Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2024

Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

RE: CCN: 245363
Cycle Start Date: November 1, 2023

Dear Administrator:

On January 9, 2024, we notified you a remedy was imposed. On December 22, 2023 and January 10, 2024, the Minnesota Departments of Health and Public Safety complete revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 22, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 1, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 9, 2024, 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 February 1, 2024, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 22, 2023, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
November 21, 2023

Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

RE: CCN: 245363
Cycle Start Date: November 1, 2023

Dear Administrator:

On November 1, 2023, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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, 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, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 1, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by May 1, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 ______	C 11/01/2023

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 On 10/30/23 through 11/1/23 , a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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 The CMS-2567 was revised for an adminstration review. On 10/30/23 through 11/1/23, 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 complaint was reviewed: H53636802C (MN97748) with a deficiency cited at F625 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 validate substantial compliance with the	F 000		

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

Electronically Signed — 11/28/2023

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 regulations has been attained.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or	F 622		12/20/23

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F 622	Continued From page 2	F 622		

discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including

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F 622	Continued From page 3 contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were allowed to transfer back to the facility following transfer to the hospital for 1 of 2 residents (R204) reviewed for hospitalization. Findings include: R204's significant change Minimum Data Set (MDS) dated 8/19/23, identified R204 had moderate cognitive impairment. Diagnoses included infection to the right hip prosthesis, vascular dementia, heart failure and metabolic encephalopathy. R204's discharge MDS dated 10/6/23, identified R204 was discharged from the facility on 10/6/23, to a short term general hospital with return anticipated. R204's progress notes identified the following: - 10/6/23, R204 experienced a hypoglycemic episode (low blood sugar) and low oxygen saturation of 85% with shortness of breath. An order was received to transport R204 to the emergency department to be evaluated. R204 was transported to the hospital via ambulance at	F 622	Resident 204 will be allowed to return to the facility. Resident was re-admitted to facility on 11/27/2023. DON/designee will ensure all residents discharged from the facility are in accordance with guidelines identified in the State Operations Manual (SOM). The facility discharge policy was developed with best practices and all staff will be educated on the new policy. DON/designee will complete facility discharge audits to ensure all residents being discharged to hospital with anticipated return to facility are in accordance with the policy. Audits will be conducted on all residents discharged to hospital with return anticipated x 30 days and then every other up to 60 days. Audits will be brought to the next Quality Council meeting for review and recommendations.	

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F 622	Continued From page 4 1:10 p.m. - 10/7/23, R204 was admitted to the hospital. The form Transfer, Discharge or Therapeutic Leave Notice with date 10/6/23, identified the facility's intent to transfer or discharge R204 because it was necessary to meet the resident's well-being and the resident's well-being could not be met in the facility. The facility's bed hold policy applied to all residents regardless of source of payment and any resident could choose to have bed held while hospitalized at 30% of the current per diem rate. The form was signed by registered nurse (RN)-A dated 10/6/23 with notation that a verbal consent had been received from R204. The form lacked a signature and the medical record lacked evidence of attempts made to obtain the signature. A letter addressed to R204 dated 10/16/23, identified the purpose was to notify R204 the facility was serving her a 30 day discharge notice due to her inability to pay for her care and stay at the facility. The facility received notification from the county R204's application for medical assistance was denied a second time for non compliance of paperwork requested. The letter notified R204 of her right to appeal and was signed by the facility's administrator. During interview on 10/30/23, at 1:09 p.m. with the director of nursing (DON) and administrator, the DON stated the facility's current census was 50 with no residents in the hospital. A Resident List Report dated 10/30/23, lacked R204's name on the current census.	F 622		

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F 622	Continued From page 5	F 622		

During interview on 11/1/23, at 1:35 a.m. registered nurse (RN)-A stated she obtained a verbal bed hold consent from R204 when she transferred to the emergency room on 10/6/23. RN-A received an update from the hospital on 10/10/23, and there was no immediate plans for discharge.

During interview on 11/1/23, at 1:45 p.m. the long term care ombudsman stated she never received a discharge notice from the facility identifying a 30 day notice of discharge for non payment. The ombudsman received the discharge notice information from the hospital staff. The facility sent the hospital the 30 day notice of discharge and were refusing to allow R204 to return to the facility. The ombudsman tried to reach out to the facility but no one had responded. The hospital was attempting to get R204 out of the hospital and the facility kept telling the hospital they did not have a bed hold for R204. R204 was in the hospital over 25 days because R204 wanted to return to that facility and the facility was not allowing her back. R204's medical assistance had not been completed correctly and was denied, but the hospital was assisting her with the application and it was getting sorted out The ombudsman had spoken with R204 and R204 had stated she wanted to return to the facility so she had reached out to the Senior Linkage Line and they assisted her to secure an attorney as well as assisting R204 to find nursing home placement.

During joint interview on 11/1/23, at 2:55 p.m. with administrator and the director of nursing (DON), the administrator stated it was not the facility's responsibility to assist residents to fill out their medical assistance paperwork; however, they

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F 622	Continued From page 6	F 622		

had documented attempts of assisting R204 to complete her application. The facility never stated they would not accept R204 back when she was discharged from the hospital. It had been relayed to the administrator, R204 had called after receiving the 30 day notice of discharge from the facility and stated R204 did not want to come back. The administrator understood R204 was still in the hospital and was not stable for discharge due to illness and could not return yet.

During telephone interview on 11/1/23, at 3:15 p.m. the hospital licensed social worker (LSW)-A stated the hospital phoned the facility on 10/12/23 and 10/13/23, and spoke with RN-A. Their notes indicated discharge planning was discussed. On 10/13/23, the hospital documentation identified the hospital received a call from the facility from RN-B, in which RN-B informed the hospital after review of R204's records, a bed hold was not on file and so the facility would not take her back on her discharge from the hospital.

During joint interview on 11/1/23, at 3:25 p.m. with the administrator and RN-B, RN-B stated she received a call from the hospital to discuss R204's discharge and return to the facility. For all admissions and readmissions, RN-B always discussed the situation with the administrator. RN-B discussed R204's case with the administrator and was told to notify the hospital the facility did not have a bed hold for R204 and therefore would not be taking her back, which she did.

During telephone interview on 11/2/23 at 11:50 p.m. LSW-B stated R204 was stable to return to the skilled nursing facility as of 10/16/23, then the

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F 622	Continued From page 7	F 622		

facility called and informed them they would not accept R204 back. R204 has remained in the hospital since and even though she was getting some therapy while at the hospital, R204 would have benefited to return to the skilled nursing facility where she would receive more intensive rehabilitation, as R204's goal was to return to her own home. LSW-B knew R204 wanted to return to the facility and had legal representation involved.

R204's hospital records/notes identified the following:

- Hospital Discharge Planning Assessment dated 10/9/23, R204 was admitted to the hospital from a skilled nursing facility and her preference and plan was to return to the facility. RN-B at the facility was notified of the discharge plan.

- Case management note dated 10/12/23, the facility was contacted to discuss equipment and supplies R204 would need on her transfer back to the facility.

- Case management note dated 10/13/23, the facility was contacted regarding discharge plans and dressing supplies needed.

- Progress note dated 10/17/23, the orthopedic surgeon stated R204 was medically stable for discharge.

- Orthopedic note dated 11/2/23, R204 was cleared for discharge since 10/16/23. R204 had ongoing hospitalization as the hospital waited for rehabilitation placement and discharge plan for R204.

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F 622	Continued From page 8 An email communication from LSW-B dated 11/2/23, identified the hospital stopped communicating with the facility when the ombudsman became involved with R204's case. During interview on 11/1/23, at 3:30 p.m. the administrator stated he notified his staff to keep R204's room with her belongings as her room needed to be available for her. The facility did not have a bed hold on file for R204, and so they did not legally have to hold a bed for her. The hospital was indicating the facility had to take R204 back and that was not correct. The administrator felt the hospital was trying to force the issue because no other facility would admit R204 due to her complexity and multiple infections. The facility's policy Discharge of Resident from Aicota dated 7/1/23, identified a purpose to insure the resident a safe and courteous departure from the facility and to provide and organize a discharge that would promote the highest quality of well being for the resident in their new surrounding.	F 622		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to	F 625		12/20/23

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F 625	Continued From page 9 return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written notice of bed hold was provided at the time of transfer along with ongoing attempts at getting the beg hold signed following an emergent transfer for 1 of 1 resident (R204) reviewed for hospitalization. Findings include: R204's significant change Minimum Data Set (MDS) dated 8/19/23, identified R204 had moderate cognitive impairment. Diagnoses included infection to right hip prosthesis, vascular dementia, heart failure and metabolic encephalopathy. R204's progress notes identified the following: - 10/6/23, R204 experienced a hypoglycemic episode (low blood sugar) and low oxygen	F 625	Resident 204 was re-admitted to Aicota Health Care Center on 11/27/23. Bed Hold Policy updated to include sending bed hold to resident/resident representative for signature if a signature was unable to be obtained at the time of discharge. All residents being transferred from the facility have the potential to be affected. Education regarding bed hold policy and bed hold form will be completed with nursing staff. All residents will receive bed hold upon transfer from the facility. Audits to assure bed hold completion will be done following each transfer X 1 month and then 2 monthly as available thereafter. Audit results will be brought to Quality Council for review and recommendations.	

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F 625	Continued From page 10	F 625		

saturation of 85% with shortness of breath. An order was received to transport R204 to the emergency department to be evaluated. R204 was transported to the hospital via ambulance at 1:10 p.m.

- 10/7/23, R204 was admitted to the hospital.

The medical record lacked evidence R204 or her family representative was provided a written notice of bed hold upon transfer, or within a 24 hour period following, to ensure potential costs and bed reservation were explained while R204 was hospitalized. Further, the medical record lacked evidence the bed hold was provided at the time of transfer as well as ongoing attempts by the facility to obtain a signed bedhold.

The form Transfer, Discharge or Therapeutic Leave Notice dated 10/6/23, identified the facility's intent to transfer or discharge R204 because it was necessary to meet the resident's well-being and the resident's well-being could not be met in the facility. The form indicated the facility's bed hold policy applied to all residents regardless of source of payment and any resident could choose to have bed held while hospitalized at 30% of the current per diem rate. The form was signed by registered nurse (RN)-A dated 10/6/23, with notation that a verbal consent was received by R204. The form was not physically signed by the resident or their representative.

When interviewed on 11/1/23, at 1:30 p.m. RN-A stated she did not complete a written notice of transfer and bed hold, nor sent the form with when the resident was transferred to the hospital. RN-A obtained a verbal consent for transfer and bed hold from R204 when RN-A arranged the

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F 625	Continued From page 11 transfer. During interview on 11/1/23, at 1:20 p.m. the administrator stated the facility did obtain a verbal bed hold from R204 at the time of transfer on 10/6/23. It was filed incorrectly in a billing folder in the billing office and had not been scanned into the patients chart. The bed hold form identified a verbal bed hold was obtained from R204 by RN-A; however, lacked a signature from R204 or a representative. The administrator was unable to find documentation the written bed hold had been sent to R204 or her representative, or evidence of ongoing attempts to obtain a signature. The facility policy Bed Hold Policy dated 11/27/17, identified nursing staff would get a signed or verbal consent for bed hold and document on Transfer, Discharge or Therapeutic Leave Notice. A copy would be provided to the resident and/or family member/legal representative as proof of their Bed Hold Policy once signed.	F 625		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 732		12/20/23

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F 732	Continued From page 12 vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the actual hours and amount of staff were posted per each shift. This had the potential to affect all residents residing in the facility. Findings include: On 10/31/23, at 11:15 a.m. the nurse staff posting was observed posted in the hallway near the business office. The posting Today's Staffing contained the following information: census, date, start of day shift, start of evening shift, start of	F 732	Nurse Staffing sheet (Today's Staffing) will be edited prior to posting to correct the number of people on for each shift. Staffing sheets will be adjusted daily based on actual hours worked and number of people per discipline/per shift and with current census and posted in the Southeast Hall. Staffing sheet procedure was created. Education has been provided to staff responsible for completing staffing sheet. Education will be provided to staff responsible for updating the sheet as the schedule	

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F 732	Continued From page 13 night shift, number of registered nurses (RN) with a total hours and full time equivalent (FTE) for each shift, number of licensed practical nurses (LPN) with a total hours, FTE's for each shift, and number of assistants with a total hours and FTE's for each shift, and then an accumulated total. The schedule and nurse posting were compared and identified the following: - The Today's Staffing dated 10/29/23, identified a census of 50. Start time day shift of 6:00 a.m., start time of evening shift at 2:15 p.m. and start time of night shift of 10:45 p.m. The number of RN's identified for the day shift were 15.75 hours with 1.97 FTE's, evening shift 17 hours and 2.13 FTE's and night shift of 39.50 hours with 4.94 FTE's. The number of LPN's identified for the day shift were 8.25 hours with 1.03 FTE, evening shift 9 hours with 1.13 FTE's and night shift with 24 hours and 3 FTE's. The numbers of assistants identified for the day shift were 32.50 hours with 5.03 FTE's , evening shift 34.25 hours and 4.31 FTE's and night shift 20.25 hours and 2.53 FTE's. The posting lacked the actual number and actual hours worked by each discipline on each shift. The corresponding working schedule Daily Attendance Report dated 10/29/23, identified the following for day shift: one RN 6:00 a.m. to 2:30 p.m., one RN 6:00 a.m. to 6:30 p.m., one LPN 6:00 a.m. to 6:30 p.m.; one nursing assistant (NA) 6:00 a.m. to 9:00 a.m., one NA 9:00 a.m. to 2:30 p.m., two NA's 6:00 a.m. to 2:30 p.m., and two NA's 6:00 a.m. to 6:30 p.m. The evening shift identified the following staff: two RN's 2:00 p.m. to 10:30 p.m. , one LPN 2:00 p.m. to 10:30 p.m. and four NA's 2:00 p.m. to 10:30 p.m.. The following were identified to work the night shift: one RN	F 732	changes. Audits of Staffing sheet for accuracy will be conducted 3 per week X4 weeks, then 1 per week X4 weeks and monthly thereafter. Audit results will be brought to Quality Council for review and recommendations.	

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F 732	Continued From page 14	F 732		

6:00 p.m. to 6:30 a.m., one LPN 6:00 p.m. to 6:30 a.m., and three NA's 6:00 p.m. to 6:30 a.m..

- The Today's Staffing dated 10/30/23, identified a census of 50. Start time day shift of 6:00 a.m., start time of evening shift at 2:15 p.m. and start time of night shift of 10:45 p.m. The number of RN identified for the day shift were 12.5 hours with 1.56 FTE's, evening shift 25.5 hours and 3.19 FTE's and night shift of 13.5 hours with 1.69 FTE's. The number of LPN's identified for the day shift were 31.5 hours with 3.94 FTE, evening shift 5 hours with .63 FTE's and night shift with 0 hours and 0 FTE's. The numbers of assistants identified for the day shift were 38.25 hours with 5.75 FTE's , evening shift 35.25 hours and 4.44 FTE's and night shift 13.5 hours and 1.69 FTE's. The posting lacked the actual number and actual hours worked by each discipline on each shift.

The corresponding Daily Attendance Report dated 10/30/23, identified the following for day shift: two management RN's 8:00 a.m. to 4:30 p.m., three LPN 6:00 a.m. to 2:30 p.m.; one LPN 6:00 a.m. to 6:30 p.m. one NA 6:00 a.m. to 9:00 a.m., one NA 9:00 a.m. to 2:30 p.m., three NA's 6:00 a.m. to 2:30 p.m., and one NA 6:00 a.m. to 6:30 p.m. The evening shift identified the following staff: two RN's 2:00 p.m. to 10:30 p.m. , one NA 2:00 p.m. to 10:30 p.m., one NA 2:00 p.m. to 10 : 00 p.m., and one NA 2:30 p.m. to 10:30 p.m. The following were identified to work the night shift: one RN 6:00 p.m. to 6:30 a.m., one RN 10:00 p.m. to 6:30 p.m. LPN 6:00 p.m. to 6:30 a.m., one NA's 6:00 p.m. to 6:30 a.m. and one NA 10: p.m. to 6:30 a.m.

- The Today's Staffing dated 10/31/23, identified a census of 52. Start time day shift of 6:00 a.m.,

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F 732	Continued From page 15	F 732		

start time of evening shift at 2:15 p.m. and start time of night shift of 10:45 p.m. The number of RN's identified for the day shift were 26.25 hours with 3.28 FTE's, evening shift 20 hours and 2.5 FTE's and night shift of 6.75 hours with .84 FTE's. The number of LPN's identified for the day shift were 15.5 hours with 1.94 FTE, evening shift 12.75 hours with 1.59 FTE's and night shift with 6.75 hours and 0.84 FTE's. The numbers of assistants identified for the day shift were 46 hours with 5.75 FTE's , evening shift 40 hours and 5 FTE's and night shift 13.5 hours and 1.69 FTE's. The posting lacked the actual number and actual hours worked by each discipline on each shift.

The corresponding Daily Attendance Report dated 10/31/23, identified the following for day shift: three management RN's 8:00 a.m. to 4:30 p.m., one RN 6:00 a.m. to 2:30 p.m. one LPN 6:00 a.m. to 6:30 p.m.; one LPN 6:00 a.m. to 2:30 p.m. one NA 6:00 a.m. to 9:00 a.m., one NA 9:00 a.m. to 2:30 p.m., three NA's 6:00 a.m. to 2:30 p.m., and two NA 6:00 a.m. to 6:30 p.m. The evening shift identified the following staff: one RN 2:00 p.m. to 10:30 p.m. , one RN 6:00 p.m. to 10:30 p.m., one LPN 2:30 p.m. to 10:30 p.m., one trained medication assistant (TMA) 2:00 p.m. to 6:00 p.m., three NA's 2:00 p.m. to 10 : 00 p.m., and four NA's names written in without identifying the hours they worked. The following were identified to work the night shift: one RN 10:00 p.m. to 6:30 a.m., one LPN 6:00 p.m. to 6:30 a.m., one NA's 6:00 p.m. to 6:30 a.m. and one NA 10:00 p.m. to 6:30 a.m.

During interview on 10/31/23, at 2:37 p.m. the director of nursing stated the facility used Smartlinks staffing system for scheduling and it

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F 732	Continued From page 16 pulled the information from the schedule in to the form the facility used for the nurse staff posting requirement. The DON didn't realize the actual numbers and total numbers of staff were not pulled per actual shift, as the facility used multiple shifts in their schedule to cover the resident needs. For instance the day shift had people that worked 6:00 a.m. to 2:30 p.m. and 6:00 a.m. to 6:00 p.m. and all the staff scheduled to start at 6:00 a.m. were listed under the day shift of the nurse staff posting. A policy on nurse staff posting was requested and not received.	F 732		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza	F 883		12/20/23

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F 883	Continued From page 17 immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer pneumococcal conjugate vaccine 20 variant (PVC20) as directed by the Centers for Disease Control (CDC) for 4 of 5 residents (R11, R16, R37, R44) reviewed for immunizations.	F 883	Facility failed to offer immunizations to residents that were eligible to receive. Resident 44 and 37 have received the immunization. Resident 16 declined immunization when offered. Resident 11 has been offered immunization via phone	

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Continued From page 18

Findings include:

R11's quarterly Minimum Data Set (MDS) dated 10/12/23, identified diagnoses of Alzheimer's disease, diabetes and kidney disease. R11's undated immunization record, identified R11 received pneumococcal polysaccharide vaccine (PPSV23) on 2/21/11, and the pneumococcal conjugate vaccine (PCV13) on 11/4/14. R11's medical record failed to provide evidence the PCV20 (pneumonia immunization) was offered and/or education was provided in conjunction with the provider to R11/R11's representative.

R16's annual MDS dated 7/26/23, identified diagnoses of heart and kidney disease. R16's undated immunization record, identified R16 received PPSV23 on 5/30/02, and the PCV13 on 10/27/15. R16's medical record failed to provide evidence the PCV20 was offered and/or education was provided in conjunction with the provider to R16/R16's representative.

R37's annual MDS dated 10/02/23, identified a diagnosis of dementia and Parkinson's disease. R37's undated immunization record, identified R37 received the pneumococcal 23 (PPSV23) on 10/23/03 and the pneumococcal conjugate vaccine 13 variant (PCV13) on 1/26/18. R37's medical record failed to provide evidence the PCV20 was offered and/or education was provided in conjunction with the provider to R37/R37's representative.

R44's quarterly MDS dated 10/16/23, identified a diagnosis of Alzheimer's, heart and kidney disease. R44's undated immunization record, identified R44 received the pneumococcal poly on

F 883

call to representative with no response. DON/designee reviewed all resident's immunization status and medical director was consulted for clinical shared decision-making for eligible residents. All residents received the immunization if they were eligible and consented. Residents who were eligible and declined the immunization have updated declinations on file. Nursing staff will be educated on CDC guidelines pertaining to resident immunizations. DON/designee will audit all residents to determine if they are eligible for immunizations on resident quarterly assessment. Audit results will be brought to the next Quality Council meeting for review and recommendations.

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F 883	Continued From page 19 8/29/14 and the pneumococcal conjugate vaccine 13 variant (PCV13) on 8/31/15. R44's medical record failed to provide evidence the PCV20 was offered and/or education was provided in conjunction with the provider to R44/R44's representative. During an joint interview on 11/1/23, at 9:45 a.m. with the director of nursing (DON) and registered nurse (RN)-A, the DON indicated the facility was not currently offering the PCV20 to their residents. They had just completed resident's yearly influenza vaccination and had not began to update their resident's with their PCV20 vaccinations, but was on their radar. The facility's undated Influenza/Pneumococcal Vaccine policy, indicated pneumococcal vaccines would be offered to each resident according to the current recommendations from the CDC unless contraindicated.	F 883		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 21, 2023

Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

Re: Event ID: 5VXP21

Dear Administrator:

The above facility survey was completed on November 2, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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AICOTA HEALTH CARE CENTER	**850 SECOND STREET NORTHWEST** **AITKIN, MN 56431**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/02/2023. At the time of this survey, Aicota Health Care Centerwas 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/29/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING **01 - AICOTA NURSING HOME** B. WING ______	**11/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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.	K 000		

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

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K 000	Continued From page 2 The facility has a capacity of 65 beds and had a census of 51 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 324		12/20/23

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K 324	Continued From page 3 Based on observation, a review of available documentation, and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/02/2023 at 11:46am, it was revealed by observation that the lock-out switch installed on the residential stove located in physical therapy was not on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cook-top or range, independent of staff action. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 324	Facility failed to ensure proper lock-out switch with 120-minute timer was installed on residential oven in therapy space. Residential oven was unhooked to make oven inoperable until facility can install proper lock-out switch. A proper lock-out switch has been ordered and will be installed by a licensed electrician.	
K 372 SS=C	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced	K 372		12/20/23

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K 372	Continued From page 4 by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/02/2023, Between 09:30 and 1:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors in the following areas: 1) Above fire door FD 10 2) Above fire door FD 11 3) Above fire door FD 04 (missing cover plate on electrical box) 4) Above fire door FD at end of southwest corridor 5) Above fire door by nursing office (missing electrical box cover plate) An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery. * deficiencies were fixed while on site *	K 372	Facility failed to ensure proper sealing of penetrations running from one smoke compartment to another. The sealing of penetrations was fixed at time of survey. Administrator/designee will ensure proper sealing of smoke compartment by adding monthly checks on TELS facility management system. Monthly audits of the TELS facility management system on smoke barriers will be conducted and brought to the safety committee/quality council for review and recommendations.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second	K 918		12/20/23

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K 918	Continued From page 5 criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, 5.6.6, 8.3.8,8.4.1, 8.4.2.1, 8.4.2.3,8.4.9,	K 918	Facility failed to ensure proper documentation and testing on 36-month, 4-hour load bank test was completed on generator systems. The load bank test was completed by the contractor on 11/06/2023. Administrator/designee will ensure compliance with load bank testing by adding annual load bank test to TELS	

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K 918	Continued From page 6	K 918		

8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility.

Findings include:

On 11/02/2023, at 11:05am, it was revealed by a review of available documentation of the emergency generator maintenance and testing that the facility failed to provide documentation for a 36 month, 4 hour load bank test.

An interview with the Maintenance Director and Facility Administrator verified these deficient findings at the time of discovery.

facility management system and three-year schedule added to contractor schedule for testing. Annual audits on the TELS facility management system for load bank testing will be conducted and brought to safety committee/quality council for review and recommendations.