1.3 cm, and described it as peeling skin, but covered with no depth, red scarred, and healed. LPN-A stated there was no registered nurse (RN) available to assess R33's pressure ulcer at that time, and she was the nurse responsible for pressure ulcer documentation.

On 5/2/18, at 12:28 p.m. LPN-A stated R33 was to be repositioned every two hours, and verified

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F 686	Continued From page 10 the NAs went over R33's two hour time on his repositioning and toileting. On 5/2/18, at 1:49 p.m. the director of nursing (DON) stated the standard off-loading time should be every 2 hours. The DON verified R33's Tissue Tolerance assessment directed to reposition every two hours, and R33's care plan directed every two hour repositioning. The DON stated the Kardex system is set up to reflect whatever is on the care plan, but R33's repositioning was not checked in the care plan, so it was not reflected on the Kardex. The facility policy and procedure for Pressure Ulcer Prevention/Resident Risk Assessment dated 10/13, directed residents confined to their bed or chair and unable to reposition themselves, would be repositioned every two hours or more often if necessary, unless a physician has ordered a different interval. The facility policy and procedure directed care to maintain clean and dry skin free from urine and feces. R32's Admission Record, printed on 5/3/18, indicated diagnoses that included weakness, dementia, adult failure to thrive, venous insufficiency, edema, chronic kidney disease, and an unstageable pressure ulcer. R32's quarterly MDS dated 3/13/18, indicated R32 required extensive assistance with activities of daily living (ADLs) including bed mobility, was	F 686		

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F 686	Continued From page 11	F 686		

at risk for pressure ulcers, and had two unstageable pressure ulcers.

R32's Care Area Assessment (CAA) dated 12/14/17, indicated R32 had one or more unhealed pressures at Stage 2 or higher, and one or more likely pressure ulcers that were unstageable due to coverage of wound bed by slough and/or eschar.

R32's care plan dated 7/14/17, indicated R32 required assistance for bed mobility. R32's care plan further indicated R32 had an unstageable pressure ulcer on her left heel. The care plan indicated interventions that included to float R32's heels, and to use a heel manager when in bed.

R32's Kardex Report printed on 5/3/18, directed staff to float R32's heels, and to use the heel manager when R32 was in bed.

R32's Wound Care Flow Sheet dated 11/29/17, described the first observation of R32's left heel pressure ulcer as 5.2 centimeters (cm) x 3.5 cm, unstageable, with serosanguanous drainage. The ulcer was further described as having blackened skin, spongy in the center of wound, firm outside with 2.0 cm of black area.

During continuous observations on 5/2/18, from 7:11 a.m. until 8:41 a.m. R32 was observed in bed asleep, on her back. Although R32 was covered with a blanket, a pillow or device was evident under R32's knees, making them bend up and making R32's heels be directly on the mattress.

On 5/2/18, at 8:41 a.m. NA-A entered R32's room to provide morning cares. At 8:43 a.m. when

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F 686	Continued From page 12	F 686		

NA-A uncovered R32, a heel manager was observed under R32's knees, and R32's heels were observed directly on the mattress. NA-A confirmed the heel manager was under R32's knees, and R32's heels were directly on the mattress. NA-A stated she thought that was how the heel manager was supposed to be placed. Heel impression marks were visible on R31's mattress.

On 5/2/18, at 12:00 p.m. RN-B and LPN-A provided wound cares to R32's heel wound according to physician's order. RN-B described the wound as dry and scaley, peeling, one small open spot, no odor, and pink in color. RN-B stated a flap of dry skin was almost ready to come off, and then the pressure ulcer would be healed.

On 5/2/18, at 12:21 p.m. RN-B confirmed R32's heels were to be floated and not be directly on the mattress. RN-B stated the intention of the heel manager was to ensure R32's heels were not directly on the mattress.

On 5/2/18, at 11:17 a.m. the DON stated the intent of the heel manager was to keep heels floated (off of the mattress). The DON stated R32 was at risk of developing pressure ulcers, and she had a pressure ulcer on her left heel that was healing. The DON stated she expected staff who had not used a heel manager, or had questions about it, to reach out to a nurse supervisor or someone else to ask how to use it. The DON stated R32 had used a heel manager for quite a while, and did not know if they had provided training on its use prior to implementation.

An undated manufacturer's information sheet on

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F 686	Continued From page 13 the heel manager indicated the device would fully offload heels. The facility's Pressure Ulcer Prevention/Resident Risk Assessment policy dated 10/15/13, indicated pressure-reducing devices are to be used where indicated.	F 686		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		6/6/18

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F 880	Continued From page 14 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hand hygiene	F 880	It is the policy of Aicota Health Care Center to establish and maintain an	

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F 880	Continued From page 15 was maintained during personal cares of 1 of 1 residents (R26) on contact precautions, and 2 of 4 residents (R32, R52) observed during personal cares. In addition, the facility failed to ensure a urinary drainage bag was kept off the floor for 1 of 1 residents (R32) observed with a catheter. Findings include: R26's Diagnoses List dated 4/18/18, indicated R26's diagnoses included dementia with behaviors. R26's quarterly Minimum Data Set (MDS) dated 3/12/18, indicated R26 hade moderately impaired cognition, and required extensive assistance with bed mobility, transfers and toilet use. R26 was occasionally incontinent of bladder, and always continent of bowel. A Progress Note dated 5/1/18, indicated R26 had two watery loose stools and was put on contact precautions. The note indicated R26 understood, as she could not go too far from the bathroom. On 5/2/18, The Transmission Based Precaution Assessment indicated R26 was on contact precautions due to diarrhea. A specimen for culture was not obtained due to being unable to contain the stool. R26 was alert and orientated, and able to understand and follow the appropriate precautions. R26 did use appropriate hand hygiene and interventions that had been implemented included R26's name was placed in follow up book for every shift charting and monitoring. The precaution stand had been placed, covered hamper and trash cans were placed, supplies for the room have been gathered, a sign was placed on room door, and	F 880	infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This is in place and reviewed as needed and at least annually. Alcohol gel dispensers are being installed to the outside of R26□s room and every resident room on 05/28/18 for easier access for staff to perform proper hand hygiene when entering and leaving a resident room. Staff involved in R26, R32 and R52□s cares were educated on proper hand hygiene including washing hands between glove use and during cares. R32□s care plan and kardex were updated to keep catheter collection bag off floor. All residents with catheters were reviewed to ensure they have basins to place urine collection bags in to keep off floor. Staff were educated on proper catheter collection bag placement while in use and not in use. The hand hygiene compliance plan, glove technique and prevention of catheter associated urinary tract infections policies were reviewed to ensure they address all aspects of proper hand hygiene. The glove technique (non-sterile) policy dated 11-01-17 does address performing hand hygiene between glove use. All nursing	

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F 880	Continued From page 16 the doctor or nurse practitioner was updated. On 5/02/18, at 9:17 a.m. R26's morning cares were observed provided by nursing assistant (NA)-C and NA-D. Prior to entering R26's room, NA-C and NA-D donned gowns and gloves. NA-C and NA-D provided R26's morning cares using appropriate hand hygiene and infection control practices. When cares were competed NA-D removed her gloves and gown, washed her hands in the bathroom and exited R26's room. NA-C cleaned the lift and the blood pressure cuff and machine. NA-C then removed her gown and gloves and exited R26's room with the commode. NA-C did not wash or sanitize her hands prior to exiting R26's room. On 5/02/18, at 9:54 a.m. the trained medication aide (TMA)-A donned a gown, gloves and a mask prior to entering R26's room. TMA-A gave R26 medication and put in R26's hearing aids. TMA-A then removed the gown, gloves and mask and exited the room. TMA-A did not wash or sanitize her hands prior to exiting R26's room. TMA-A sanitized her hands from a dispenser on the wall approximately 50 feet down the hall. On 5/02/18, at 10:03 a.m. R26's call light was on. NA-C donned a gown and gloves. NA-C took R26's temperature. NA-C removed the gown and gloves, sanitized the thermometer, and exited R26's room. NA-C walked down the hall, placed the thermometer on the medication cart, and then washed her hands in nurse charting room. On 5/02/18, at 10:08 a.m. NA-C stated she brought the commode soiled with stool and urine to the dirty utility room and cleaned it there. NA-C stated she did not wash or sanitize her hand	F 880	staff will review these policies and will be educated on 06/06/18 about the importance of proper hand hygiene, catheter care and transmission based precautions with special emphasis being placed on washing hands between glove use and during cares. In addition ICAR training is scheduled for all staff on 06/25/18. DON and Infection Preventionist will monitor for compliance by completing daily audits on all shifts for two weeks and then three times weekly until compliance is sustained and then weekly thereafter. Results will be reported to the QA/QAPI committee quarterly until compliance is sustained.	

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F 880	Continued From page 17 before exiting R26's room because she had the commode, and had to clean that so her hands were already dirty. NA-C verified she did not wash or sanitize her hands prior to exiting the room after taking R26's temperature. On 5/02/18, at 10:23 a.m. TMA-A verified she did not wash or sanitize her hands prior to exiting R26's room. TMA-A stated there was not any hand sanitizer on the stand outside the door. TMA-A was asked if she could have washed her hands in the bathroom. TMA-A stated then she would have had to touch the faucets and the door. TMA-A stated she could have left the door open. On 5/02/18, at 1:50 a.m. registered nurse (RN)-B (the infection control nurse) stated R26 was on contact precautions due to watery diarrhea stools they could not be contained in the incontinent brief. RN-B stated as much designated equipment as possible should remain in R26's room, including the commode. RN-B stated the best scenario was for the commode to be cleaned in the soiled utility room. RN-B stated staff should have washed their hands prior to exiting room, put on gloves, taken the commode to the utility room, cleaned the commode and washed their hands. RN-B stated if feces was present staff should wash their hands in the bathroom before leaving the room. On 5/4/18, at approximately 10:00 a.m. the DON stated she would expect staff to wash their hands after removing their gowns and gloves and prior to exiting a resident on contact precautions room. The facility's Transmission Based Precautions policy dated 7/13/17, indicated transmission	F 880		

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F 880	Continued From page 18 based precautions were used for residents who were known to be or suspected of being infected or colonized with infectious agent. This included pathogens that required additional control measures to prevent transmission. The policy directed staff to perform hand hygiene prior to leaving the contact precaution room. R32's Admission Record, printed on 5/3/18, indicated diagnoses that included chronic kidney disease, neurogenic bladder, retention of urine, and functional urinary incontinence.. R32's quarterly MDS dated 3/13/18, indicated R32 required extensive assistance with toileting, and had an indwelling urinary catheter. R32's care plan dated 5/14/17, indicated R32 had an indwelling catheter related to urinary retention and neurogenic bladder. The care plan directed staff to place the catheter collection bag in R32's lower drawer after it was clean and dry, but lacked direction on keeping the catheter bag off the floor while in use. R32's Kardex Report printed on 5/3/18, directed staff to place the catheter collection bag in R32's lower drawer after it was clean and dry, but lacked direction on keeping the catheter collection bag off the floor while in use. On 5/2/18, at 8:41 a.m. NA-A was observed to enter R32's room to provide morning cares. R32's catheter collection bag was observed on the floor next to her bed, uncovered. Urine was visible in the bag. NA-A assisted R32 to sit on the edge of her bed, applied a transfer belt, assisted R32 to	F 880		

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F 880	Continued From page 19	F 880		

sit in her wheelchair.

On 5/2/18, at 8:45 a.m. NA-A picked up R32's catheter collection bag and placed it in R32's lap before pushing R32 to the bathroom. NA-A put the catheter collection bag on the floor of R32's bathroom, assisted R32 onto the toilet, continued to assist R32 with morning cares, and gave R32 time to sit on the toilet. The catheter collection bag remained flat on the floor until NA-A provided catheter cares, and switched R32 to a leg collection bag. After NA-A completed catheter cares for R32, NA-A removed her gloves and donned a new pair of gloves without completing hand hygiene in between. While R32 continued to sit on the toilet, NA-A assisted R32 to slip her pants over her feet to be around her ankles, went into R32's room, opened a dresser drawer, took out deodorant, turned on the sink, wet a washcloth, added soap, and proceeded to wash, and then dry R32's underarms, and under her breasts. Still wearing the same pair of gloves, NA-A applied lotion to R32's back and put deodorant on R32, and helped her complete dressing. NA-A then removed the soiled gloves and without performing hand hygiene, put on clean gloves. NA-A put a transfer belt on R32, assisted her to standing by the toilet and provided peri cares for R32. After providing peri-cares, NA-A assisted R32 with pulling up her pants and straightening her top, and transferred her into her wheelchair. NA-A then removed her soiled gloves, and without performing hand hygiene, picked up R32's glasses and placed them on her face, and brushed R32's hair. NA-A went back into R32' bathroom and put on a clean pair of gloves without performing hand hygiene. NA-A asked if she could brush R32's dentures and with gloved hands, assisted R32 in the removal of her

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F 880	Continued From page 20	F 880		

dentures from her mouth. NA-A then brushed R32's dentures with running water, toothpaste and a toothbrush. NA-A assisted R32 with replacing her dentures in her mouth. NA-A then removed her soiled gloves, and assisted R32 into her recliner. NA-A left R32's room with soiled linen bags, and did not perform hand hygiene until she entered the facility spa room.

On 5/2/18, at 9:16 a.m. NA-A stated R32's catheter collection bag was on the floor when she entered the room. NA-A stated, "I walked into that." NA-A said they normally put the catheter collection bag in a basin. NA-A confirmed she placed the catheter collection bag directly on the bathroom floor. NA-A confirmed that while she carried hand sanitizer in her uniform pocket, she did not perform hand hygiene between each glove change.

On 5/2/18, at 12:24 p.m. RN-B stated she expected staff to perform hand hygiene between each glove change, that they have provided education and completed audits on hand hygiene. RN-B also confirmed catheter collection bags should not be directly on the floor when a resident is in bed or when a resident was in the bathroom.

On 5/3/19, at 11:13 a.m. the DON stated she would expect hand hygiene to be performed between glove changes, that was how the facility trained staff. The DON also stated they had pink wash basins that were used specifically to place catheter collection bags in, so they would not be directly on the floor or exposed while a resident was in bed. The DON stated staff were expected to use the basin when a resident was in the bathroom, or attach the collection bag to a grab bar.

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F 880	Continued From page 21 The facility policy Hand Hygiene Compliance Plan effective 2/1/17, directed employees are expected to comply with the World Health Organization guidelines for hand hygiene. The plan did not include directions for performing hand hygiene between glove changes. R52's Face Sheet printed 5/3/18, identified diagnoses that included dementia. R52's admission MDS dated 4/3/18, indicated R52 was severely cognitively impaired, was occasionally incontinent of urine, and required staff assistance with weight bearing support during toilet use. R52's care plan printed 5/3/18, directed staff to assist with toileting with assistance of one for transfers/adjust clothing/change incontinent product. On 5/2/18, at 8:53 a.m. NA-B was observed toileting R52. NA-B was wearing gloves and removed R52's wet incontinence brief from around R52's ankles as R52 sat on the toilet. NA-B placed the soiled incontinence brief in a plastic bag, and placed the bag in the bathroom sink. NA-B placed a clean incontinent brief around R52's ankles and cleansed R52's peri area. NA-B pulled the clean incontinent brief up to R52's waist and assisted R52 to her wheelchair before removing the soiled gloves and immediately donning a clean pair of gloves from her pocket. NA-B did not perform hand hygiene. NA-B preceded to dress R52, removed the garbage bag out of the sink, rinsed R52's dentures, combed R52's hair, and then removed	F 880		

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F 880	Continued From page 22 her soiled gloves before pushing R52 out of the bedroom and taking the garbage bag to the disposal area. After disposing of the garbage, NA-B sanitized her hands and took R52 to breakfast. On 5/2/18, at 9:17 a.m. NA-B confirmed she sanitized her hands prior to working with R52. NA-B confirmed she changed gloves during the toileting process but did not perform hand hygiene until she disposed of the soiled incontinence produce garbage. On 5/2/18, at 10:04 a.m. RN-B stated her expectation was that staff their remove gloves after doing peri care and wash their hands before donning clean gloves. On 5/3/18, at 1:39 p.m. the DON stated she expected that gloves be applied to clean hands. When soiled gloves were removed, some form of hand hygiene was to be done before donning the next pair of gloves. The facility's Incontinent Products (Proper Handling of Soiled) policy dated 7/13/17, directed staff to wash hands and don gloves before removing incontinent product from a resident. Soiled brief is rolled and secured with tapes and then placed in a plastic bag. Perineal care is done and a new incontinent product applied. Gloves are then removed and placed in the bag with the soiled incontinent product and disposable wipe and the bag is tied shut; Bag is placed in a covered hamper and then hands are to be washed.	F 880		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3)	F 909		6/6/18

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F 909	Continued From page 23 §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that a mattress was assessed for safe size in relation to the bed frame for 1 of 1 residents (R31) reviewed for accidents. Findings include: The Guidance for Industry and Food and Drug Administration (FDA) Staff dated 3/10/06, indicated Zone 7 (between the head or foot board and the end of the mattress) may present a risk of head entrapment when taking into account the mattress compressibility, any shift of the mattress, and degree of play from loosened head or foot boards. The FDA recognized this area as a potential for entrapment and encourages facilities and manufacturers to report entrapment events at this zone. The Guidance indicated the FDA monitors entrapment reports for this area, but has not determined a measurement standard. On 4/30/18, at 6:36 p.m. a large gap that measured 6 1/2 inches was noticed between the bottom edge of R31's mattress and the foot board. There was no gap noted between R31's mattress and headboard.	F 909	It is the policy of Aicota Health Care Center to conduct regular inspection of all bed frames, mattresses and bed rails as part of a regular maintenance program to identify areas of possible entrapment. R31 had a new longer mattress meeting FDA guidelines placed in his bed on 05/02/18. All residents currently with a hospital bed were reviewed and found to be appropriate for a hospital bed based on their physical and cognitive abilities. Aicota□s Bed System Inspections policy was reviewed to ensure it meets FDA guidelines. The maintenance department conducts monthly inspections of all beds to ensure proper spacing for the bed systems entrapment zones. New longer mattresses meeting FDA guidelines for entrapment were ordered and are expected to be delivered and installed in all hospital beds on 06/05/18. Housekeeping Supervisor will monitor for	

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	245363	A. BUILDING _____ B. WING _____	05/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST 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 909	Continued From page 24 R31's Face Sheet printed 5/3/18, indicated R31's diagnoses included hemiplegia, weakness, and dementia. R31's admission Minimum Data Set (MDS) dated 3/6/18, indicated R31 had moderately impaired cognition, and required extensive assistance with bed mobility and transfers. R31's care plan dated 2/27/18, indicated R31 was non-ambulatory, used a left positioning rail to assist with turning, and when in bed, the bed was to be in low position. R31's Kardex Report, printed on 5/3/18, indicated a low bed when R31 was in bed, required total assistance for bed mobility, and used a left positioning rail to assist with turning and repositioning in bed. On 5/2/18, at 1:56 p.m. the director of maintenance (DM) stated housekeeping was responsible for placing mattresses on beds. The DM stated maintenance would get involved if housekeeping needed help. On 5/2/18, at 1:58 p.m. the director of housekeeping (DH) stated mattresses don't usually switch bed frames unless an alternating air pressure mattress was needed. DH stated they had new beds from the hospital. The DH stated they had the federal guidelines for bedrails and beds. On 5/2/18, at 2:03 p.m. R31's mattress had shifted. The DH measured and confirmed the gap between R31's headboard and the top of his mattress to be 5.0 inches. The DH confirmed there was room for the mattress to push down	F 909	compliance by completing three times weekly audits for two weeks and then monthly thereafter. Results will be reported to the QA/QAPI committee quarterly until compliance is sustained.	

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F 909	Continued From page 25	F 909		

further, which would create a larger gap. The DH confirmed this was a risk for entrapment.

On 5/3/18, at 11:05 a.m. the DH stated maintenance checks to ensure the bed and side rail mechanics are working on a regular bases. The DH stated they are not routinely measuring mattresses and bed frames to ensure the gaps are within limits. The DH stated they had 13 beds that were the same as R31's bed frame/mattress.

The facility's undated Equipment List indicated R31 was assigned a Huntleigh (brand name) bed and mattress. On 5/3/18, at 11:05 a.m. the DH stated these were the beds and mattresses they had received from the hospital.

On 5/3/18, at 11:22 a.m. the director of nursing (DON) stated maintenance usually does the safety checks on equipment. The DON stated she had recently developed a side rail assessment, and they have been monitoring and watching side rails to ensure the gaps were within Federal guidelines. The DON stated physical therapy (PT) does a bed rail assessment during their initial assessment. The DON confirmed neither nursing nor PT measures the gap between mattresses and headboards, but they do measure side rails. The DON confirmed R31 had a bed rail assessment, but they did not assess the mattress to head board fit.

The facility's Bed System Inspections (for beds with side rails or positioning bars) policy, dated 10/1/17, indicated Zone 7 (between the mattress and the headboard) was a space that may present a risk. The policy further directed staff to take into account the mattress compressibility, any shift of the mattress, and degree of play from

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F 909	Continued From page 26 loosened head or foot boards.	F 909		

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	245363	A. BUILDING **01 - AICOTA NURSING HOME** B. WING _____	**05/01/2018**

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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 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Aicota Health Care Center 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 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/25/2018

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 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: 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. The facility was inspected as one building. Aicota Health Care Center, is a 1-story building with no basement. The original building was constructed in 1969 and was determined to be of Type II(111) construction. In 1983 an addition was constructed to the building that was determined to be of Type II(111) construction. In 2007 an assisted living facility was attached, that is properly 2 hour fire rated separated. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building is fully sprinklered throughout. The	K 000		

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K 000	Continued From page 2 facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 75 beds and had a census of 57 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not complete the annual fire door inspections in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition and the NFPA 80 Standard for Fire Doors and Other Opening Protectives 2010 edition. This deficient practice could affect 75 of 75 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable.	K 211	The fire/smoke doors will be inspected by maintenance per NFPA requirements on an annual basis. A fire/smoke door inspection annual inspection policy has been implemented. This policy includes a facility map to identify location of all fire/smoke doors. A fire/smoke door inspection form that includes all required items to inspect has also been implemented.	6/22/18

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K 211	Continued From page 3 Findings include: On facility tour between 9:30 a.m. and 1:30 p.m. on 05/01/2018, during a records review and an interview with the Maintenance Supervisor, the facility did not completed the fire door inspection or inspection documentation for all of the fire rated doors located throughout the facility. This deficient condition was confirmed by a Maintenance Supervisor.	K 211	Maintenance Supervisor is responsible to monitor for continued compliance.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been installed and maintained in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.9.3. This deficient practice could affect 75 of 75 residents, as well as an undetermined number of staff, and visitors in the event of a generator failure thus not allowing the maintenance staff the ability to see and repair during a power failure. Findings include: On facility tour between 9:30 a.m. and 1:30 p.m. on 05/01/2018, observation during a review of all available testing and maintenance documentation	K 291	A battery operated emergency lighting policy and inspection form have been implemented. The battery operated emergency lighting testing will be performed by maintenance per NFPA requirements on a monthly basis. Maintenance Supervisor is responsible to monitor for continued compliance.	6/25/18

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K 291	Continued From page 4 and an interview with the program manager revealed that the facility has not been conducting a monthly 30 second test or the 90 minute annual test of the battery operated emergency lighting. This deficient condition was confirmed by a Maintenance Supervisor.	K 291		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 75 of 75 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 a.m. and 1:30 p.m.	K 712	Fire drills will be held at expected and unexpected times under varying conditions at least quarterly on each shift as required by NFPA. Fire drills will be reviewed monthly by maintenance and the safety committee to ensure all shifts are participating in fire drills at the required varied intervals. Maintenance Supervisor is responsible to monitor for continued compliance.	5/31/18

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K 712	Continued From page 5 on 05/01/2018, during the review of all available fire drill documentation and interview with a maintenance staff member the following deficient conditions were found: 1. It was revealed that the facility did not conduct 1 overnight shift fire drill in the second quarter. 2. It was revealed that the facility did not conduct 1 overnight shift fire drill in the fourth quarter. This deficient condition was confirmed by a Maintenance Supervisor.	K 712		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 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 REQUIREMENT 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 75 of 75 residents, as well as an undetermined number of staff, and visitors.	K 901	The Risk Assessment in accordance with NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1 will be completed by the Director of Nursing and Maintenance Supervisor and reviewed on an annual basis or sooner if needed. Maintenance Supervisor is responsible to	6/1/18

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K 901	Continued From page 6 Findings include: On facility tour between 9:30 a.m. and 1:30 p.m. on 05/01/2018, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility's risk assessment document did not account for all of the systems and equipment identified in chapter 10 and 11 of the NFPA 99 "Health Care Facilities Code" 2012 edition. This deficient condition was confirmed by a Maintenance Supervisor.	K 901	monitor for continued compliance.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or	K 914		6/25/18

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K 914	Continued From page 7 area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 75 of 75 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:30 a.m. and 1:30 p.m. on 05/01/2018, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the completion of the annual electrical outlet inspection and testing for the electrical outlets located in the patient/resident rooms located throughout the facility. This deficient condition was confirmed by a Maintenance Supervisor.	K 914	An electrical testing policy has been implemented. The electrical outlet testing will be performed and receptacle testing records will be completed and maintained by Maintenance Supervisor (state of MN registered electrician) as required by NFPA. Maintenance Supervisor is responsible to monitor for continued compliance.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 930	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the Liquid oxygen use and storage in resident rooms was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 section 11.7.4. This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:30 a.m. and 1:30 p.m. on 05/01/2018, observations revealed that there are 120 liter liquid oxygen cylinders located in resident rooms 11 and 27. This deficient condition was confirmed by a Maintenance Supervisor.

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The above isolated deficiencies pose no actual harm to the residents