DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 12, 2025

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

RE: CCN: 245363
Cycle Start Date: January 17, 2025

Dear Administrator:

On February 4, 2025, we notified you a remedy was imposed. On March 3, 2025 the Minnesota Departments of Health and Public Safety 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 March 1, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 17, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 4, 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 April 17, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 1, 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 Therefore, the NATCEP prohibition is rescinded.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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 12, 2025

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

Re: Reinspection Results
Event ID: 66MO12

Dear Administrator:

On March 3, 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 January 17, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 4, 2025

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

RE: CCN: 245363
Cycle Start Date: January 17, 2025

Dear Administrator:

On January 17, 2025, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (level F), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E),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 Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 17, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 17, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 17, 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.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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 $12,924; 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 April 17, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Aicota Health Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 17, 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. .

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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

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.

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 July 17, 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 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.

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:

Steven.Delich@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 Steven.Delich@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:

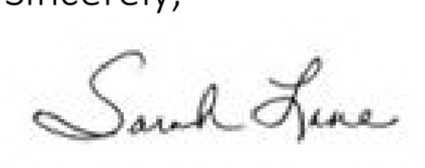
Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov

Cell: 1-507-308-4189

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.

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
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
	245363	A. BUILDING _____ B. WING _____	01/17/2025

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 1/14/25-1/17/25, 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 1/14/2025-1/17/2025, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 570 SS=E	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security.	F 570		3/1/25

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

Electronically Signed — 02/11/2025

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.

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 570	Continued From page 1 The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to consistently provide a surety bond (a written agreement to guarantee payment of another company's obligation under a separate contract) to protect the account balance of the resident trust fund. This had the potential to affect 26 of 26 residents at the facility who have a trust account. Findings include: Review of the facility Trust-Current Account Balance report dated 1/17/25, identified 26 current resident trust accounts were managed by the facility. The sum of all 26 resident trust accounts on 1/17/25 totaled $3,142.09. During interview on 1/16/25 at 3:03 p.m., revenue cycle manager (RCM) confirmed having partial responsibility for managing the resident trust fund account and was unaware of a surety bond. During interview on 1/17/24 at 12:40., business office manager (BOM) confirmed having the primary responsibility of managing the resident trust fund account. BOM was unsure of the amount of the surety bond or how to locate the surety bond. BOM stated the administrator would provide the surety bond shortly. A Merchants Bonding Company Resident Trust Fund Surety Bond notarized on 1/17/25 and effective from 1/1/25 to 1/1/26 was provided on	F 570	Surety Bond was produced dated January 17th, with an effective date of January 1, 2025. Production of Surety Bond corrects this deficient practice for all 26 residents who could have been affected. Policy reflects the current standard of practice stating that the purpose is to comply with applicable regulatory agency rules. All-staff education will be provided on regulatory rules regarding Resident Trust Account and need for surety bond. Surety bond is effective for the 2025 calendar year. ED or designee will audit in December to assure that a renewal has been started or obtained.	

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 570	Continued From page 2 1/17/25. A request for the surety bond effective prior to 1/1/25 was requested but not received. A policy Trust Fund dated 5/10/24, identified a primary purpose was to comply with applicable regulatory agency rules. The policy did not address surety bonds.	F 570		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure submitted Minimum Data Set (MDS) assessments were accurate and/or comprehensive for 35 out of 54 residents (R2, R3, R4, R5, R6, R7, R9, R11, R13, R14, R17, R20, R21, R24, R25, R26, R28, R29, R31, R32, R33, R34, R35, R36, R38, R39, R42, R43, R44, R47, R48, R49, R50, R152. R204) reviewed for MDS accuracy. Findings include: The following resident's MDS assessments indicated restraints were being utilized in MDS section P- Restraints: -R3's admission MDS assessment dated 11/26/24, Section P indicated restraint use. -R5's admission MDS assessment dated 12/26/24, Section P indicated restraint use. -R6's annual MDS assessment dated 11/14/24, Section P indicated restraint use.	F 641	Aicota will ensure that all submitted MDS assessments are accurate and comprehensive. MDS modified for all resident's coded to have restraints. All residents include R2, R3, R5, R6, R9, R11, R13, R14, R17, R20, R24, R25, R26, R28, R29, R31, R32, R33, R34, R36, R38, R39, R42, R43, R47, R48, R49, R50, and R204. All MDS were submitted and accepted. R21 did not have restraints marked on the indicated MDS. RAI manual reviewed and education was provided to MDS coordinator by DON regarding the requirements of restraints as identified in the RAI manual and Appendix PP, indicating that mobility (side) rails used for mobility purposes do not qualify under the definition of a restraint. BIMS assessment has been completed for R4, R14, R24, R33, R34, R35, R36, R38, R43, and R204. R8, R13,	3/1/25

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 3 -R7's quarterly MDS assessment dated 12/10/24, Section P indicated restraint use. -R9's significant change MDS assessment dated 12/3/24, Section P indicated restraint use. -R11's annual MDS assessment dated 12/4/24, Section P indicated restraint use. -R13's significant change MDS assessment dated 12/11/24, Section P indicated restraint use. -R14's significant change MDS assessment dated 12/11/24, Section P indicated restraint use. -R17's quarterly MDS assessment dated 12/15/24, Section P indicated restraint use. -R20's admission MDS assessment dated 12/10/24, Section P indicated restraint use. -R21's quarterly MDS assessment dated 12/4/24, Section P indicated restraint use. -R24's quarterly MDS assessment dated 11/3/24, Section P indicated restraint use. -R25's annual MDS assessment dated 12/12/24, Section P indicated restraint use. -R26's admission MDS assessment dated 11/27/24, Section P indicated restraint use. -R28's quarterly MDS assessment dated 12/15/24, Section P indicated restraint use. -R29's quarterly MDS assessment dated 11/18/24, Section P indicated restraint use. -R31's quarterly MDS assessment dated 10/19/24, Section P indicated restraint use. -R32's quarterly MDS assessment dated 12/18/24, Section P indicated restraint use. -R33's annual MDS assessment dated 10/9/24, Section P indicated restraint use. -R34's quarterly MDS assessment dated 11/30/24, Section P indicated restraint use. -R36's significant change MDS assessment dated 12/11/24, Section P indicated restraint use. -R38's annual MDS assessment dated 10/25/24, Section P indicated restraint use. -R39's annual MDS assessment dated 1/3/25,	F 641	and R152 have discharged. Social Service Director, MDS Coordinator, and Nurse Team Leaders were educated regarding the BIMS assessment and when it is required to be completed. Aicota has signed a contract with MDS Solutions to complete all MDS Assessments starting 2/17/25. Audits of MDS will be completed to ensure that restraints are not marked unless appropriate and that all MDS have a BIMS score or staff assessment if unable to complete the BIMS. DON or Designee will audit the MDS 2/week X4 weeks, then 1/week X4 weeks, and monthly thereafter. Audit results will be brought to QAPI for further review and recommendation.	

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 4 Section P indicated restraint use. -R42's admission MDS assessment dated 11/7/24, Section P indicated restraint use. -R43's quarterly MDS assessment dated 10/9/24, Section P indicated restraint use. -R44's quarterly MDS assessment dated 11/13/24, Section P indicated restraint use. -R47's admission MDS assessment dated 12/17/24, Section P indicated restraint use. -R48's admission MDS assessment dated 12/18/24, Section P indicated restraint use. -R49's admission MDS assessment dated 12/19/24, Section P indicated restraint use. -R50's admission MDS assessment dated 12/24/24, Section P indicated restraint use. -R204's admission MDS assessment dated 1/8/25, Section P indicated restraint use. The following resident's MDS assessments lacked BIMS scores in section C - Cognition: -R4's quarterly MDS assessment dated 10/26/24, did not include a BIMS score. -R8's quarterly MDS assessment dated 1/2/25, did not include a BIMS score. -R13's significant change MDS assessment dated 12/11/24, did not include a BIMS score. -R14's significant change MDS assessment dated 12/11/24, did not include a BIMS score. -R24's quarterly MDS assessment dated 11/3/24, did not include a BIMS score. -R33's annual MDS assessment dated 10/9/24, did not include a BIMS score. -R34's quarterly MDS assessment dated 11/30/24, did not include a BIMS score. -R35's quarterly MDS assessment dated 12/27/24, did not include a BIMS score. -R36's significant change MDS assessment dated 12/11/24, did not include a BIMS score. -R38's annual MDS assessment dated 10/25/24,	F 641		

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5 did not include a BIMS score. -R43's quarterly MDS assessment dated 10/9/24, did not include a BIMS score. -R152's admission MDS assessment dated 12/26/24, did not include a BIMS score. -R204's admission MDS assessment dated 1/8/25, did not include a BIMS score. On 1/17/25, the MDS coordinator was not available for interview. During an interview on 1/17/25 at 12:46 p.m., the director of nursing (DON) stated the facility was a restraint free facility and indicated restraints were not being utilized with any of their residents. There should not be any residents with a current MDS assessment coded with restraint use. The Cogntive section should be completed everytime a MDS assessment is due. All resident's should have a BIMS score each time their MDS data is due and submitted.	F 641		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.	F 712		3/1/25

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 712	Continued From page 6 §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure provider required regulatory visits occurred face to face for 33 out of 54 residents (R1, R3, R4, R6, R7, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R21, R23, R24, R25, R27, R28, R30, R31, R32, R33, R34, R35, R39, R43, R44, R45, R49) reviewed for regulatory visit compliance. Findings include: On 1/21/25, the facility provided documentation which identified the following residents as having received regulatory visits via telemedicine [a visit conducted via audio and sound by a provider located in a different location] instead of required in person visits on the following dates: R1's quarterly MDS assessment dated 10/18/24, indicated R1 was cognitively intact with diagnoses of coronary artery disease, and heart failure. R1 had regulatory visits via telehealth on 8/2/24, and 12/22/24. R3's admission MDS assessment dated 11/26/24, indicated R3 was cognitively intact with diagnoses of wedge compression fracture of fourth lumbar vertebra and atrial fibrillation. R3 had a regulatory visit via telehealth on 12/18/24. R4's quarterly MDS assessment dated 10/26/24,	F 712	Aicota requires physicians to complete regulatory visits in person and follow an outlined schedule of 30, 60, 90-day visits and every 2 months thereafter. Visits can alternate between physician and nurse practitioner. These visits will not be made via Telehealth and will be completed in person per the regulation. R6 and R21 were seen for a regulatory visit on 1/24/25. R1, R3, R4, R9, R10, R11, R12, R15, R16, R17, R18, R19, R23, R24, R25, R27, R28, R30, R31, R32, R33, R34, R35, R39, R43, R44, R45, and R49 will all be seen for regulatory visit by 2/25/25. Aicota will track regulatory visits and ensure that these are done face to face with resident. Policy on physician visits is reviewed and revised to specifically address the need for in-person regulatory visits. MDS Coordinator, Nurse Team Leaders, and TCP (Twin Cities Physicians) providers and administrative staff educated on need for in-person physician visits per QSO-22-15-NH. DON or designee will audit regulatory visits 2/week X4 weeks, 1/week X4 weeks and monthly thereafter. Audit results will be brought to QAPI for further review and recommendation.	

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 712	Continued From page 7 indicated R4 did not have a cognitive assessment completed. R4's diagnoses included atrial fibrillation, coronary artery disease, hypertension, and renal insufficiency. R4 had regulatory visits via telehealth on 8/2/24 and 12/18/24. R6's annual MDS assessment dated 11/14/24, indicated R6 had moderate cognitive impairment with diagnoses of post-traumatic osteoarthritis, right ankle and foot and heart failure. R6 had regulatory visits via telehealth on 8/2/24, and 12/18/24. R7's quarterly MDS assessment dated 12/10/24, indicated R7 had moderate cognitive impairment with the diagnoses of atrial fibrillation, hypertension, and depression. R7 had regulatory visits via telehealth on 11/22/24, and 12/18/24. R9's significant change MDS assessment dated 12/3/24, indicated R9 had mild cognitive impairment with diagnoses of left femur fracture and hypertension. R9 had a regulatory visit via telehealth on 12/18/24. R10's quarterly MDS assessment dated 12/26/24, indicated R10 had moderate cognitive impairment with diagnoses of hypertension, CVA, aphasia, and dementia. R10 had regulatory visits via telehealth on 8/2/24, and 12/18/24. R11's annual MDS assessment dated 12/4/24, indicated R11 had moderate cognitive impairment with diagnoses of stroke, cancer, and hypertension. R11 had a regulatory visit via telehealth on 12/18/24. R12's quarterly MDS assessment dated 12/16/24, indicated R12 had severe cognitive impairment	F 712		

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 712	Continued From page 8 with diagnoses of atrial fibrillation and hypertension. R12 had a regulatory visit via telehealth on 11/18/24. R13's significant change MDS assessment dated 12/11/24, indicated R13 was cognitively intact with diagnoses of cerebrovascular accident, aphasia, and depression. R13 had regulatory visits via telehealth on: 8/2/24, and 11/22/24. R14's significant change MDS assessment dated 12/11/24, indicated R14 had severe cognitive impairment with diagnoses of dementia and cancer. R14 had a regulatory visit via telehealth on 12/18/24. R15 significant change MDS dated 12/14/24, indicated R15 had severe cognitive impairment with diagnoses of dementia and cancer. R15 had a regulatory visit via telehealth on 12/18/24. R16's quarterly MDS assessment dated 10/25/34, indicated R16 had severe cognitive impairment with diagnoses of Alzheimer's disease and atrial fibrillation. R16 had regulatory visit via telehealth on 12/18/24. R17's quarterly MDS assessment dated 12/15/24, indicated R17 had mild cognitive impairment with diagnoses of dementia and hypertension. R17 had a regulatory visit via telehealth on 11/22/24. R18's quarterly MDS assessment 11/4/24, indicated R18 had moderate cognitive impairment with diagnoses of CVA, hypertension, aphasia, hemiplegia, and seizure disorder. R18 had a regulatory visit via telehealth on 12/18/24. R19's quarterly MDS assessment dated 12/5/24,	F 712		

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 712	Continued From page 9 indicated a cognitive assessment was not completed. R19 had the diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R19 had a regulatory visit via telehealth on 12/18/24. R21's quarterly MDS assessment dated 12/4/24, indicated R21 was cognitively intact with diagnoses of cancer, hypertension, congestive heart failure, diabetes, and Parkinson's disease. R21 had a regulatory visit via telehealth on 12/18/24. R23's quarterly MDS assessment dated 12/4/24, indicated R23 had severe cognitive impairment with diagnoses of Alzheimer's disease, hypertension, anxiety, and depression. R23 had a regulatory visit via telehealth on 12/18/24. R24's quarterly MDS assessment dated 11/3/24, indicated a cognitive assessment was not completed. R24's diagnoses included cerebrovascular accident, traumatic brain injury, seizure disorder, hypertension, aphasia, and dementia. R24 had a regulatory visit via telehealth on 11/22/24. R25's annual MDS assessment dated 12/12/24, indicated R25 had moderate cognitive impairment with diagnoses of coronary artery disease, hypertension, and dementia. R25 had a regulatory visit via telehealth on 12/18/25. R27's quarterly MDS assessment dated 11/16/24, indicated R27 was cognitively intact with the diagnoses of cerebrovascular accident, hemiplegia, dementia, asthma, and depression. R27 had a regulatory visit via telehealth on 12/18/24.	F 712		

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 712	Continued From page 10 R28's quarterly MDS assessment dated 12/15/24, indicated R28 was cognitively intact with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R28 had a regulatory visit via telehealth on 11/22/24. R30's quarterly assessment dated 12/17/24, indicated R30 had severe cognitive impairment with diagnoses of hypertension, benign prostatic hyperplasia, dementia, and Parkinson's disease. R30 had a regulatory visit via telehealth on 12/18/24. R31's quarterly MDS assessment dated 10/19/24, indicated R31 was cognitively intact with diagnoses of atrial fibrillation, heart failure, hypertension, and peripheral vascular disease. R31 had a regulatory visit via telehealth on 11/22/24. R32's quarterly MDS assessment dated 12/18/24, indicated R32 had moderate cognitive impairment with diagnoses of hypertension, CVA, aphasia, and dementia. R32 had a regulatory visit via telehealth on 8/2/24. R33's annual MDS assessment dated 10/9/24, indicated a cognitive assessment was not completed. R33 had diagnoses of renal insufficiency, diabetes, Alzheimer's disease, and depression. R33 had a regulatory visit via telehealth on 12/18/24. R34's quarterly MDS assessment dated 11/30/24, indicated a cognitive assessment was not completed. R34's diagnoses included hypertension, diabetes, and Parkinson's disease.	F 712		

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 712	Continued From page 11 R34 had a regulatory visit via telehealth on 12/18/24. R35's quarterly MDS assessment dated 12/27/24, indicated a cognitive assessment was not completed. R35's diagnoses included end stage renal disease, Alzheimer's disease, and anxiety disorder. R35 had a regulatory visit via telehealth on 12/18/24. R39's annual MDS assessment dated 1/3/25, indicated R39 had severe cognitive impairment with diagnoses of congestive heart failure, dementia, and atrial fibrillation. R39 had a regulatory visit via telehealth on 12/18/24. R43's quarterly MDS assessment dated 10/9/24, indicated a cognitive assessment was not completed. R43 had the diagnoses of neurocognitive disorder with Lewy bodies and coronary artery disease. R43 had a regulatory visit via telehealth on 12/18/24. R44's quarterly MDS assessment dated 11/13/24, indicated R44 had severe cognitive impairment with diagnoses of osteoarthritis and chronic pain. R44 had a regulatory visit via telehealth on 12/18/24. R45's quarterly MDS assessment dated 12/11/24, indicated R45 had moderate cognitive impairment with diagnoses of atrial fibrillation, multiple rib fractures, and a seizure disorder. R45 had a regulatory visit via telehealth on 12/18/24. R49's admission MDS assessment dated 12/19/24, indicated R49 was cognitively intact with diagnoses of Staphylococcal arthritis, left knee and seizure disorder. R49 had a regulatory	F 712		

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 712	Continued From page 12 visit via telehealth on 12/18/24. During an interview on 1/17/25 at 12:46 p.m., the director of nursing (DON) stated the facility had started to do Telehealth visits back in August of 2024, when they switched to the Twin Cities Physician Group. The DON confirmed telehealth was being utilized at the facility to complete required provider regulatory visits. During an interview on 1/17/25 at 4:30 p.m., the Twin Cities Physician group vice president of operations confirmed their group provided telehealth services at the facility and stated they primarily used telehealth for regulatory visits. During an interview on 1/21/25 at 10:30 a.m., the medical director confirmed they were utilizing telehealth visits to perform provider regulatory visits. The MD explained they sent a registered nurse to the facility who was trained to operate telehealth equipment and perform assessments like auscultation of heart and lung when needed. The MD indicated they believed the telehealth visits were complaint with federal regulations. The facility policy Telehealth dated 5/1/2020, indicated the Twin Cities Physicians provided HIPPA compliant interactive audio/video telehealth visits at their facility. The policy did not address federal regulation requirements for in-person provider regulatory visits at long term care facilities. The Centers for Medicare & Medicare Services (CMS) memo Ref: QSO-22-15-NH & NLTC & LSC issued 4/7/22, identified long term care regulatory visits could no longer be conducted via	F 712		

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 712	Continued From page 13 telehealth as of 30 days from the issuance of the memo.	F 712		
F 741 SS=D	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.71. These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.71, and §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure non-pharmacological interventions were attempted prior to the administration of psychotropic medications [mood altering medications] for 1 of 6 residents (R252) reviewed	F 741	Aicota will ensure that non-pharmacological interventions are attempted prior to the administration of psychotropic medications. R252 discharged. All residents were reviewed for the use of psychotropic medications.	3/1/25

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 741	Continued From page 14 for psychotropic medications. Findings include: R252's admission Minimum Data Set (MDS) dated 1/8/25, did not include a cognitive assessment. R252's Section I Active Diagnoses included: cerebrovascular accident (CVA), hemiplegia, anxiety, hallucinations, attention deficit disorder, and depression. Section E -Behaviors indicated R252 experienced hallucinations and delusional thinking and exhibited behaviors which included: physical and verbal symptoms directed towards others one to three times during the assessment period. Part E0500 indicated the behaviors put the resident at significant risk for physical illness/harm, significantly interfered with resident's care, and significantly impacted the resident's participation in activities and social interaction. R252's Care plan last reviewed on 1/14/25, included the following focus, goal, and interventions: -Focus: the resident uses anti-anxiety medications related to anxiety disorder. Goal: R252 will be free from discomfort or adverse reactions related to anti-anxiety therapy. Interventions: give antianxiety medications as ordered by physician. Monitor for side effects and effectiveness. -Focus: R252 is on sedative/hypnotic therapy d/t hallucinations/delusions: diphenhydramine use. Goal: resident will be free of any discomfort or adverse side effect. Intervention: administer -Focus: Behavior management r/t anxiety dx evidenced by anger, decreased mood, irritability, paranoia, hallucinations, delusional thoughts, physical aggression, verbal aggression. Goal:	F 741	Any residents on psychotropic medications were reviewed for target behaviors and non-pharmacological interventions. All psychotropic medication orders were reviewed, and target behaviors and interventions were added to all psychotropic medication orders. All care plans were reviewed, and target behaviors and interventions were added to all care plans for residents who use psychotropic medications. Medication consents have been updated with target behaviors and non-pharmacological interventions. POC tasks for NAR's regarding behavior charting were updated to include the ability to chart interventions as well. Policy regarding psychotropic medication administration and non-pharmacological interventions were reviewed and revised. All staff will be educated regarding policy changes and the use of non-pharmacological interventions prior to the use of psychotropic medications. All new psychotropic medication orders will be audited X1 month, then 2 orders weekly X4 weeks, monthly thereafter. DON or designee will complete audits. Audit results will be brought to QAPI for further review and recommendations.	

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 741	Continued From page 15 R252 will respond well to pscyh med use with no increase in behaviors/symptoms through next review. Interventions: included non-pharmacological interventions and instructed staff to document effectiveness of interventions. R252's care plan lacked evidence that R252's use of antipsychotic medications had been incorporated into R252's plan of care. The care plan also lacked evidence of direction for non-pharmacological interventions to be attempted prior to the administration of as needed (PRN) psychotropic medications. R252's Orders Summary Report Dated 1/17/25, and Medication Administration Record for the Month of January 2025, (documented dates 1/1 - 1/17/25) included the following orders for psychotropic medications: -diphenhydramine HCl Injection Solution (Diphenhydramine HCl) Inject 50 mg intramuscularly every 8 hours as needed for Hallucinations related to other hallucinations (R44.2) Mix Benadryl and Haldol together- give injection along with Ativan Injection (B52 Shot). Ordered: 1/11/25 no stop date. -If B52 injection (Benadryl, Haldol, Ativan) is given, vitals should be monitored every 2 hours for 6 hours. -Haldol injection Solution 5 MG/ML Inject 5 mg intramuscularly every 8 hours as needed for hallucinations related to other hallucinations (R44.2). Mix Benadryl and Haldol together- give injection along with Ativan Injection (B52 Shot). Order renewed 1/11/25 no stop date.	F 741		

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 741	Continued From page 16 -Ativan injection solution 2 MG/ML (lorazepam) Inject 2 mg intramuscularly one time only for hallucinations until 1/7/25. To be given as part of B52 shot. Reordered: 1/11/25 no stop date. -haloperidol Oral Tablet 5 MG (Haloperidol) Give 5 mg by mouth every 4 hours as needed for restlessness, agitation related to restlessness and agitation (R45.1) for 3 Days Ordered 1/15/25. -Haldol Oral Tablet 2 MG (Haloperidol) Give 2 mg by mouth every 6 hours as needed for hallucinations. Start date: 1/10/25 discontinued: 1/15/25. -Haldol Oral Tablet 2 MG (Haloperidol) Give 2 mg by mouth every 6 hours as needed for hallucinations. Start date: 1/3/25 discontinued: 1/10/25. -Lorazepam SoluTab Give 0.5 mg by mouth every 4 hours as needed for anxiety and shortness of breath. Start date: 1/16/25. -clonazepam oral tablet 1 mg (Klonopin) give 1 mg by mouth every 12 hours as needed for anxiety/behaviors related to anxiety disorder unspecified (F41.9). ensure 4 hours between schedule dose and prn dose. Start Date; 1/11/25 -D/C Date- 1/15/25. -clonazepam oral tablet 1 mg (Klonopin) give 1 mg by mouth every 4 hours as needed for anxiety/behaviors related to anxiety disorder unspecified (F41.9). for 3 days. Start date: 1/15/24. R252's Medication Administration Record	F 741		

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 741	Continued From page 17 indicated the following PRN medications were administered to R252 between 1/2/25 and 1/17/25: -haloperidol Oral Tablet 5 MG (Haloperidol). Two doses on 1/16/25. -Haldol 2mg every 6 hours PRN. Doses were administered on: 1/3/25, 1/4/25, 1/6/25, 1/7/25, 2 doses 1/8/25, 2 doses 1/9/25, 2 doses 1/10/25, 1/12/25, 2 doses 1/14,25, and 1/15/25. -Ativan Injection Solution 2 MG/ML (Lorazepam) Inject 2 mg intramuscularly: one dose was administered on 1/7/25. -lorazepam soluble tab 0.5 mg as needed at bedtime PRN. Doses were administered on: 1/16/25 and two doses 1/17/25. -clonazepam oral tablet 1 mg give 1 mg by mouth every 12 hours as needed for anxiety/behaviors. Doses were administered on: 1/3/25, 1/4/25, 1/5/25, 1/7/25, two doses 1/8/25, 1/9/25, two doses 1/10/25, two doses 1/11/25, 1/13/25, and two doses 1/14/25. -clonazepam oral tablet 1 mg (Klonopin) give 1 mg by mouth every 4 hours as needed for anxiety/behaviors. Doses were administered on: 1/15/25, and two doses 1/16/25. R252's medical record lacked evidence to support staff had attempted non-pharmacological interventions prior to the administration of the psychotropic medications: Haldol, lorazepam, clonazepam, and Benadryl. . During an intermittent observation on 01/14/25	F 741		

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 741	Continued From page 18 between 3:28 and 7:02 p.m., R252 was in bed intermittently making low volume non-distinguishable sounds. During an interview on 1/16/25 at 2:01 p.m., licensed practical nurse (LPN-B) stated when a resident had a medication like Ativan or Haldol, they would do an assessment on the resident to see what was going on before they gave the medication. If the resident could not speak, then they would base thier assessment to give on non-verbal cues. During an interview on 1/16/25 at 2:27 p.m., registered nurse (RN-B) stated for PRNs, if a resident had PRN medication like Haldol or Ativan ordered, they would give the PRN to the resident if they requested it. Likewise, if they assessed a resident and found they had symptoms of anxiety or behaviors that were uncomfortable or could become worse they would also give the PRN in that instance. During an interview on 1/17/25 at 8:06 a.m., (LPN-A) stated they did not have a specific place where they charted non-pharmacological interventions prior to administration of medications like Haldol or Ativan. LPN-A stated their practice was to make sure order parameters were met prior to administering PRN medications and they did try to do non-pharmacological interventions like essential oils when they could. During an interview on 1/17/25 at 12:23 p.m., (RN-A) stated R252's care plan did have non-pharmacological interventions however they would have to review to R252's chart to determine if interventions were being attempted prior to administration of psychotropics.	F 741		

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 741	Continued From page 19 During an interview on 1/17/25 at 1:29 p.m. the director of nursing (DON) stated they had reviewed R252's documentation and they had not found documentation of non-pharmacological interventions being attempted prior to administered doses of Haldol and lorazepam. The DON stated they had the expectation that staff would attempt non-pharmacologic interventions prior to administration of lorazepam or Haldol. The DON indicated they had discussed with staff that non-pharmacologic interventions prior to psychotropic drug administation should be included in the orders so it can be documented on. The facility policy Medications: Psychotropic Medications dated 12/23/24, indicated the facility would comply with state and federal regulations related to psychotropic medications and line item 19 indicated non-pharmacologic interventions should be attempted prior to the administration of PRN psychotropic medications.	F 741		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758		3/1/25

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 20 resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure orders for PRN (as needed) psychotropic medication (mood altering	F 758	All residents should be free from unnecessary psychotropic medications which include limiting prn psychotropic	

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 21 medications) were time limited to 14 days for 2 of 6 residents (R29, R42). In addition, the facility failed to ensure provider assessment and documentation of rationale and duration of continuation of a psychotropic PRN medication beyond 14 days occurred for one of six residents (R29) reviewed for PRN psychotropic medication use. R29 R29's Minimum Data Set (MDS) dated 11/18/24, identified R29 was cognitively intact. R29's diagnoses included wedge compression fracture of second lumbar vertebra, congestive heart failure, major depression, anxiety disorder, intermittent explosive disorder. R29's Order Summary Report listed orders as of 1/2025, identified lorazepam solu tab give 0.5 mg by mouth every 4 hours as needed for anxiety ordered. Order date was 8/16/24, with no stop date. A document titled Order Number 280894 from the hospice agency documented the following hospice order dated 11/15/24: Pt appropriate to continue lorazepam 0.5 mg q 4 hours prn for anxiety/SOB. RNCM/hospice md to review in 60 days 1/14/25. An unrequested facility provided document titled PRN Medication Audit Report 12/1/24 to 1/17/25, indicated R29 had received Morphine PRN twice and had not received PRN Ativan during the reported time interval. R29's medical record and provided documentation lacked evidence to show R29's	F 758	medications to a 14-day timeframe and reviewing each medication to ensure provider assessment and documentation of rationale and duration of continuation of a psychotropic prn medication beyond 14 days occurs. R29's prn Ativan Order was discontinued on 1/24/25 due to non-use. R42 psychoactive medication consent was updated. On 1/25/25 PRN Ativan order was reviewed and continued for 60 days as needed for anxiety and SOB. All residents on prn psychotropic medications were reviewed and all orders with no stop date were reviewed, providers were updated and stop dates were either added at the 2-week interval or assessed with determination to continue for longer duration with rationale and expected length of use. As noted during survey prn psychotropic medication orders are being written primarily by contracted Hospice agency for Hospice patients. DON, ED, CEO, Nurse Team Leads met with Hospice Agency to discuss requirements surrounding prn psychotropic and anti-psychotic meds and outlined the requirements that must be met when ordering medications for our patients. Psychotropic Medications policy was reviewed and reflects the current standard of practice. Education will be provided to all licensed staff regarding the need for a 14 day stop date on all prn psychotropic medications. Hospice provider is doing weekly audits on all hospice patients for the next 2 months and as needed thereafter. DON or Designee will complete audits on 2 patients per week X 4 weeks, then 1 patient per week X4 weeks and	

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 22 PRN Ativan had been reviewed between 8/16/24 and 11/15/24, nor was there documented rationale for a greater than 14 day order duration for PRN Ativan. During an interview on 1/17/25 at 12:15 p.m., the director of nursing (DON) stated PRN psychotropic medication should be reviewed every 14 days and indicated they were checking with hospice to determine if the hospice agency had a process in place to review R29's prn Ativan order every 14 days. During a follow-up interview on 1/17/25 at 4:29 p.m., the DON stated they had not been able to find evidence that PRN psychotropics were being reviewed every 14 days for order continuation or at an alternative interval determined by the provider. The facility policy Medications: Psychotropic Medications dated 12/23/24, indicated the facility would comply with state and federal regulations related to psychotropic medications and line item 18 indicated PRN psychotropic medications will be ordered for 2 weeks and only for specific clearly documented circumstances and will be re-evaluated if extension past 2 weeks is needed and documented rationale written by provider. R42	F 758	monthly thereafter. Audit results from both in-house and Hospice will be brought to QAPI for further review and recommendations.	

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 23 R42's admission minimum data set (MDS) dated 11/1/24, identified severe cognitive impairment and diagnoses of traumatic subarachnoid hemorrhage with loss of consciousness, hypertension, post-traumatic stress disorder, bipolar disorder, dementia, depression, and type 2 diabetes. R42's orders dated 1/10/25 with no end date, identified lorazepam (anti-anxiety medication) oral tablet 1 milligram (mg) give 0.5 mg by mouth every 4 hours as needed (PRN) for anxiety. R42's care plan last revised on 11/27/24, identified resident as taking psychoactive medication related to dementia, and taking antidepressant medication related to dementia and bipolar disorder. Psychoactive medication informed consent form dated 11/1/24, identified R42's spouse consented to R42 receiving melatonin (sleep aid), Abilify (antipsychotic medication), memantine (dementia medication), and sertraline (antidepressant). During interview on 1/17/25 at 4:29 p.m., the director of nursing (DON) stated they had not been able to find evidence that PRN psychotropics were being reviewed every 14 days for order continuation or at an alternative interval determined by the provider. Facility policy Psychotropic Medications dated 5/23/24, stated "PRN psychotropic medications will be ordered for 2 weeks and only for specific clearly documented circumstances and will be re-evaluated if extension past 2 weeks is needed and documented rationale written by provider."	F 758		

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 24	F 851		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each	F 851		

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 25 category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to timely submit staffing data for 2 of 4 quarters reviewed (quarter 1 and 2) to the Centers for Medicare and Medicaid Services (CMS) according to specifications established by CMS. The provider had implemented corrective action prior to the investigation, therefore, the deficiency was issued as past non-compliance. Findings include: Review of the Payroll Based Journal Report (PBJ) Casper Report 1705D for fiscal year 2024 quarter 1 (October 1- December 31) and fiscal year 2024 quarter 2 (January 1- March 31), identified no	F 851	Past noncompliance: no plan of correction required.	

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 _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 26 data had been submitted. During interview on 1/17/25 at 4:35 p.m., director of nursing (DON) stated it was their responsibility to send staffing data to CMS. DON further stated not being aware of submission failure until after an internal audit revealed the problem. DON identified an incorrect data file had been used for the submission of staffing data. DON reported the problem was addressed already and the correct file type was now used for submitting staffing data to CMS. The expectation was for staffing data to be submitted correctly each quarter before the deadline. It was important to ensure staffing data was submitted before the deadline because it could interfere with the facility's overall star rating and impact the accuracy staffing information being presented to CMS.	F 851		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 4, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 66MO11

Dear Administrator:

The above facility was surveyed on January 14, 2025 through January 17, 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.

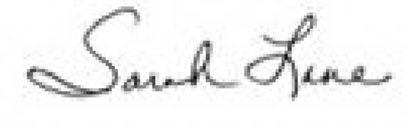
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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, 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
	00848	A. BUILDING: _____ B. WING _____	01/17/2025

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) 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 1/14/25 to 1/17/25, 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00848	A. BUILDING: _____ B. WING _____	01/17/2025

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) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following licensing orders were issued at 550 and 1290. 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 Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00848	A. BUILDING: _____ B. WING _____	01/17/2025

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) COMPLETE DATE
2 000	Continued From page 2 "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		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure submitted Minimum Data Set (MDS) assessments were accurate and/or comprehensive for 35 out of 54 residents (R2, R3, R4, R5, R6, R7, R9, R11, R13, R14, R17, R20, R21, R24, R25, R26, R28, R29, R31, R32, R33, R34, R35, R36, R38, R39, R42, R43, R44, R47, R48, R49, R50, R152. R204) reviewed for MDS accuracy. Findings include: The following resident's MDS assessments indicated restraints were being utilized in MDS section P- Restraints: -R3's admission MDS assessment dated 11/26/24, Section P indicated restraint use. -R5's admission MDS assessment dated 12/26/24, Section P indicated restraint use. -R6's annual MDS assessment dated 11/14/24,	2 550	Plan of Correction not required: See Accuracy of Assessments POC	3/1/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00848	A. BUILDING: _____ B. WING _____	01/17/2025

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) COMPLETE DATE
2 550	Continued From page 3 Section P indicated restraint use. -R7's quarterly MDS assessment dated 12/10/24, Section P indicated restraint use. -R9's significant change MDS assessment dated 12/3/24, Section P indicated restraint use. -R11's annual MDS assessment dated 12/4/24, Section P indicated restraint use. -R13's significant change MDS assessment dated 12/11/24, Section P indicated restraint use. -R14's significant change MDS assessment dated 12/11/24, Section P indicated restraint use. -R17's quarterly MDS assessment dated 12/15/24, Section P indicated restraint use. -R20's admission MDS assessment dated 12/10/24, Section P indicated restraint use. -R21's quarterly MDS assessment dated 12/4/24, Section P indicated restraint use. -R24's quarterly MDS assessment dated 11/3/24, Section P indicated restraint use. -R25's annual MDS assessment dated 12/12/24, Section P indicated restraint use. -R26's admission MDS assessment dated 11/27/24, Section P indicated restraint use. -R28's quarterly MDS assessment dated 12/15/24, Section P indicated restraint use. -R29's quarterly MDS assessment dated 11/18/24, Section P indicated restraint use. -R31's quarterly MDS assessment dated 10/19/24, Section P indicated restraint use. -R32's quarterly MDS assessment dated 12/18/24, Section P indicated restraint use. -R33's annual MDS assessment dated 10/9/24, Section P indicated restraint use. -R34's quarterly MDS assessment dated 11/30/24, Section P indicated restraint use. -R36's significant change MDS assessment dated 12/11/24, Section P indicated restraint use. -R38's annual MDS assessment dated 10/25/24, Section P indicated restraint use. -R39's annual MDS assessment dated 1/3/25,	2 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00848	A. BUILDING: _____ B. WING _____	01/17/2025

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) COMPLETE DATE
2 550	Continued From page 4 Section P indicated restraint use. -R42's admission MDS assessment dated 11/7/24, Section P indicated restraint use. -R43's quarterly MDS assessment dated 10/9/24, Section P indicated restraint use. -R44's quarterly MDS assessment dated 11/13/24, Section P indicated restraint use. -R47's admission MDS assessment dated 12/17/24, Section P indicated restraint use. -R48's admission MDS assessment dated 12/18/24, Section P indicated restraint use. -R49's admission MDS assessment dated 12/19/24, Section P indicated restraint use. -R50's admission MDS assessment dated 12/24/24, Section P indicated restraint use. -R204's admission MDS assessment dated 1/8/25, Section P indicated restraint use. The following resident's MDS assessments lacked BIMS scores in section C - Cognition: -R4's quarterly MDS assessment dated 10/26/24, did not include a BIMS score. -R8's quarterly MDS assessment dated 1/2/25, did not include a BIMS score. -R13's significant change MDS assessment dated 12/11/24, did not include a BIMS score. -R14's significant change MDS assessment dated 12/11/24, did not include a BIMS score. -R24's quarterly MDS assessment dated 11/3/24, did not include a BIMS score. -R33's annual MDS assessment dated 10/9/24, did not include a BIMS score. -R34's quarterly MDS assessment dated 11/30/24, did not include a BIMS score. -R35's quarterly MDS assessment dated 12/27/24, did not include a BIMS score. -R36's significant change MDS assessment dated 12/11/24, did not include a BIMS score. -R38's annual MDS assessment dated 10/25/24, did not include a BIMS score.	2 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00848	A. BUILDING: _____ B. WING _____	01/17/2025

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) COMPLETE DATE
2 550	Continued From page 5 -R43's quarterly MDS assessment dated 10/9/24, did not include a BIMS score. -R152's admission MDS assessment dated 12/26/24, did not include a BIMS score. -R204's admission MDS assessment dated 1/8/25, did not include a BIMS score. On 1/17/25, the MDS coordinator was not available for interview. During an interview on 1/17/25 at 12:46 p.m., the director of nursing (DON) stated the facility was a restraint free facility and indicated restraints were not being utilized with any of their residents. There should not be any residents with a current MDS assessment coded with restraint use. The Cogntive section should be completed everytime a MDS assessment is due. All resident's should have a BIMS score each time their MDS data is due and submitted. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS)assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00848	A. BUILDING: _____ B. WING _____	01/17/2025

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) COMPLETE DATE
21290	Continued From page 6	21290		
21290	MN Rule 4658.0710 Subp. 3 A AdmissionOrders & Physician Evaluations Subp. 3. Frequency of physician evaluations. A. A resident must be evaluated by a physician at least once every 30 days for the first 90 days after admission, and then whenever medically necessary. A physician visit is considered timely if it occurs within ten days after the date the visit was required. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure provider required regulatory visits occurred face to face for 33 out of 54 residents (R1, R3, R4, R6, R7, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R21, R23, R24, R25, R27, R28, R30, R31, R32, R33, R34, R35, R39, R43, R44, R45, R49) reviewed for regulatory visit compliance. Findings include: On 1/21/25, the facility provided documentation which identified the following residents as having received regulatory visits via telemedicine [a visit conducted via audio and sound by a provider located in a different location] instead of required in person visits on the following dates: R1's quarterly MDS assessment dated 10/18/24, indicated R1 was cognitively intact with diagnoses of coronary artery disease, and heart failure. R1 had regulatory visits via telehealth on 8/2/24, and 12/22/24.	21290	No plan of Correction Required- See physician visits POC	3/1/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00848	A. BUILDING: _____ B. WING _____	01/17/2025

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) COMPLETE DATE
21290	Continued From page 7 R3's admission MDS assessment dated 11/26/24, indicated R3 was cognitively intact with diagnoses of wedge compression fracture of fourth lumbar vertebra and atrial fibrillation. R3 had a regulatory visit via telehealth on 12/18/24. R4's quarterly MDS assessment dated 10/26/24, indicated R4 did not have a cognitive assessment completed. R4's diagnoses included atrial fibrillation, coronary artery disease, hypertension, and renal insufficiency. R4 had regulatory visits via telehealth on 8/2/24 and 12/18/24. R6's annual MDS assessment dated 11/14/24, indicated R6 had moderate cognitive impairment with diagnoses of post-traumatic osteoarthritis, right ankle and foot and heart failure. R6 had regulatory visits via telehealth on 8/2/24, and 12/18/24. R7's quarterly MDS assessment dated 12/10/24, indicated R7 had moderate cognitive impairment with the diagnoses of atrial fibrillation, hypertension, and depression. R7 had regulatory visits via telehealth on 11/22/24, and 12/18/24. R9's significant change MDS assessment dated 12/3/24, indicated R9 had mild cognitive impairment with diagnoses of left femur fracture and hypertension. R9 had a regulatory visit via telehealth on 12/18/24. R10's quarterly MDS assessment dated 12/26/24, indicated R10 had moderate cognitive impairment with diagnoses of hypertension, CVA, aphasia, and dementia. R10 had regulatory visits via telehealth on 8/2/24, and 12/18/24. R11's annual MDS assessment dated 12/4/24, indicated R11 had moderate cognitive impairment	21290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00848	A. BUILDING: _____ B. WING _____	01/17/2025

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) COMPLETE DATE
21290	Continued From page 8 with diagnoses of stroke, cancer, and hypertension. R11 had a regulatory visit via telehealth on 12/18/24. R12's quarterly MDS assessment dated 12/16/24, indicated R12 had severe cognitive impairment with diagnoses of atrial fibrillation and hypertension. R12 had a regulatory visit via telehealth on 11/18/24. R13's significant change MDS assessment dated 12/11/24, indicated R13 was cognitively intact with diagnoses of cerebrovascular accident, aphasia, and depression. R13 had regulatory visits via telehealth on: 8/2/24, and 11/22/24. R14's significant change MDS assessment dated 12/11/24, indicated R14 had severe cognitive impairment with diagnoses of dementia and cancer. R14 had a regulatory visit via telehealth on 12/18/24. R15 significant change MDS dated 12/14/24, indicated R15 had severe cognitive impairment with diagnoses of dementia and cancer. R15 had a regulatory visit via telehealth on 12/18/24. R16's quarterly MDS assessment dated 10/25/34, indicated R16 had severe cognitive impairment with diagnoses of Alzheimer's disease and atrial fibrillation. R16 had regulatory visit via telehealth on 12/18/24. R17's quarterly MDS assessment dated 12/15/24, indicated R17 had mild cognitive impairment with diagnoses of dementia and hypertension. R17 had a regulatory visit via telehealth on 11/22/24. R18's quarterly MDS assessment 11/4/24, indicated R18 had moderate cognitive impairment	21290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00848	A. BUILDING: _____ B. WING _____	01/17/2025

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) COMPLETE DATE
21290	Continued From page 9 with diagnoses of CVA, hypertension, aphasia, hemiplegia, and seizure disorder. R18 had a regulatory visit via telehealth on 12/18/24. R19's quarterly MDS assessment dated 12/5/24, indicated a cognitive assessment was not completed. R19 had the diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R19 had a regulatory visit via telehealth on 12/18/24. R21's quarterly MDS assessment dated 12/4/24, indicated R21 was cognitively intact with diagnoses of cancer, hypertension, congestive heart failure, diabetes, and Parkinson's disease. R21 had a regulatory visit via telehealth on 12/18/24. R23's quarterly MDS assessment dated 12/4/24, indicated R23 had severe cognitive impairment with diagnoses of Alzheimer's disease, hypertension, anxiety, and depression. R23 had a regulatory visit via telehealth on 12/18/24. R24's quarterly MDS assessment dated 11/3/24, indicated a cognitive assessment was not completed. R24's diagnoses included cerebrovascular accident, traumatic brain injury, seizure disorder, hypertension, aphasia, and dementia. R24 had a regulatory visit via telehealth on 11/22/24. R25's annual MDS assessment dated 12/12/24, indicated R25 had moderate cognitive impairment with diagnoses of coronary artery disease, hypertension, and dementia. R25 had a regulatory visit via telehealth on 12/18/25. R27's quarterly MDS assessment dated 11/16/24, indicated R27 was cognitively intact with the	21290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00848	A. BUILDING: _____ B. WING _____	01/17/2025

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) COMPLETE DATE
21290	Continued From page 10 diagnoses of cerebrovascular accident, hemiplegia, dementia, asthma, and depression. R27 had a regulatory visit via telehealth on 12/18/24. R28's quarterly MDS assessment dated 12/15/24, indicated R28 was cognitively intact with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R28 had a regulatory visit via telehealth on 11/22/24. R30's quarterly assessment dated 12/17/24, indicated R30 had severe cognitive impairment with diagnoses of hypertension, benign prostatic hyperplasia, dementia, and Parkinson's disease. R30 had a regulatory visit via telehealth on 12/18/24. R31's quarterly MDS assessment dated 10/19/24, indicated R31 was cognitively intact with diagnoses of atrial fibrillation, heart failure, hypertension, and peripheral vascular disease. R31 had a regulatory visit via telehealth on 11/22/24. R32's quarterly MDS assessment dated 12/18/24, indicated R32 had moderate cognitive impairment with diagnoses of hypertension, CVA, aphasia, and dementia. R32 had a regulatory visit via telehealth on 8/2/24. R33's annual MDS assessment dated 10/9/24, indicated a cognitive assessment was not completed. R33 had diagnoses of renal insufficiency, diabetes, Alzheimer's disease, and depression. R33 had a regulatory visit via telehealth on 12/18/24. R34's quarterly MDS assessment dated 11/30/24,	21290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00848	A. BUILDING: _____ B. WING _____	01/17/2025

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) COMPLETE DATE
21290	Continued From page 11 indicated a cognitive assessment was not completed. R34's diagnoses included hypertension, diabetes, and Parkinson's disease. R34 had a regulatory visit via telehealth on 12/18/24. R35's quarterly MDS assessment dated 12/27/24, indicated a cognitive assessment was not completed. R35's diagnoses included end stage renal disease, Alzheimer's disease, and anxiety disorder. R35 had a regulatory visit via telehealth on 12/18/24. R39's annual MDS assessment dated 1/3/25, indicated R39 had severe cognitive impairment with diagnoses of congestive heart failure, dementia, and atrial fibrillation. R39 had a regulatory visit via telehealth on 12/18/24. R43's quarterly MDS assessment dated 10/9/24, indicated a cognitive assessment was not completed. R43 had the diagnoses of neurocognitive disorder with Lewy bodies and coronary artery disease. R43 had a regulatory visit via telehealth on 12/18/24. R44's quarterly MDS assessment dated 11/13/24, indicated R44 had severe cognitive impairment with diagnoses of osteoarthritis and chronic pain. R44 had a regulatory visit via telehealth on 12/18/24. R45's quarterly MDS assessment dated 12/11/24, indicated R45 had moderate cognitive impairment with diagnoses of atrial fibrillation, multiple rib fractures, and a seizure disorder. R45 had a regulatory visit via telehealth on 12/18/24. R49's admission MDS assessment dated 12/19/24, indicated R49 was cognitively intact	21290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00848	A. BUILDING: _____ B. WING _____	01/17/2025

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) COMPLETE DATE
21290	Continued From page 12 with diagnoses of Staphylococcal arthritis, left knee and seizure disorder. R49 had a regulatory visit via telehealth on 12/18/24. During an interview on 1/17/25 at 12:46 p.m., the director of nursing (DON) stated the facility had started to do Telehealth visits back in August of 2024, when they switched to the Twin Cities Physician Group. The DON confirmed telehealth was being utilized at the facility to complete required provider regulatory visits. During an interview on 1/17/25 at 4:30 p.m., the Twin Cities Physician group vice president of operations confirmed their group provided telehealth services at the facility and stated they primarily used telehealth for regulatory visits. During an interview on 1/21/25 at 10:30 a.m., the medical director confirmed they were utilizing telehealth visits to perform provider regulatory visits. The MD explained they sent a registered nurse to the facility who was trained to operate telehealth equipment and perform assessments like auscultation of heart and lung when needed. The MD indicated they believed the telehealth visits were complaint with federal regulations. The facility policy Telehealth dated 5/1/2020, indicated the Twin Cities Physicians provided HIPPA compliant interactive audio/video telehealth visits at their facility. The policy did not address federal regulation requirements for in-person provider regulatory visits at long term care facilities. The Centers for Medicare & Medicare Services (CMS) memo Ref: QSO-22-15-NH & NLTC & LSC issued 4/7/22, identified long term care	21290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00848	A. BUILDING: _____ B. WING _____	01/17/2025

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) COMPLETE DATE
21290	Continued From page 13 regulatory visits could no longer be conducted via telehealth as of 30 days from the issuance of the memo. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures so residents receive face to face physician visits. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure residents receive physician visits at the required intervals and in person. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21290		

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 _____	**01/15/2025**

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
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 01/15/2025. 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 | 02/11/2025

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.

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 _____	**01/15/2025**

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
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		

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 _____	**01/15/2025**

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
K 000	Continued From page 2 The facility has a capacity of 56 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 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress corridors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/15/2025 at 12:00 PM, it was revealed by observation that there were three new file cabinets and two 96-gallon Shred-it collection containers in the corridor by the therapy area, when we returned to the area at 1:26 PM they were still there and when interviewing the staff they stated they had been there "awhile". An interview with the Executive Administrator to	K 211	1. File cabinets and shred it containers have been removed from the exit corridor. 2. Daily rounds will ensure all corridors are continuously maintained free of all obstructions to full use in case of emergency. All-staff education will be provided on regulatory rules regarding Means of Egress. 3. Audits will be completed on rounds by Director of Plant Operations or designee 2/week x 4 weeks, 1/week x 4 weeks and monthly thereafter. Audit results will be brought to QAPI for further review and recommendations 4. Director of Plan Operations will ensure compliance	3/1/25

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 _____	**01/15/2025**

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
K 211	Continued From page 3 the CEO, Maintenance Supervisor, Director of Plant Operations verified this deficient finding at the time of discovery.	K 211		