Electronically Delivered

April 12, 2024

Licensee
Aicota Health Care Center
850 2nd Street North West
Aitkin, MN 56431

RE: Project Number(s) SL30585016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 13, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30585	A. BUILDING: _____ B. WING _____	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	850 2ND STREET NW 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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30585016 On March 11, 2024, through March 13, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were thirty-three residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control related to COVID-19 when the licensee failed to ensure staff wore the proper personal protective equipment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 11, 2024, at 1:05 p.m., surveyor entered the assisted living and was greeted at the entrance by director of nursing (DON)-A. DON-A was placing a mask on their face and advised surveyor they had a current outbreak of	0 510		

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0 510	Continued From page 2 COVID-19 in their building. DON-A stated they needed to check how many days it had been since the resident had tested positive for COVID-19. DON-A stated she was not sure how many days it was, but that the licensee followed a 10-day quarantine and required staff to wear face masks during this time. DON-A then provided surveyor a mask to apply. DON-A proceeded to have surveyor follow her down the hallway to her office. As DON-A was walking down hallway she stated to two staff members that were in hallway that they would need to apply a face mask as the licensee was still in a COVID-19 outbreak. Both staff members acknowledged understanding and walked down hallway to obtain a face mask. During a tour of the licensee's establishment on March 11, 2024, at 1:15 p.m., R1's room was noted to have a sign on their door indicating R1 was in quarantine. Outside of the room was a three-drawer plastic container that contained personal protective equipment. During entrance conference on March 11, 2024, at 11:45 a.m., DON-A advised surveyor that the resident was on day eight of having tested positive for COVID-19 and would remain in quarantine until day ten. DON-A stated this was the licensee's policy. DON-A provided to surveyor an undated COVID-19 update which DON-A stated the licensee used as their current COVID-19 policy. The licensee's undated COVID-19 Update indicated if a resident tested positive for COVID-19, that resident would need to stay in their room for 10 days and staff would need to wear personal protective equipment during this time.	0 510		

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0 510	Continued From page 3 The licensee's Infection Control policy dated August 1, 2021, did not contain any information in regard to COVID-19 or personal protective equipment requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 730 SS=C	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to	0 730		

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0 730	Continued From page 4 the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Service and Amenities (UDALSA) to two of three residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on September 1,	0 730		

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0 730	Continued From page 5 2017. R1's Service Plan dated January 8, 2024, indicated R1 received services to include medication administration, meal assistance, and transportation for shopping assistance. R2 was admitted to the licensee on April 7, 2021. R2's Service Plan dated January 19, 2024, indicated R2 received services to include medication administration and meal assistance. R1 and R2's records lacked a UDALSA checklist to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist of all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On March 13, 2024, at 12:40 p.m., director of nursing (DON)-A acknowledged R1 and R2 had not received a written UDALSA listing all services provided under the licensee's assisted living license, and the services not provided under the licensee's assisted living license. DON-A stated she recently provided all residents with an up-to-date UDALSA at a resident council meeting. DON-A stated the licensee did not have the residents sign any acknowledgement that they had received the updated UDALSA. DON-A did state that the new admission paperwork does include a place for residents to sign that they did receive the UDALSA upon admission.	0 730		

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0 730	Continued From page 6 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) 30585 for four of four employees (unlicensed personnel (ULP)-D, ULP-E, ULP-F, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01290		

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01290	Continued From page 7 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 11, 2024, at 1:00 p.m., director of nursing (DON)-A provided surveyor a current employee roster which indicated the name, title and hire date for each employee. During entrance conference on March 11, 2024, at 1:05 p.m., licensed assisted living director stated the ULPs working on the night shift were hired to work in the long-term care center (separate licensee owned by the same owner) but were responsible to answer call lights and conduct timed resident safety checks throughout the night to the licensee's residents. ULP-D was hired on March 28, 2012, to assist with resident care needs in the long-term care center. ULP-E was hired on September 27, 2023, to assist with resident care needing the long-term care center. ULP-F was hired on February 8, 2018, to assist with resident care needs in the long-term care center. ULP-G was hired September 8, 2020, to assist with resident care needs in the long-term care center. ULP-D, ULP-E, ULP-F, and ULP-G lacked a background study result on Minnesota Department of Human Services (DHS) NETStudy	01290		

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01290	Continued From page 8 2.0 website that was affiliated with the licensee's HFID 30585. During interview on March 12, 2024, at 2:30 p.m., DON-A stated ULP-D, ULP-E, ULP-F, and ULP-G worked the overnight shift in the long-term care center and were responsible to answer any call notifications from residents for the licensee. DON-A also stated ULP-D, ULP-E, ULP-F, and ULP-G completed timed checks on resident for the licensee when working the night shift. DON-A stated the ULPs did not provide any delegated tasks or cares on the night shift. The licensee's Recruitment and Hiring policy effective date August 1, 2021, stated the director or designee is responsible for initiating the criminal background study at the time of hire. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	01290		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by:	01460		

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01460	Continued From page 9 Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living licensing requirements and regulations before providing services for four of four employees (unlicensed personnel (ULP)-D, ULP-E, ULP-F, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 11, 2024, at 1:00 p.m., director of nursing (DON)-A provided surveyor a current employee roster which indicated the name, title and hire date for each employee. During entrance conference on March 11, 2024, at 1:05 p.m., licensed assisted living director stated the ULPs working on the night shift were hired to work in the long-term care center (separate licensee owned by the same owner) but were responsible to answer call lights and conduct timed resident safety checks throughout the night to the licensee's residents. ULP-D was hired on March 28, 2012, to assist with resident care needs in the long-term care center. ULP-E was hired on September 27, 2023, to assist with resident care needing the long-term	01460		

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01460	Continued From page 10 care center. ULP-F was hired on February 8, 2018, to assist with resident care needs in the long-term care center. ULP-G was hired September 8, 2020, to assist with resident care needs in the long-term care center. ULP-D, ULP-E, ULP-F, and ULP-G's employee records lacked an orientation to assisted living licensing requirements and regulations before providing services to the licensee's residents. During interview on March 12, 2024, at 2:30 p.m., director of nursing stated ULP-D, ULP-E, ULP-F, and ULP-G worked the overnight shift in the long-term care center and were responsible answer any call notifications from residents for the licensee. DON-A also stated ULP-D, ULP-E, ULP-F, and ULP-G completed timed checks on resident for the licensee when working the night shift. DON-A stated the ULPs did not provide any delegated tasks or cares on the night shift. The licensee's Recruitment and Hiring policy effective date August 1, 2021, stated the director or designee is responsible for initiating the criminal background study at the time of hire. The licensee's Orientation Policy was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		

Minnesota Department of Health
Food, Pools & Lodging Section
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/11/24*
Time: 13:30:00
Report: 6808241040

Food and Beverage Establishment Inspection Report

Location:

Aicota Health Care Center AL
840 2nd St. NW
Aitkin, MN
Aitkin County, 01

Establishment Info:

ID #: 0030585
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: BOTH A1 & A2 DISHWASHERS
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: CHEESE IN A1 COOLER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: STORAGE COOLER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: A2 REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

Type: Full
Date: *03/11/24*
Time: 13:30:00
Report: 6808241040
Aicota Health Care Center AL

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 6808241040 of 03/11/24.

Certified Food Protection Manager: Holly Downing

Certification Number: _____ Expires: 11/17/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Lee Ann Austin
Lee Ann Austin
Public Health Sanitarian
St. Cloud
320-223-7341
leeann.austin@state.mn.us