Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 1, 2025

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

Re: Reinspection Results
Event ID: 2Z1B12

Dear Administrator:

On June 25, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 15, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Electronically delivered
July 1, 2025

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

RE: CCN: 245119
Cycle Start Date: April 30, 2025

Dear Administrator:

On May 28, 2025, we notified you a remedy was imposed. On June 25, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 20, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 30, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 28, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 30, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 20, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 28, 2025

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

RE: CCN: 245119
Cycle Start Date: April 30, 2025

Dear Administrator:

On May 15, 2025, we informed you that we may impose enforcement remedies.

On May 15, 2025, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 30, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 30, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 30, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 30, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Aitkin Health Services will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 30, 2025. You will receive further information regarding this from the State agency. 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. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 October 30, 2025 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	C 05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/12/25 to 5/15/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/12/25 to 5/15/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited. H51194667C(MN00113008) H51194189C(MN00109181) H51194188C(MN00107720) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to	F 000		

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

Electronically Signed | 06/06/2025

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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F 000	Continued From page 1 validate substantial compliance with the regulations has been attained.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.	F 582		6/18/25

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F 582	Continued From page 2 (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the Notice of Medicare Non-Coverage (NOMNC, Form CMS-10123) to 2 of 3 residents (R10, R37) reviewed whose Medicare Part A coverage ended and remained in the facility. Findings included: R10's Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage form (SNF ABN, CMS-10055), dated 3/10/25, identified on 3/13/25, estimated a daily rate of $515,44 would be charged and not covered by Medicare-A. R10's medical record lacked indication CMS-10123 was provided to the resident at least 48 hours prior to stoppage of Medicare part A. R10's census list dated 5/15/25, identified R10 remained a resident of the facility after 3/13/25,	F 582	AHS failed to provide Notice of Medicare Non-Coverage (NOMNC) to two residents (R10, R37) at end of coverage for Medicare A. R37 affected by deficient practice received the correct documentation. R10 died 5/28/2025. All Medicare A residents receiving skilled services have the potential to be affected by this deficient practice when skilled services end. NOMNC process reviewed by DON and process changes were made to include all residents who have their skilled Medicare A coverage ending will receive both the CMS-10123 and CMS-10055. Nurse managers educated on SNF ABN NOMNC documents CMS-10123 and CMS-10055 use and notice guidelines. NOMNC audits will be completed through verifying the presence of signed NOMNC forms in the NOMNC	

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F 582	Continued From page 3 but not on Medicare part A as payer source. R37's Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage form (SNF ABN, CMS-10055), dated 11/25/24, identified on 11/28/24, an estimated daily rate of $500.00 would be charged and not covered by Medicare-A. R37's medical record lacked indication CMS-10123 was provided to the resident at least 48 hours prior to stoppage of Medicare part A. R37's census list dated 5/15/25, identified R10 remained a resident of the facility after 11/28/24, but not on Medicare part A as payer source. During an interview on 5/14/25 at 9:36 a.m., registered nurse (RN)-A stated she was responsible for providing the resident with the NOMNC and the SNF ABN forms when Medicare part A stopped coverage. RN-A stated the NOMNC was provided to the resident when they were discharged from the facility and the SNF ABN form was provided to the resident when Medicare part A coverage stopped but the resident stayed in the facility. The NOMNC was not provided to the residents that stayed in the facility after Medicare part A coverage stopped and they still stayed in the facility. During an interview on 5/14/25 at 9:49 a.m. the administrator and the regional director of operations (RDO) stated they were not aware both CMS-10123 and CMS-10055 had to be given to the resident when they were discharged from Medicare A but remained in the facility. Facility policy Medicare Denial Procedure last reviewed 2/27/24 indicated the Medicare Denial	F 582	binder each time a resident has their skilled Medicare A coverage ending or discharging from the facility x 2 months. Findings will be brought to the facilities Quality Assurance Committee for review and further auditing recommendations.	

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F 582	Continued From page 4 Notice would be delivered no later than 48 hours prior to discharge from services and far enough in advance to allow the Medicare beneficiary sufficient time to consider their options and make an informed choice regarding their right to appeal the decision that Medicare will not cover specific services. If the beneficiary will continue to stay in the care center, the facility would provide CMS-10055.	F 582		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is	F 605		6/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 605	Continued From page 5 indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure ordered as needed (PRN) antipsychotic medications were limited to a 14-day time period and a face-to-face provider visit with clinical documentation indicating the medication needed to remain was performed prior to the medication extended past the 14 day period. The facility also failed to document behaviors and non-pharmacological interventions utilized prior to usage of an antipsychotic for 1 of 5 (R39) residents reviewed for unnecessary medications. Findings include: R39's admission Minimum Data Set (MDS) assessment dated 4/25/25, identified R39 had significant cognitive impairment. Diagnoses included hypertension and dementia. Medications received included an antipsychotic. R39's active Order Summary Report dated 5/15/25, indicated Quetiapine Fumarate (an antipsychotic medication used for mental health behaviors) 25mg by mouth every 8 hours PRN for agitation, anxiety, or delusion was ordered on 4/17/25. The order lacked a 14 day stop date. R39's Medication Administration Report (MAR) for 4/25 and 5/25 were reviewed. R39 reviewed the antipsychotic medication was administered on 4/20/25 at 9:30 p.m., 4/23/25 at 8:45 a.m., 5/6/25 at 5:58 p.m., and 5/7/25 at 2:30 p.m.	F 605	AHS failed to ensure ordered as needed (PRN) antipsychotic medications are limited to a 14-day time period and a face-to-face provider visit with the clinical documentation indicating the medication needed to remain was performed prior to the medication extended past the 14-day period. AHS failed to document behaviors and non-pharmacological interventions utilized prior to usage of an antipsychotic for 1 of 5 residents. R39 medication had been discontinued by provider, no further corrections indicated. All licensed nursing staff reeducated on Psychotropic Medication Policy. All residents receiving psychotropic medications have the potential to be affected by this deficient practice. PCC Dashboard ll residents currently with orders for psychotropic medications were checked for stop dates being in place. Psychotropic Medications policy was reviewed by DON and no changes were made. New admissions or new orders for psychotropic medications will have a 14-day hard stop added at the time of order entry. Triple check forms will be used for all new admissions with or new physician Psychotropic orders to guarantee a 14-day hard stop for the psychotropic medication to be in place. Orders for target behaviors and non-pharm interventions are present and utilized prior to dispensing psychotropic	

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F 605	Continued From page 6 R39's nursing progress notes were reviewed for 4/25, and 5/25, and lacked documentation of any behaviors other than wandering the hallways and wandering into resident rooms. The progress notes also lacked behaviors that occurred or non-pharmacological interventions that were attempted before medication was given for each incident the antipsychotic was administered in April and May of 2025. R39's provider visit note dated 5/8/25, indicated a diagnosis of dementia and hallucinations. The record also indicated R39 did not have behavioral disturbances and had remained stable mentally. Per staff and provider assessment today R39 appeared to have adjusted well to the new environment and was pleasantly confused. During an interview on 5/15/25 at 7:41 a.m., nurse assistant/ trained medication assistant (TMA)-A stated if a resident needed any kind of as needed medication administered the nurse would need to be notified because assessments needed to be performed and documented prior to medications being given. TMA-A stated R39 never had any behaviors except for wandering in the hallways and occasionally into a different resident room. R39 was pleasant and always very easy to redirect when he wandered into a different resident room. During an interview on 5/15/25 at 9:34 a.m. registered nurse (RN)-B stated if a PRN antipsychotic medication was needed to be administered then the nurse would assess the resident to see what behaviors had occurred and what non-pharmacological interventions had been attempted prior to the request for the medication.	F 605	medications to residents along with the needed supportive documentation required. DON or designee will be complete audits with each new psychotropic order for confirmation of 14-day hard stop, target behaviors, non-pharm interventions in resident orders and required supporting documentation in progress notes x2 months. Findings will be brought to the facilities Quality Assurance Committee for review and further auditing recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	C 05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 605	Continued From page 7 That would be documented in the resident's nursing progress notes as well as the response to the medication after it was given. RN-B stated she had never given R39 any PRN antipsychotic because she was not aware R39 had any true behaviors that would warrant an antipsychotic. RN-B was unsure how long a PRN antipsychotic order was good for. During an interview on 5/25/25 at 11:04 a.m., the director of nursing stated a PRN antipsychotic medication order was only good for 14 days, then needed to have the provider see the resident before it could be renewed. Wandering was not a reason to give an antipsychotic medication. The DON stated an expectation that all staff would utilize a PRN antipsychotic only when necessary and only after nonpharmacological interventions were attempted first. All behaviors and interventions would need to be documented in the progress notes. Facility policy Psychotropic Medications last issued 8/20/24, indicated PRN psychotropic medications ordered would be limited to 14 days. The prescribing practitioner would evaluate and document the medications necessity, benefits, and improvement (expressions, indications of distress). If the physician deemed appropriate to extend beyond the 14-day limit, supporting rationale must be documented. The policy also indicated all nursing staff would utilize PRN psychotropic medication, following provider order, if non-pharmacological intervention(s) are unsuccessful.	F 605		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		6/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 8 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to enter and follow provider orders for 1 of 1 resident (R9) reviewed for provider orders. Findings included: R9's admission Minimum Data Set (MDS) Assessment dated 4/24/25, indicated R9 was cognitively intact and diagnoses included coronary artery disease, heart failure, and hypertension. Medications taken daily included a diuretic (water removing pill). R9's admission orders dated 4/17/25, indicated daily weights and to notify the provider for a 2-pound (lb.) weight gain in 24 hours or a 5 lb. weight gain in 7 days. R9's active Order Summary Report dated 5/13/25 lacked an order for daily weights or to call the provider based on weight gain parameters specified in the orders. During an interview on 5/13/25 at 1:18 p.m., nurse assistant (NA)-A stated all residents with daily weights were done by the NA and then given to the nurse to review. NA-A looked at her list and	F 684	AHS failed to enter and follow provider orders related to daily diuretic medication (water removal pill) for daily weights or to call the provider based on weight gain parameters specified in the orders for a cognitively intact resident with coronary artery disease, heart failure and hypertension for 1 of 1 (R9). R9 orders were updated to include orders for daily weights prior to his discharge. All residents with daily weight orders have the potential risk of being affected by this deficient practice. All residents with coronary artery disease, heart failure and hypertension diagnosis were reviewed by provider for necessity of addition VS or assessment needs. Processing Physician Orders document was reviewed by DON, no changes were made. Re-education on Processing Physician Orders document to licensed nurse staff. New admissions or new orders for diuretic medications will be checked for orders for daily weights or to call the provider based on weight gain parameters specified in the orders. Triple check forms will be utilized for all new admissions order entry, looking for diuretic orders or when new physician	

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F 684	Continued From page 9 stated R9 was not a daily weight. During an interview 5/13/25 registered nurse (RN)-A stated the nurse manager entered all admission orders into R9's electronic medical record (EMR) at time of admission. The charge nurse would review that all orders were entered correctly and a third nurse would then triple check all orders were entered correctly. All three staff members would sign a form which indicated the checks were performed. During an interview on 5/15/25 at 9:34 a.m., register nurse (RN)-B confirmed admission orders were entered by the nurse manager at time of admission, the charge nurse then did a double check, and finally the next shift RN would do a triple check all orders were entered correctly. RN-B reviewed R9's medical record and confirmed there were no orders for daily weights entered or parameters to notify the provider related to weight gains. During an interview on 5/15/25 at 11:04 a.m., the director of nursing (DON) stated an expectation all orders would be entered at the time they are ordered, both completely and correctly. Facility physician order policy was requested but not provided.	F 684	orders for diuretics. If weight orders and or parameters are ordered that they are in the TAR/POC to be completed by nursing staff as ordered. DON or designee will complete audits with each new admission and/or diuretic order for orders for daily weights or to call the provider based on weight gain parameters specified in the orders x2 months. Findings will be brought to the facilities Quality Assurance Committee for review and further auditing recommendations.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 28, 2025

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

Re: State Nursing Home Licensing Orders
Event ID: 2Z1B11

Dear Administrator:

The above facility was surveyed on May 12, 2025 through May 15, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00002	A. BUILDING: _____ B. WING _____	C 05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/12/25 to 5/15/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H51194667C(MN00113008), H51194189C(MN00109181), H51194188C(MN00107720). NO citations were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the	2 000		

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2 000	Continued From page 2 Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to enter and follow provider orders for 1 of 1 resident (R9) reviewed for provider orders. Findings included: R9's admission Minimum Data Set (MDS) Assessment dated 4/24/25, indicated R9 was cognitively intact and diagnoses included coronary artery disease, heart failure, and hypertension. Medications taken daily included a diuretic (water removing pill).	2 875	Corrected	6/18/25

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2 875	Continued From page 3 R9's admission orders dated 4/17/25, indicated daily weights and to notify the provider for a 2-pound (lb.) weight gain in 24 hours or a 5 lb. weight gain in 7 days. R9's active Order Summary Report dated 5/13/25 lacked an order for daily weights or to call the provider based on weight gain parameters specified in the orders. During an interview on 5/13/25 at 1:18 p.m., nurse assistant (NA)-A stated all residents with daily weights were done by the NA and then given to the nurse to review. NA-A looked at her list and stated R9 was not a daily weight. During an interview 5/13/25 registered nurse (RN)-A stated the nurse manager entered all admission orders into R9's electronic medical record (EMR) at time of admission. The charge nurse would review that all orders were entered correctly and a third nurse would then triple check all orders were entered correctly. All three staff members would sign a form which indicated the checks were performed. During an interview on 5/15/25 at 9:34 a.m., register nurse (RN)-B confirmed admission orders were entered by the nurse manager at time of admission, the charge nurse then did a double check, and finally the next shift RN would do a triple check all orders were entered correctly. RN-B reviewed R9's medical record and confirmed there were no orders for daily weights entered or parameters to notify the provider related to weight gains. During an interview on 5/15/25 at 11:04 a.m., the director of nursing (DON) stated an expectation all orders would be entered at the time they are	2 875		

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2 875	Continued From page 4 ordered, both completely and correctly. Facility physician order policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review facility policy and procedures on frequency of taking residents' weights. The DON or designee could provide education on these policies and procedures to all nursing staff. The DON or designee could conduct audits of resident weights, and report the results of these audits to the Quality Assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 875		

APPROVED
By Travis Z. Ahrens at 7:31 am, May 28, 2025

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

Travis Z. Ahrens 49207

PRINTED: 05/28/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/13/2025**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 05/13/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Aitkin Health Services was found 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. Aitkin Health Services is a one story building with a full basement. The original building was constructed in 1955 with additions in 1962, and a dining room main entry was added in 2002. Both the existing building and the addition are type II(111) construction. In 2009-2010 an addition was added that was a one story addition with a full basement that was determined to be of Type II(111) Constructions. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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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