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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 81JF

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

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

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

3. NAME AND ADDRESS OF FACILITY
(L3) **AICOTA HEALTH CARE CENTER**
(L4) **850 SECOND STREET NORTHWEST**
(L5) **AITKIN, MN** (L6) **56431**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/17/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Teresa Ament, HFE NEII — 04/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 04/30/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/17/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY	**00**	INVOLUNTARY
01-Merger, Closure		05-Fail to Meet Health/Safety
02-Dissatisfaction W/ Reimbursement		06-Fail to Meet Agreement
03-Risk of Involuntary Termination		OTHER
04-Other Reason for Withdrawal		07-Provider Status Change
		00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 05/13/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/29/2015
(L33)

DETERMINATION APPROVAL

CCN: 24-5363

At the time of the standard survey conducted March 2 and 3, 2015, the facility was not in substantial compliance with Federal participation requirements. Conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety and an extended survey was conducted March 4 and 5, 2015. The facility has been given an opportunity to correct before remedies would be imposed.

A Post Certificatoin Revisit was complete on April 17, 2015 and verfied correction of deficiencies issued purusant to the extended survey completed March 5, 2015, effective April 17, 2015.

Please refer to the CMS-2567b forms for health.

Effective April 17, 2015, the facility is certified for 75 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245363
April 30, 2015

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

Dear Ms. Matalamaki:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 17, 2015 the above facility is certified for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 30, 2015

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

RE: Project Number S5363024

Dear Ms. Matalamaki:

On March 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 5, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 17, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 14, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 5, 2015, effective April 17, 2015 and therefore remedies outlined in our letter to you dated March 20, 2015, will not be imposed.

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245363	A. Building B. Wing	4/17/2015

Name of Facility	Street Address, City, State, Zip Code
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**04/17/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**04/17/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** CC/mm	**Date:** 04/30/2015	**Signature of Surveyor:** 29433	**Date:** 04/17/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 3/5/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

April 30, 2015

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

Re: Reinspection Results - Project Number S5363024

Dear Ms. Matalamaki:

On April 17, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 5, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

AH Form Approved
4/30/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00848	A. Building B. Wing	4/17/2015

Name of Facility	Street Address, City, State, Zip Code
AICOTA HEALTH CARE CENTER	850 SECOND STREET NORTHWEST AITKIN, MN 56431

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **21995** Reg. # **MN St. Statute 626.557 Subd. 4** LSC	**04/17/2015**	ID Prefix **22000** Reg. # **MN St. Statute 626.557 Subd.** LSC	**04/17/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** CC/mm	**Date:** 04/30/2015	**Signature of Surveyor:** 29433	**Date:** 04/17/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 3/5/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 81JF

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

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

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

3. NAME AND ADDRESS OF FACILITY
(L3) **AICOTA HEALTH CARE CENTER**
(L4) **850 SECOND STREET NORTHWEST**
(L5) **AITKIN, MN** (L6) **56431**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/05/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 04/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/28/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
11/17/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5363

At the time of the standard survey conducted March 2 and 3, 2015, the facility was not in substantial compliance with Federal participation requirements. Conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety and an extended survey was conducted March 4 and 5, 2015. The facility has been given an opportunity to correct before remedies would be imposed.

Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 20, 2015

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

RE: Project Number S5363024

Dear Ms. Matalamaki:

On March 5, 2015, an extended survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. Conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR §

483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: chris.campbell@state.mn.us

Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 14, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 14, 2015 the following remedy will be imposed:

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Aicota Health Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective March 5, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made

timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed

for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by June 5, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 5, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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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 _____	03/05/2015

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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted by the Minnesota Department of Health on 3/4/15-3/5/15.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225		4/14/15

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

Electronically Signed | 03/30/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report potential allegations of abuse/neglect/mistreatment to the State Agency (SA) and thoroughly investigate allegations for 7 of 10 residents (R53, R34, R31, R7, R3, R28, R75) reviewed for potential allegations of mistreatment. Findings include: R53 alleged an incident of mistreatment which was not reported to the SA immediately. R53 was interviewed on 3/2/15, at 4:17 p.m. and stated one staff member handled him roughly when assisting R53 with cares. R53 described the rough treatment as "jerking" him around in bed. R53 stated he had reported the rough	F 225	F 225 The facility will ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident□s property are reported immediately to the administrator of the facility and other officials in accordance with state law. On 3/3/15 R 53 reported to the state surveyors that a staff member handled him roughly when assisting with cares. That afternoon, R 53 was interviewed by the DON and Social worker and he stated that he hurts when he is gotten up/out of bed in am. He was unable to give a	

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F 225	Continued From page 2 treatment to a staff member, but hadn't heard anything more and the staff member who treated him "roughly" continued to work with him. R53's Admission Record identified diagnoses that included osteoarthritis, congestive heart failure, urinary incontinence and hemiplegia (weakness on one side of the body) due to cerebral vascular accident (CVA). The quarterly Minimum Data Set (MDS) dated 1/20/15, indicated R53 was cognitively intact, and required total assistance of two staff for bed mobility, extensive assistance of two staff for transfers, dressing and toileting, and extensive assistance of one staff for personal hygiene. The facility individual abuse assessment undated, indicated R53 was at low risk of vulnerability by others. On 3/3/15, at 3:45 p.m. SW-A and the DON were informed that R53's complaints of alleged mistreatment were not in the facility log of reported incidents. On 3/4/15, at 10:34 a.m. SW-A and the DON were interviewed. The DON stated they had just investigated R53's complaints of alleged mistreatment, and were not going to report to the SA. SW-A stated they always investigate first, before they report to the SA to assist them in determining if something is reportable. R34 was mistreated by R102 and the allegation was not reported immediately to the SA. R34's arm was grabbed and shaken by R102 on 5/22/14, at 5:15 p.m. Staff witnessed the incident. The facility did not immediately report the alleged incident of mistreatment to the state agency; a	F 225	specific name of staff. This alleged mistreatment was reported to OHFC and Aitkin County/Common Entry Point (CEP) on 3/4/15. R 53 had previously talked to the Social worker on 3/2/15 and stated that a staff is on a new kick stating he should have larger pants. R 53 stated that he preferred to lose some weight as he has a closet full of clothes. He did not mention being treated roughly at any time during the discussion on 3/2/15. Staff was reminded to report to the team leader when a resident experiences any pain/discomfort during transfers. R53 has diagnosis of chronic pain related to osteoarthritis. R53 prefers to sleep on his right side and he declines to be repositioned during night. He receives Tylenol TID and his first dose of Tylenol is offered one hour prior to getting up in the morning. Going forward, a more thorough investigation will occur to include conducting interviews with other residents cared for by the alleged NA as well as conducting interviews with staff that work with the alleged NA. Aicota□s Vulnerable Adult (VA) policy was revised and updated with an emphasis on immediately reporting to OHFC and CEP. All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP and treating residents gently.	

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F 225	Continued From page 3 report was filed on 5/23/14 (time unknown). The facility's investigation determined R102 often confused female residents as his wife. On 3/4/15, at 10:34 a.m. SW-A stated the facility always investigated before they reported to the SA. R34's Admission Record identified diagnoses that included Alzheimer's disease, chronic pain, and anxiety. The quarterly MDS dated 1/21/15, indicated R34 had short and long term memory problems, and severely impaired cognitive skills for daily decision making (never/rarely made decisions). The MDS further identified R34 as having mood problems of little interest or pleasure in doing things, poor appetite or overeating, and trouble concentrating on things. The MDS identified no behaviors. The facility Individual Abuse Assessment dated 9/21/10, indicated R34 was at high risk of vulnerability by others. R31 sustained 3 injuries of unknown origin which were not reported to the SA immediately, and lacked a thorough investigation to determine if abuse/mistreatment occurred. 1. On 12/8/14, R31 was discovered to have a 6.7 centimeter (cm) by 6 cm bruise of unknown origin on his chest. [An injury of unknown origin is one in which the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one point in time or the incidence of injuries over time.] The facility originally did not report the bruise to the SA, however, on 12/10/14, R31's spouse was uncertain if the facility's explanation that R34 bruised himself by clenching	F 225	DON or designee will complete NA observations of ADLs to ensure that residents are treated gently. Social worker or designee will conduct audits of incident reports to ensure immediate reporting and that thorough investigations occurred. VA reports will be monitored to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 34□s arm was shaken by R 102 on 5/22/14 at 17:15. R 102 had poor vision, was ambulatory and was often looking for his wife. He was kind, easily redirected and did not mean any harm. The incident was reported to the OHFC and CEP on 5/23/14 even though R 34 did not appear in any distress over the incident. Staff was reminded to do an initial report immediately to OHFC and CEP. A follow up report will continue to be completed within 5 working days of the incident. Aicota□s VA policy was revised and updated with an emphasis on immediately reporting to OHFC and CEP. All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP.	

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F 225	Continued From page 4 his hands/fists near his chest was accurate. The facility then reported the bruise to the SA on 12/10/14 (time unknown). The facility further investigated, and determined the injury could have been done by another resident or staff, could have been self-inflicted, or could have been a result of being resistive to cares. However, the investigation was not thorough enough to rule out possible abuse/mistreatment. 2. On 2/4/15, at 3:15 p.m. R31 was noted to have a 4.2 cm by 3.8 cm bruise of unknown origin on his chest. The facility did not report the bruise to the SA. Although the injury remained an unknown origin, there was no further investigation. 3. On 2/9/15, R31 was noted to have a 2 cm by 2.3 cm bruise of unknown origin on his right jaw. The facility's Resident Fall/Incident Report/Investigtion identified the cause of incident to be: "Resident with strong facial hair growth. question to whether resident's daily shaving may have caused brusing." The report also identified "Resident does use a lidded sippy cup independently at times with meals and may have bumped jaw." The facility did not report the bruise to the state agency, nor was there an investigation. R31's Admission Record identified diagnoses that included dementia. The annual MDS dated 11/26/14, indicated R31 had severe cognitive impairment, and had mood indicators of feeling bad about self or a failure or have let your family down. The MDS further identified R31 required extensive assistance of two staff with bed mobility and transfers, extensive assistance of one staff for toileting, and total assistance of one staff for dressing, eating and personal hygiene. The MDS	F 225	Social worker or designee will conduct audits of incident reports to ensure immediate reporting and that thorough investigations occurred. VA reports will be monitored to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 31 sustained three bruises of unknown origin, two bruises on his chest and one on his chin. Social worker and Resident Care Coordinator (RCC) interviewed R 31, R 31□s wife and daughter and felt that there was sufficient reasoning for the bruising related to R 31□s resistiveness, rigidity, clenching fists and holding against his chest, hanging onto items during transfers and his skin bruising easily. All nursing staff who have been caring recently for R 31 were interviewed. The care plan was followed and bruising could be self- inflicted. All unexplained bruising/bruise of unknown origin will be reported immediately to OHFC and CEP. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. Aicota□s VA policy was revised and updated with an emphasis on immediately reporting to OHFC and CEP. All staff will be in serviced by reviewing	

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F 225	Continued From page 5 identified no behaviors issues. The facility Individual Abuse Assessment undated, indicated R31 was at moderate risk of vulnerability by others. On 3/04/15, at 10:34 a.m. SW-A and the DON were interviewed. SW-A stated they always investigated alleged incidents of abuse/neglect/mistreatment, and if they are unable to come up with any explanation, they report to the SA. investigated. R7 alleged rough treatment by staff which was not reported to the SA, and lacked a thorough investigation. R7's annual MDS dated 12/4/14, indicated R7 had no cognitive impairments. R7 had no delirium, psychosis, behaviors or rejection of cares. R7 required the extensive assistance of one staff with bed mobility. On 3/3/15, at 10:00 a.m. R7 stated there was one male NA who was rough when he turned her in bed. R7 stated, "He's big and I don't think he's aware he's rough when he moves me." R7 stated she had bruises on her upper inner legs from the NA's hands when he moved her. R7 stated further the NA had been more careful because he did say the bruises matched his hands. R7 had not told anyone. R7 stated, "He's not here very often and I just put up with it. It's just his manner of handling." On 3/3/15, at 3:45 p.m. the DON and the SW-A were informed of R7's allegation of rough treatment. The SW stated she was aware because R7 reported it during her care conference on 3/3/15.	F 225	our updated VA policy by April 14, 15 with an emphasis on immediate reporting of bruising of an unknown origin to OHFC and CEP. Social worker or designee will conduct audits of incident reports to ensure immediate reporting and that thorough investigations occurred. VA reports will be monitored to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 7 reported bruising on her upper legs to the interdisciplinary team on 3/3/15 during her care conference. She stated she was treated rough by a big guy NA, while she was turned/repositioned. DON attempted to investigate the alleged bruising that afternoon, but R 7 had a visitor, than participated in activities and declined having skin assessment completed at these times. At HS, the LPN on duty checked R 7□s skin and found a fading bruise on the inside of her left thigh and a small round newer looking bruise was noticed on the left outer thigh. Due to R 7□s request to have her bed position with her right side against the wall (as it is more comfortable and feels safe for her), R 7 is always turned towards her left side and assisted by staff using a turning sheet. The big guy NA was interviewed by Social worker and DON. He stated that he followed the plan of care and always repositions/turns with a turning sheet.	

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F 225	Continued From page 6 The facility's Resident Fall/Incident Report/Investigation report completed on 3/4/15, by the DON indicated on 3/3/15, during a care conference R7 reported bruising on her upper legs. The facility's Report of Alleged Incident of Abuse/Neglect completed by the SW indicated R7 reported the incident on 3/3/15, during a care conference at 2:00 p.m. R7 reported she had bruising on her upper legs/thighs. R7 reported a long time ago from a male staff member who "just didn't know his own strength" when handling her. R7 was not upset and indicated things had improved. The report indicated on 3/5/15, a licensed practical nurse (LPN) observed R7's legs and found three old bruises. R7 reported to the LPN that the "big guy with the beard" turns her. The incident report indicated R7 had two light blue discolored areas on the left inner thigh which measured 2.5 by 3 centimeters (cm) and a 1 by 1 cm darker blue area on the left outer thigh. The incident report's investigative findings (cause of the incident) included the bruises on the left thigh were very pale and appeared old. The findings further stated the bruises were "more likely caused by removing incontinent briefs while on the commode or toilet and the bruises on the outer thighs were probably from items in R7's chair" even though R7 was cognitively intact and had reported the bruises were from rough treatment. There was no evidence of any further investigation. The incident report indicated the rough treatment and bruises were not reported to the SA. The incident report's department review and interventions discussed dated 3/4/15,	F 225	Staff would not hold onto left inner thigh while turning R 7 for cares. Resident likes to have multiple items on the inside of her wheel chair and recliner. She bruises easily related to monoclonal gammopathy. During interview with R 7, she indicated that she has not been hurt by the NA and has no problem with that NA continuing to care for her. An incident report was filed and reported to OHFC and CEP on 3/4/15. All unexplained bruising/bruise of unknown origin will be reported immediately to OHFC and CEP. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. Going forward, a more thorough investigation will occur to include conducting interviews with other residents cared for by the alleged NA as well as conducting interviews with staff that work with the alleged NA. Aicota□s VA policy was revised and updated with an emphasis on immediately reporting to OHFC and CEP. All staff will be in serviced by reviewing our updated VA policy by April 14, 15 with emphasis on immediate reporting of bruising with unknown origin. DON or designee will complete NA observations of ADLs to ensure that residents are treated gently.	

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F 225	Continued From page 7 indicated R7 bruised easily and had multiple items in the wheelchair. On 3/4/15, at 10:36 a.m. the DON stated the incident report contained all of the information about the "rough treatment." The DON further stated they were not going to report the incident. R3 sustained an injury following an incident where staff did not follow the plan of care. The neglect of care was not reported immediately to the SA, and lacked a thorough investigation. R3 was lowered to the floor during a staff assisted transfer on 10/6/14, at 5:00 a.m. Staff was not transferring R3 as directed by the care plan. The incident was not reported right away by the staff. The incident was reported to the facility by R3 on 10/6/14, at 2:30 p.m. R3's quarterly MDS dated 11/14/14, indicated R3 had short and long term memory problems but was able to recall the season, the location of her room, staff names and faces and that she was in a nursing home. R3 had modified independence with some difficulty in new situations when making decisions. R3 had no behaviors or rejection of cares. R3 needed the extensive assistance of two staff with bed mobility and transfers. R3 was not ambulatory. The Activities of Daily Living (ADL) care plan revised on 8/7/14, directed staff to transfer R3 with the EZ (mechanical) lift and two staff. The facility's Resident Fall/Incident Report/Investigation report completed on 10/6/14, indicated the incident occurred on 10/6/14, at 5:00 a.m. and was not reported until 2:30 p.m. by R3. R3 reported the staff dropped her to the floor while transferring her to the commode. Although	F 225	Social worker or designee will conduct audits of incident reports to ensure immediate reporting and that thorough investigations occurred. VA reports will be monitored to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 3 was transferred by two nursing assistants at 05:00 on 10/6/14 from chair to commode without using a transfer belt. The resident lost her footing and was eased to the floor to avoid injury/fall. This incident was reported by the resident later during the day at 14:30. An initial report was made online to OHFC and to CEP on 10/6/14. Calls were made to the night shift nursing assistants to conduct further investigation and both verified that resident was transferred without a transfer belt and lowered to floor when she lost her footing to avoid injury/prevent fall. Both nursing assistants (NA) were fairly new in their positions. The NA□s were educated on the importance of following a resident□s plan of care and using a transfer belt while transferring residents. They were also educated on the definition of falls/incidents and the importance of immediately reporting incidents to the nurse in charge. Going forward, a more thorough investigation will occur to include	

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F 225	Continued From page 8 the care plan directed staff to use an E-Z Lift, staff utilized a pivot transfer without a transfer belt. The incident report's investigative findings included staff was contacted and verified R3 was lowered to the floor while being transferred. R3 lost her footing and was lowered to the floor to avoid injury. On 10/6/14, at 6:30 p.m. a penny size bruise was found on R3's left hand, R3's right wrist had swelling and a bruise on the right forearm which measured five inches by one and a half inches. The incident report's follow up indicated staff was counseled. The incident was reported to the state agency on 10/6/14. However, no further investigation was conducted. R28 alleged mistreatment which was not reported to the SA, and lacked a thorough investigation. R28's MDS dated 11/18/14, indicated R28 had no cognitive impairment and R28 required the extensive assistance of one staff with bed mobility, transfers and toilet use. The facility's Report of Alleged Incident of Abuse/Neglect form dated 1/19/15, at 8:10 a.m. indicated a NA reported another NA unplugged the call light when R28 put the call light on for assistance to use the bathroom. The NA heard R28 calling for help and stated, "he unplugged my call light and said I couldn't use the bathroom." At 8:50 a.m. R28 reported to a registered nurse a "gentleman pulled my call light out of the wall when I needed to go to the bathroom. I want to make sure this does not happen to anyone else." The incident report's follow up at 10:20 a.m. indicated the SW spoke with the NA. The report indicated the NA must have unplugged the call light when he walked out of the room and tripped. The NA informed the SW he had been "behind" and R28 had been using the call light "every 15 to	F 225	conducting interviews with other residents cared for by the alleged NAs as well as conducting interviews with staff that work with the alleged NAs to ensure that care plans are followed. Aicota□s VA policy was revised and updated with an emphasis on immediately reporting to OHFC and CEP. All staff will be in-serviced by reviewing our updated VA policy and the internal incident report form by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP and the importance of following a resident□s care plan. DON or designee will monitor/complete NA observations of transfers and other ADLs to ensure that safe transfers are completed and that resident care plans are followed. Social worker or designee will conduct audits of incident reports to ensure immediate reporting and that thorough investigations occurred. VA reports will be monitored to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 28 yelled out for help to use the bathroom at 08:10 on 1/19/15. At this time, R 28 stated to the NA who provided the assistance he unplugged my call light. The NA who assisted R 28 reported this to	

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F 225	Continued From page 9 20 minutes." The NA stated it was not intentional and should have gone back right away and plugged the call light back in. The NA understood call lights should never be unplugged. On 3/4/15, at 10:34 a.m. the DON stated the NA was interviewed and stated he accidentally tripped on the call light. The DON stated she felt the incident did not need to be reported to the state agency. However, the incident was not thoroughly investigated to determine possible neglect of care. R75 sustained an injury as a result of staff not following the plan of care. The neglect of care lacked a thorough investigation, and the investigative report was not reported to the SA timely. R75's MDS dated 10/13/14, indicated she was diagnosed with dementia, orthostatic hypotension,and fracture. The MDS also indicated she required extensive assist with transfers, toileting, locomotion on and off the unit, and occasionally incontinent of bowel and bladder. R75's care plan initiated 9/23/14, indicated R75 had a fall with a resulting left hip fracture. R75's care plan further identified she had impaired physical mobility, requiring assist with transfers, toileting and incontinence cares. Review of an incident report dated 10/14/14, at 2:25 a.m. revealed R75 was found sitting on the floor near her walker (unwitnessed fall). As a result of the fall, R75 received a small cut inside her bottom lip. The incident report indicated,	F 225	the Resident Care Coordinator (RCC). At 08:50 after the resident was toileted, the RCC went to discuss the reported incident with R 28. R 28 stated that a gentleman pulled my call light out of the wall. An internal incident report was filed. The NA was interviewed. He stated that he must have tripped on the cord when leaving R 28□s room. He stated that unplugging the call light was not intentional. R 28□s needs were met, she was not distressed and no mental anguish was noticed. She was assisted to toilet (able to toilet self during day) and it was not reported to OHFC and CEP. A call light report was ran for the wing that caregiver worked on to ensure that other residents call light cords were not unplugged. Through the investigation of the incident, it was determined that a call light can be turned off, even if it is disconnected from the wall outlet. The call light system has since been reprogrammed so that a call light cannot be turned off or silenced when disconnected from wall in a resident□s room. If a call light is unplugged from the wall, it will now activate the call light. Staff was counseled/educated that if they feel they may have tripped on something, to make sure to go back immediately and check to ensure nothing has been disconnected and that everything is in place and safe for the resident. Initial report will be filed immediately if resident reports that staff unplugged call light. An immediate report will be made to	

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F 225	Continued From page 10 R75's care plan was not being followed, as the fall mat was supposed to be placed near the bed and toileting schedule may also be a factor. The administrator and SA were notified on 10/14/14. However, the facility failed to complete a thorough investigation into the possible neglect of care. In addition, the investigation was not reported to the SA until 10/20/14, 7 days after the incident.	F 225	OHFC and CEP if a resident has a claim of neglect. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. . Going forward, a more thorough investigation will occur to include conducting interviews with other residents cared for by the alleged NA as well as conducting interviews with staff that work with the alleged NA. Aicota□s VA policy was revised and updated with an emphasis on immediately reporting to OHFC and CEP. All staff will be in-serviced by reviewing our updated VA policy and the internal incident report form by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP. Social worker or designee will conduct audits of incident reports to ensure immediate reporting and that thorough investigations occurred. VA reports will be monitored to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 75 was admitted on 9/16/14 for short term rehab after a fall at home resulting in hip fracture. Admission diagnosis included status post-surgical repair of hip, history of CVA and dementia. R 75 had a history of being more restless on afternoons and	

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F 225	Continued From page 11	F 225	nights. She got up at night and slept poorly possibly related to dementia. When talking to husband he stated that this was not unusual for her. On 10/14/14 at 02:25 R 75 was found in her room, across from her bed, sitting on floor and had sustained a small cut inside her bottom lip. The floor mat was not in front of bed on floor according to the plan of care. An internal initial incident report was filed. The nursing assistants caring for R 75 were interviewed and the nursing assistant who assisted R 75 to bathroom several times prior to fall stated that she must have forgotten to place the mat after she went to the bathroom earlier that night. R 75 was discharged to home on 10/28/14. Nursing assistants working that night were counseled/educated on the importance of following the plan of care for each resident. Staff was reminded to do an initial report immediately to OHFC and CEP for any incident with injury where the plan of care was not followed. A follow up report will continue to be completed within 5 working days of the incident. Going forward, a more thorough investigation will occur to include conducting interviews with other residents cared for by the alleged NAs as well as conducting interviews with staff that work with the alleged NAs to ensure that care plans are followed. Aicota□s VA policy was revised and updated with an emphasis on immediately reporting to OHFC and CEP.	

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F 225	Continued From page 12	F 225	All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP and the importance of following a resident□s care plan. DON or designee will monitor/complete NA observations to ensure that resident care plans are followed. Social worker or designee will conduct audits of incident reports to ensure immediate reporting and that thorough investigations occurred. VA reports will be monitored to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015	
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement an abuse prohibition policy which required immediate notification to the State Agency (SA) allegations	F 226	F 226 Aicota Health Care Center (Aicota) does have a policy and procedure that prohibits	4/14/15

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F 226	Continued From page 13 of abuse/neglect/mistreatment prior to conducting investigations. The facility failed to report allegations of timely to the SA and/or failed to conduct thorough investigations for 7 of 10 residents (R53, R34, R31, R7, R3, R28, R75) reviewed for potential allegations of abuse/neglect/mistreatment. This practice had the potential to affect all 57 residents residing in the facility. Findings include: The facility policy and procedure on Vulnerable Adult Abuse Prevention Plan dated 5/21/12, directed staff to report a suspected incident of abuse/neglect/mistreatment immediately, not to exceed 24 hours. The policy further directed staff to initiate an investigation immediately. The policy later explained that investigation was necessary to determine if the incident should be reported. The policy explained the internal reporting procedure was to be followed to ensure reporting of only those incidents which are required to be reported. The reporting procedure was then defined as immediately making a report to the team leader (TL)/nurse in charge. As soon as possible, but no later than leaving work for the day, the TL was to complete an incident report. The incident report should not only define what happened but also explain the investigation completed, findings and action taken. The TL was to consult the policy and decision tree to determine if a report needed to be made. "Special attention shall be made to the immediately, not to exceed 24-hour time frames, especially on weekends." On 3/4/15, at 10:34 a.m. social worker (SW)-A and the director of nursing (DON) were	F 226	mistreatment, neglect and abuse of residents and misappropriation of property. On 3/3/15 R 53 reported to the state surveyors that a staff member handled him roughly when assisting with cares. That afternoon, R 53 was interviewed by the DON and Social worker and he stated that he hurts when he is gotten up/out of bed in am. He was unable to give a specific name of staff. This alleged mistreatment was reported to OHFC and Aitkin County/Common Entry Point (CEP) on 3/4/15. R 53 had previously talked to the Social worker on 3/2/15 and stated that a staff is on a new kick stating he should have larger pants. R 53 stated that he preferred to lose some weight as he has a closet full of clothes. He did not mention being treated roughly at any time during the discussion on 3/2/15. Staff was reminded to report to the team leader when a resident experiences any pain/discomfort during transfers. R53 has diagnosis of chronic pain related to osteoarthritis. R53 prefers to sleep on his right side and he declines to be repositioned during night. He receives Tylenol TID and his first dose of Tylenol is offered one hour prior to getting up in the morning. Our Vulnerable Adult (VA) policy and our internal incident report form have been revised and updated. The reporting time frame was redefined to remove within 24 hours and changed to immediately. All	

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F 226	Continued From page 14 interviewed. SW-A stated they always investigated alleged incidents of mistreatment/abuse/neglect, and if they are unable to come up with any explanation, they reported it to the SA. However, allegations of abuse/neglect/mistreatment are to be reported immediately and then a thorough investigation is to be conducted. R53 alleged an incident of mistreatment which was not reported to the SA immediately. R53 was interviewed on 3/2/15, at 4:17 p.m. and stated one staff member handled him roughly when assisting R53 with cares. R53 described the rough treatment as "jerking" him around in bed. R53 stated he had reported the rough treatment to a staff member, but hadn't heard anything more and the staff member who treated him "roughly" continued to work with him. R53's Admission Record identified diagnoses that included osteoarthritis, congestive heart failure, urinary incontinence and hemiplegia (weakness on one side of the body) due to cerebral vascular accident (CVA). The quarterly Minimum Data Set (MDS) dated 1/20/15, indicated R53 was cognitively intact, and required total assistance of two staff for bed mobility, extensive assistance of two staff for transfers, dressing and toileting, and extensive assistance of one staff for personal hygiene. The facility individual abuse assessment undated, indicated R53 was at low risk of vulnerability by others. On 3/3/15, at 3:45 p.m. SW-A and the DON were informed that R53's complaints of alleged mistreatment were not in the facility log of	F 226	alleged reports of mistreatment, neglect, abuse and misappropriation of resident property will be made to OHFC and CEP immediately. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. The Administrator will also continue to be notified immediately. All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP and treating residents gently. DON or designee will complete NA observations of ADLs to ensure that residents are treated gently. Social worker or designee will conduct audits of incident reports to ensure immediate reporting and that thorough investigations occurred. VA reports will be monitored to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 34□s arm was shaken by R 102 on 5/22/14 at 17:15. R 102 had poor vision, was ambulatory and was often looking for his wife. He was kind, easily redirected and did not mean any harm. The incident was reported to the OHFC and CEP on 5/23/14 even though R 34 did not appear in any distress over the incident.	

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F 226	Continued From page 15 reported incidents. On 3/4/15, at 10:34 a.m. SW-A and the DON were interviewed. The DON stated they had just investigated R53's complaints of alleged mistreatment, and were not going to report to the SA. SW-A stated they always investigate first, before they report to the SA to assist them in determining if something is reportable. R34 was mistreated by R102 and the allegation was not reported immediately to the SA. R34's arm was grabbed and shaken by R102 on 5/22/14, at 5:15 p.m. Staff witnessed the incident. The facility did not immediately report the alleged incident of mistreatment to the state agency; a report was filed on 5/23/14 (time unknown). The facility's investigation determined R102 often confused female residents as his wife. On 3/4/15, at 10:34 a.m. SW-A stated the facility always investigated before they reported to the SA. R34's Admission Record identified diagnoses that included Alzheimer's disease, chronic pain, and anxiety. The quarterly MDS dated 1/21/15, indicated R34 had short and long term memory problems, and severely impaired cognitive skills for daily decision making (never/rarely made decisions). The MDS further identified R34 as having mood problems of little interest or pleasure in doing things, poor appetite or overeating, and trouble concentrating on things. The MDS identified no behaviors. The facility Individual Abuse Assessment dated 9/21/10, indicated R34 was at high risk of vulnerability by others. R31 sustained 3 injuries of unknown origin which	F 226	Staff was reminded to do an initial report immediately to OHFC and CEP. A follow up report will continue to be completed within 5 working days of the incident. Our Vulnerable Adult (VA) policy and our internal incident report form have been revised and updated. The reporting time frame was redefined to remove within 24 hours and changed to immediately. All alleged reports of mistreatment, neglect, abuse and misappropriation of resident property will be made to OHFC and CEP immediately. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. The Administrator will also continue to be notified immediately. All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP. Social worker or designee will conduct audits of incident reports to ensure immediate reporting and that thorough investigations occurred. VA reports will be monitored to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 31 sustained three bruises of unknown origin, two bruises on his chest and one	

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F 226	Continued From page 16 were not reported to the SA immediately, and lacked a thorough investigation to determine if abuse/mistreatment occurred. 1. On 12/8/14, R31 was discovered to have a 6.7 centimeter (cm) by 6 cm bruise of unknown origin on his chest. [An injury of unknown origin is one in which the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one point in time or the incidence of injuries over time.] The facility originally did not report the bruise to the SA, however, on 12/10/14, R31's spouse was uncertain if the facility's explanation that R34 bruised himself by clenching his hands/fists near his chest was accurate. The facility then reported the bruise to the SA on 12/10/14 (time unknown). The facility further investigated, and determined the injury could have been done by another resident or staff, could have been self-inflicted, or could have been a result of being resistive to cares. However, the investigation was not thorough enough to rule out possible abuse/mistreatment. 2. On 2/4/15, at 3:15 p.m. R31 was noted to have a 4.2 cm by 3.8 cm bruise of unknown origin on his chest. The facility did not report the bruise to the SA. Although the injury remained an unknown origin, there was no further investigation. 3. On 2/9/15, R31 was noted to have a 2 cm by 2.3 cm bruise of unknown origin on his right jaw. The facility's Resident Fall/Incident Report/Investigtion identified the cause of incident to be: "Resident with strong facial hair growth. question to whether resident's daily shaving may have caused brusing." The report	F 226	on his chin. Social worker and Resident Care Coordinator (RCC) interviewed R 31, R 31□s wife and daughter and felt that there was sufficient reasoning for the bruising related to R 31□s resistiveness, rigidity, clenching fists and holding against his chest, hanging onto items during transfers and his skin bruising easily. All nursing staff who have been caring recently for R 31 were interviewed. The care plan was followed and bruising could be self- inflicted. All unexplained bruising/bruise of unknown origin will be reported immediately to OHFC and CEP. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. Our Vulnerable Adult (VA) policy and our internal incident report form have been revised and updated. The reporting time frame was redefined to remove within 24 hours and changed to immediately. All alleged reports of mistreatment, neglect, abuse and misappropriation of resident property will be made to OHFC and CEP immediately. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. The Administrator will also continue to be notified immediately. All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately	

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F 226	Continued From page 17 also identified "Resident does use a lidded sippy cup independently at times with meals and may have bumped jaw." The facility did not report the bruise to the state agency, nor was there an investigation. R31's Admission Record identified diagnoses that included dementia. The annual MDS dated 11/26/14, indicated R31 had severe cognitive impairment, and had mood indicators of feeling bad about self or a failure or have let your family down. The MDS further identified R31 required extensive assistance of two staff with bed mobility and transfers, extensive assistance of one staff for toileting, and total assistance of one staff for dressing, eating and personal hygiene. The MDS identified no behaviors issues. The facility Individual Abuse Assessment undated, indicated R31 was at moderate risk of vulnerability by others. On 3/04/15, at 10:34 a.m. SW-A and the DON were interviewed. SW-A stated they always investigated alleged incidents of abuse/neglect/mistreatment, and if they are unable to come up with any explanation, they report to the SA. investigated. R7 alleged rough treatment by staff which was not reported to the SA, and lacked a thorough investigation. R7's annual MDS dated 12/4/14, indicated R7 had no cognitive impairments. R7 had no delirium, psychosis, behaviors or rejection of cares. R7 required the extensive assistance of one staff with bed mobility. On 3/3/15, at 10:00 a.m. R7 stated there was one	F 226	reporting to OHFC and CEP. Social worker or designee will conduct audits of incident reports to ensure immediate reporting and that thorough investigations occurred. VA reports will be monitored to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 7 reported bruising on her upper legs to the interdisciplinary team on 3/3/15 during her care conference. She stated she was treated rough by a big guy NA, while she was turned/repositioned. DON attempted to investigate the alleged bruising that afternoon, but R 7 had a visitor, than participated in activities and declined having skin assessment completed at these times. At HS, the LPN on duty checked R 7□s skin and found a fading bruise on the inside of her left thigh and a small round newer looking bruise was noticed on the left outer thigh. Due to R 7□s request to have her bed position with her right side against the wall (as it is more comfortable and feels safe for her), R 7 is always turned towards her left side and assisted by staff using a turning sheet. The big guy NA was interviewed by Social worker and DON. He stated that he followed the plan of care and always repositions/turns with a turning sheet. Staff would not hold onto left inner thigh while turning R 7 for cares. Resident likes	

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F 226	Continued From page 18 male NA who was rough when he turned her in bed. R7 stated, "He's big and I don't think he's aware he's rough when he moves me." R7 stated she had bruises on her upper inner legs from the NA's hands when he moved her. R7 stated further the NA had been more careful because he did say the bruises matched his hands. R7 had not told anyone. R7 stated, "He's not here very often and I just put up with it. It's just his manner of handling." On 3/3/15, at 3:45 p.m. the DON and the SW-A were informed of R7's allegation of rough treatment. The SW stated she was aware because R7 reported it during her care conference on 3/3/15. The facility's Resident Fall/Incident Report/Investigation report completed on 3/4/15, by the DON indicated on 3/3/15, during a care conference R7 reported bruising on her upper legs. The facility's Report of Alleged Incident of Abuse/Neglect completed by the SW indicated R7 reported the incident on 3/3/15, during a care conference at 2:00 p.m. R7 reported she had bruising on her upper legs/thighs. R7 reported a long time ago from a male staff member who "just didn't know his own strength" when handling her. R7 was not upset and indicated things had improved. The report indicated on 3/5/15, a licensed practical nurse (LPN) observed R7's legs and found three old bruises. R7 reported to the LPN that the "big guy with the beard" turns her. The incident report indicated R7 had two light blue discolored areas on the left inner thigh which	F 226	to have multiple items on the inside of her wheel chair and recliner. She bruises easily related to monoclonal gammopathy. During interview with R 7, she indicated that she has not been hurt by the NA and has no problem with that NA continuing to care for her. An incident report was filed and reported to OHFC and CEP on 3/4/15. All unexplained bruising/bruise of unknown origin will be reported immediately to OHFC and CEP. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. Going forward, a more thorough investigation will occur to include conducting interviews with other residents cared for by the alleged NA as well as conducting interviews with staff that work with the alleged NA. Our Vulnerable Adult (VA) policy and our internal incident report form have been revised and updated. The reporting time frame was redefined to remove within 24 hours and changed to immediately. All alleged reports of mistreatment, neglect, abuse and misappropriation of resident property will be made to OHFC and CEP immediately. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. The Administrator will also continue to be notified immediately.	

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 _____	03/05/2015

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

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F 226	Continued From page 19 measured 2.5 by 3 centimeters (cm) and a 1 by 1 cm darker blue area on the left outer thigh. The incident report's investigative findings (cause of the incident) included the bruises on the left thigh were very pale and appeared old. The findings further stated the bruises were "more likely caused by removing incontinent briefs while on the commode or toilet and the bruises on the outer thighs were probably from items in R7's chair" even though R7 was cognitively intact and had reported the bruises were from rough treatment. There was no evidence of any further investigation. The incident report indicated the rough treatment and bruises were not reported to the SA. The incident report's department review and interventions discussed dated 3/4/15, indicated R7 bruised easily and had multiple items in the wheelchair. On 3/4/15, at 10:36 a.m. the DON stated the incident report contained all of the information about the "rough treatment." The DON further stated they were not going to report the incident. R3 sustained an injury following an incident where staff did not follow the plan of care. The neglect of care was not reported immediately to the SA, and lacked a thorough investigation. R3 was lowered to the floor during a staff assisted transfer on 10/6/14, at 5:00 a.m. Staff was not transferring R3 as directed by the care plan. The incident was not reported right away by the staff. The incident was reported to the facility by R3 on 10/6/14, at 2:30 p.m. R3's quarterly MDS dated 11/14/14, indicated R3 had short and long term memory problems but was able to recall the season, the location of her room, staff names and faces and that she was in	F 226	All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP and treating residents gently. DON or designee will complete NA observations of ADLs to ensure that residents are treated gently. Social worker or designee will conduct audits of incident reports to ensure immediate reporting and that thorough investigations occurred. VA reports will be monitored to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 3 was transferred by two nursing assistants at 05:00 on 10/6/14 from chair to commode without using a transfer belt. The resident lost her footing and was eased to the floor to avoid injury/fall. This incident was reported by the resident later during the day at 14:30. An initial report was made online to OHFC and to CEP on 10/6/14. Calls were made to the night shift nursing assistants to conduct further investigation and both verified that resident was transferred without a transfer belt and lowered to floor when she lost her footing to avoid injury/prevent fall. Both nursing assistants (NA) were fairly new in their positions. The NA□s were	

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F 226	Continued From page 20 a nursing home. R3 had modified independence with some difficulty in new situations when making decisions. R3 had no behaviors or rejection of cares. R3 needed the extensive assistance of two staff with bed mobility and transfers. R3 was not ambulatory. The Activities of Daily Living (ADL) care plan revised on 8/7/14, directed staff to transfer R3 with the EZ (mechanical) lift and two staff. The facility's Resident Fall/Incident Report/Investigation report completed on 10/6/14, indicated the incident occurred on 10/6/14, at 5:00 a.m. and was not reported until 2:30 p.m. by R3. R3 reported the staff dropped her to the floor while transferring her to the commode. Although the care plan directed staff to use an E-Z Lift, staff utilized a pivot transfer without a transfer belt. The incident report's investigative findings included staff was contacted and verified R3 was lowered to the floor while being transferred. R3 lost her footing and was lowered to the floor to avoid injury. On 10/6/14, at 6:30 p.m. a penny size bruise was found on R3's left hand, R3's right wrist had swelling and a bruise on the right forearm which measured five inches by one and a half inches. The incident report's follow up indicated staff was counseled. The incident was reported to the state agency on 10/6/14. However, no further investigation was conducted. R28 alleged mistreatment which was not reported to the SA, and lacked a thorough investigation. R28's MDS dated 11/18/14, indicated R28 had no cognitive impairment and R28 required the extensive assistance of one staff with bed mobility, transfers and toilet use. The facility's Report of Alleged Incident of	F 226	educated on the importance of following a resident□s plan of care and using a transfer belt while transferring residents. They were also educated on the definition of falls/incidents and the importance of immediately reporting incidents to the nurse in charge. Our Vulnerable Adult (VA) policy and our internal incident report form have been revised and updated. The reporting time frame was redefined to remove within 24 hours and changed to immediately. All alleged reports of mistreatment, neglect, abuse and misappropriation of resident property will be made to OHFC and CEP immediately. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. The Administrator will also continue to be notified immediately. All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP and the importance of following a resident□s care plan. DON or designee will monitor/complete NA observations of transfers and other ADLs to ensure that safe transfers are completed and that resident care plans are followed. Social worker or designee will conduct audits of incident reports to ensure immediate reporting and that thorough	

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F 226	Continued From page 21 Abuse/Neglect form dated 1/19/15, at 8:10 a.m. indicated a NA reported another NA unplugged the call light when R28 put the call light on for assistance to use the bathroom. The NA heard R28 calling for help and stated, "he unplugged my call light and said I couldn't use the bathroom." At 8:50 a.m. R28 reported to a registered nurse a "gentleman pulled my call light out of the wall when I needed to go to the bathroom. I want to make sure this does not happen to anyone else." The incident report's follow up at 10:20 a.m. indicated the SW spoke with the NA. The report indicated the NA must have unplugged the call light when he walked out of the room and tripped. The NA informed the SW he had been "behind" and R28 had been using the call light "every 15 to 20 minutes." The NA stated it was not intentional and should have gone back right away and plugged the call light back in. The NA understood call lights should never be unplugged. On 3/4/15, at 10:34 a.m. the DON stated the NA was interviewed and stated he accidentally tripped on the call light. The DON stated she felt the incident did not need to be reported to the state agency. However, the incident was not thoroughly investigated to determine possible neglect of care. R75 sustained an injury as a result of staff not following the plan of care. The neglect of care lacked a thorough investigation, and the investigative report was not reported to the SA timely. R75's MDS dated 10/13/14, indicated she was diagnosed with dementia, orthostatic hypotension,and fracture. The MDS also indicated she required extensive assist with transfers, toileting, locomotion on and off the unit,	F 226	investigations occurred. VA reports will be monitored to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 28 yelled out for help to use the bathroom at 08:10 on 1/19/15. At this time, R 28 stated to the NA who provided the assistance he unplugged my call light. The NA who assisted R 28 reported this to the Resident Care Coordinator (RCC). At 08:50 after the resident was toileted, the RCC went to discuss the reported incident with R 28. R 28 stated that a gentleman pulled my call light out of the wall. An internal incident report was filed. The NA was interviewed. He stated that he must have tripped on the cord when leaving R 28□s room. He stated that unplugging the call light was not intentional. R 28□s needs were met, she was not distressed and no mental anguish was noticed. She was assisted to toilet (able to toilet self during day) and it was not reported to OHFC and CEP. A call light report was ran for the wing that caregiver worked on to ensure that other residents call light cords were not unplugged. Through the investigation of the incident, it was determined that a call light can be turned off, even if it is disconnected from the wall outlet. The call light system has since been reprogrammed so that a call light cannot be turned off or silenced when disconnected from wall in a resident□s	

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F 226	Continued From page 22 and occasionally incontinent of bowel and bladder. R75's care plan initiated 9/23/14, indicated R75 had a fall with a resulting left hip fracture. R75's care plan further identified she had impaired physical mobility, requiring assist with transfers, toileting and incontinence cares. Review of an incident report dated 10/14/14, at 2:25 a.m. revealed R75 was found sitting on the floor near her walker (unwitnessed fall). As a result of the fall, R75 received a small cut inside her bottom lip. The incident report indicated, R75's care plan was not being followed, as the fall mat was supposed to be placed near the bed and toileting schedule may also be a factor. The administrator and SA were notified on 10/14/14. However, the facility failed to complete a thorough investigation into the possible neglect of care. In addition, the investigation was not reported to the SA until 10/20/14, 7 days after the incident.	F 226	room. If a call light is unplugged from the wall, it will now activate the call light. Staff was counseled/educated that if they feel they may have tripped on something, to make sure to go back immediately and check to ensure nothing has been disconnected and that everything is in place and safe for the resident. Initial report will be filed immediately if resident reports that staff unplugged call light. Our Vulnerable Adult (VA) policy and our internal incident report form have been revised and updated. The reporting time frame was redefined to remove within 24 hours and changed to immediately. All alleged reports of mistreatment, neglect, abuse and misappropriation of resident property will be made to OHFC and CEP immediately. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. The Administrator will also continue to be notified immediately. All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP. Social worker or designee will conduct audits of incident reports to ensure immediate reporting and that thorough investigations occurred. VA reports will be monitored to ensure that we are in compliance with State regulations and report unusual findings to the QA	

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F 226	Continued From page 23	F 226	committee quarterly. Completion Date: April 14, 2015 R 75 was admitted on 9/16/14 for short term rehab after a fall at home resulting in hip fracture. Admission diagnosis included status post-surgical repair of hip, history of CVA and dementia. R 75 had a history of being more restless on afternoons and nights. She got up at night and slept poorly possibly related to dementia. When talking to husband he stated that this was not unusual for her. On 10/14/14 at 02:25 R 75 was found in her room, across from her bed, sitting on floor and had sustained a small cut inside her bottom lip. The floor mat was not in front of bed on floor according to the plan of care. An internal initial incident report was filed. The nursing assistants caring for R 75 were interviewed and the nursing assistant who assisted R 75 to bathroom several times prior to fall stated that she must have forgotten to place the mat after she went to the bathroom earlier that night. R 75 was discharged to home on 10/28/14. Nursing assistants working that night were counseled/educated on the importance of following the plan of care for each resident. Staff was reminded to do an initial report immediately to OHFC and CEP for any incident with injury where the plan of care was not followed. A follow up report will continue to be completed within 5 working days of the incident.	

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F 226	Continued From page 24	F 226	Our Vulnerable Adult (VA) policy and our internal incident report form have been revised and updated. The reporting time frame was redefined to remove within 24 hours and changed to immediately. All alleged reports of mistreatment, neglect, abuse and misappropriation of resident property will be made to OHFC and CEP immediately. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. The Administrator will also continue to be notified immediately. All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP and the importance of following a resident□s care plan. DON or designee will monitor/complete NA observations to ensure that resident care plans are followed. Social worker or designee will conduct audits of incident reports to ensure immediate reporting and that thorough investigations occurred. VA reports will be monitored to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015	

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	245363	A. BUILDING **01 - AICOTA NURSING HOME** B. WING _____	**03/04/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Aicota Health Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Aicota Health Care Center, is a 1-story building with no basement. The original building was constructed in 1969 and was determined to be of Type II(111) construction. In 1983 an addition was constructed to the building that was determined to be of Type II(111) construction. In 2007 an assisted living facility was attached, that is properly 2 hour fire rated separated. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 75 beds and had a census of 56 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 20, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5363024

Dear Ms. Matalamaki:

The above facility was surveyed on March 2, 2015 through March 5, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 Chris Campbell at (218) 302-6151 or email: chris.campbell@state.mn.us.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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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 _____	03/05/2015

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

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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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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

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2 000	Continued From page 1 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. On March 2-5, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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. 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.	2 000		

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	00848	A. BUILDING: _____ B. WING _____	03/05/2015

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report potential allegations of abuse/neglect/mistreatment to the State Agency (SA) and thoroughly investigate allegations for 7 of 10 residents (R53, R34, R31, R7, R3, R28, R75) reviewed for potential allegations of mistreatment. Findings include: R53 alleged an incident of mistreatment which was not reported to the SA immediately. R53 was interviewed on 3/2/15, at 4:17 p.m. and stated one staff member handled him roughly when assisting R53 with cares. R53 described the rough treatment as "jerking" him around in bed. R53 stated he had reported the rough	21995	The facility will establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. On 3/3/15 R 53 reported to the state surveyors that a staff member handled him roughly when assisting with cares. That afternoon, R 53 was interviewed by the DON and Social worker and he stated that he hurts when he is gotten up/out of bed in am. He was unable to give a specific name of staff. This alleged mistreatment was reported to OHFC and Aitkin County/Common Entry Point (CEP) on 3/4/15. R 53 had previously talked to	4/14/15

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treatment to a staff member, but hadn't heard anything more and the staff member who treated him "roughly" continued to work with him.

R53's Admission Record identified diagnoses that included osteoarthritis, congestive heart failure, urinary incontinence and hemiplegia (weakness on one side of the body) due to cerebral vascular accident (CVA). The quarterly Minimum Data Set (MDS) dated 1/20/15, indicated R53 was cognitively intact, and required total assistance of two staff for bed mobility, extensive assistance of two staff for transfers, dressing and toileting, and extensive assistance of one staff for personal hygiene.

The facility individual abuse assessment undated, indicated R53 was at low risk of vulnerability by others.

On 3/3/15, at 3:45 p.m. SW-A and the DON were informed that R53's complaints of alleged mistreatment were not in the facility log of reported incidents.

On 3/4/15, at 10:34 a.m. SW-A and the DON were interviewed. The DON stated they had just investigated R53's complaints of alleged mistreatment, and were not going to report to the SA. SW-A stated they always investigate first, before they report to the SA to assist them in determining if something is reportable.

R34 was mistreated by R102 and the allegation was not reported immediately to the SA.
R34's arm was grabbed and shaken by R102 on 5/22/14, at 5:15 p.m. Staff witnessed the incident. The facility did not immediately report the alleged incident of mistreatment to the state agency; a report was filed on 5/23/14 (time unknown). The

the Social worker on 3/2/15 and stated that a staff is on a new kick stating he should have larger pants. R 53 stated that he preferred to lose some weight as he has a closet full of clothes. He did not mention being treated roughly at any time during the discussion on 3/2/15.

Staff was reminded to report to the team leader when a resident experiences any pain/discomfort during transfers. R53 has diagnosis of chronic pain related to osteoarthritis. R53 prefers to sleep on his right side and he declines to be repositioned during night. He receives Tylenol TID and his first dose of Tylenol is offered one hour prior to getting up in the morning.

Aicota□s Vulnerable Adult (VA) policy was revised and updated with an emphasis on immediately reporting to OHFC and CEP.

All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP.

Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly.

Completion Date: April 14, 2015

R 34□s arm was shaken by R 102 on 5/22/14 at 17:15. R 102 had poor vision, was ambulatory and was often looking for his wife. He was kind, easily redirected

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facility's investigation determined R102 often confused female residents as his wife. On 3/4/15, at 10:34 a.m. SW-A stated the facility always investigated before they reported to the SA.

R34's Admission Record identified diagnoses that included Alzheimer's disease, chronic pain, and anxiety. The quarterly MDS dated 1/21/15, indicated R34 had short and long term memory problems, and severely impaired cognitive skills for daily decision making (never/rarely made decisions). The MDS further identified R34 as having mood problems of little interest or pleasure in doing things, poor appetite or overeating, and trouble concentrating on things. The MDS identified no behaviors.

The facility Individual Abuse Assessment dated 9/21/10, indicated R34 was at high risk of vulnerability by others.

R31 sustained 3 injuries of unknown origin which were not reported to the SA immediately, and lacked a thorough investigation to determine if abuse/mistreatment occurred.
1. On 12/8/14, R31 was discovered to have a 6.7 centimeter (cm) by 6 cm bruise of unknown origin on his chest. [An injury of unknown origin is one in which the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one point in time or the incidence of injuries over time.] The facility originally did not report the bruise to the SA, however, on 12/10/14, R31's spouse was uncertain if the facility's explanation that R34 bruised himself by clenching his hands/fists near his chest was accurate. The facility then reported the bruise to the SA on

and did not mean any harm. The incident was reported to the OHFC and CEP on 5/23/14 even though R 34 did not appear in any distress over the incident.

Staff was reminded to do an initial report immediately to OHFC and CEP. A follow up report will continue to be completed within 5 working days of the incident.

Aicota□s VA policy was revised and updated with an emphasis on immediately reporting to OHFC and CEP.

All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP.

Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly.

Completion Date: April 14, 2015

R 31 sustained three bruises of unknown origin, two bruises on his chest and one on his chin. Social worker and Resident Care Coordinator (RCC) interviewed R 31, R 31□s wife and daughter and felt that there was sufficient reasoning for the bruising related to R 31□s resistiveness, rigidity, clenching fists and holding against his chest, hanging onto items during transfers and his skin bruising easily. All nursing staff who have been caring recently for R 31 were interviewed. The care plan was followed and bruising could

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21995	Continued From page 5 12/10/14 (time unknown). The facility further investigated, and determined the injury could have been done by another resident or staff, could have been self-inflicted, or could have been a result of being resistive to cares. However, the investigation was not thorough enough to rule out possible abuse/mistreatment. 2. On 2/4/15, at 3:15 p.m. R31 was noted to have a 4.2 cm by 3.8 cm bruise of unknown origin on his chest. The facility did not report the bruise to the SA. Although the injury remained an unknown origin, there was no further investigation. 3. On 2/9/15, R31 was noted to have a 2 cm by 2.3 cm bruise of unknown origin on his right jaw. The facility's Resident Fall/Incident Report/Investigtion identified the cause of incident to be: "Resident with strong facial hair growth. question to whether resident's daily shaving may have caused brusing." The report also identified "Resident does use a lidded sippy cup independently at times with meals and may have bumped jaw." The facility did not report the bruise to the state agency, nor was there an investigation. R31's Admission Record identified diagnoses that included dementia. The annual MDS dated 11/26/14, indicated R31 had severe cognitive impairment, and had mood indicators of feeling bad about self or a failure or have let your family down. The MDS further identified R31 required extensive assistance of two staff with bed mobility and transfers, extensive assistance of one staff for toileting, and total assistance of one staff for dressing, eating and personal hygiene. The MDS identified no behaviors issues. The facility Individual Abuse Assessment	21995	be self- inflicted. All unexplained bruising/bruise of unknown origin will be reported immediately to OHFC and CEP. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. Aicota□s VA policy was revised and updated with an emphasis on immediately reporting to OHFC and CEP. All staff will be in serviced by reviewing our updated VA policy by April 14, 15 with an emphasis on immediate reporting of bruising of an unknown origin to OHFC and CEP. Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 7 reported bruising on her upper legs to the interdisciplinary team on 3/3/15 during her care conference. She stated she was treated rough by a big guy NA, while she was turned/repositioned. DON attempted to investigate the alleged bruising that afternoon, but R 7 had a visitor, than participated in activities and declined having skin assessment completed at these times. At HS, the LPN on duty checked R 7□s skin and found a fading bruise on the inside of her left thigh and a	

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21995	Continued From page 6 undated, indicated R31 was at moderate risk of vulnerability by others. On 3/04/15, at 10:34 a.m. SW-A and the DON were interviewed. SW-A stated they always investigated alleged incidents of abuse/neglect/mistreatment, and if they are unable to come up with any explanation, they report to the SA. investigated. R7 alleged rough treatment by staff which was not reported to the SA, and lacked a thorough investigation. R7's annual MDS dated 12/4/14, indicated R7 had no cognitive impairments. R7 had no delirium, psychosis, behaviors or rejection of cares. R7 required the extensive assistance of one staff with bed mobility. On 3/3/15, at 10:00 a.m. R7 stated there was one male NA who was rough when he turned her in bed. R7 stated, "He's big and I don't think he's aware he's rough when he moves me." R7 stated she had bruises on her upper inner legs from the NA's hands when he moved her. R7 stated further the NA had been more careful because he did say the bruises matched his hands. R7 had not told anyone. R7 stated, "He's not here very often and I just put up with it. It's just his manner of handling." On 3/3/15, at 3:45 p.m. the DON and the SW-A were informed of R7's allegation of rough treatment. The SW stated she was aware because R7 reported it during her care conference on 3/3/15. The facility's Resident Fall/Incident Report/Investigation report completed on 3/4/15, by the DON indicated on 3/3/15, during a care	21995	small round newer looking bruise was noticed on the left outer thigh. Due to R 7□s request to have her bed position with her right side against the wall (as it is more comfortable and feels safe for her), R 7 is always turned towards her left side and assisted by staff using a turning sheet. The big guy NA was interviewed by Social worker and DON. He stated that he followed the plan of care and always repositions/turns with a turning sheet. Staff would not hold onto left inner thigh while turning R 7 for cares. Resident likes to have multiple items on the inside of her wheel chair and recliner. She bruises easily related to monoclonal gammopathy. An incident report was filed and reported to OHFC and CEP on 3/4/15. All unexplained bruising/bruise of unknown origin will be reported immediately to OHFC and CEP. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. Aicota□s VA policy was revised and updated with an emphasis on immediately reporting to OHFC and CEP. All staff will be in serviced by reviewing our updated VA policy by April 14, 15 with emphasis on immediate reporting of bruising with unknown origin. Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and	

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21995	Continued From page 7 conference R7 reported bruising on her upper legs. The facility's Report of Alleged Incident of Abuse/Neglect completed by the SW indicated R7 reported the incident on 3/3/15, during a care conference at 2:00 p.m. R7 reported she had bruising on her upper legs/thighs. R7 reported a long time ago from a male staff member who "just didn't know his own strength" when handling her. R7 was not upset and indicated things had improved. The report indicated on 3/5/15, a licensed practical nurse (LPN) observed R7's legs and found three old bruises. R7 reported to the LPN that the "big guy with the beard" turns her. The incident report indicated R7 had two light blue discolored areas on the left inner thigh which measured 2.5 by 3 centimeters (cm) and a 1 by 1 cm darker blue area on the left outer thigh. The incident report's investigative findings (cause of the incident) included the bruises on the left thigh were very pale and appeared old. The findings further stated the bruises were "more likely caused by removing incontinent briefs while on the commode or toilet and the bruises on the outer thighs were probably from items in R7's chair" even though R7 was cognitively intact and had reported the bruises were from rough treatment. There was no evidence of any further investigation. The incident report indicated the rough treatment and bruises were not reported to the SA. The incident report's department review and interventions discussed dated 3/4/15, indicated R7 bruised easily and had multiple items in the wheelchair. On 3/4/15, at 10:36 a.m. the DON stated the incident report contained all of the information	21995	report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 3 was transferred by two nursing assistants at 05:00 on 10/6/14 from chair to commode without using a transfer belt. The resident lost her footing and was eased to the floor to avoid injury/fall. This incident was reported by the resident later during the day at 14:30. An initial report was made online to OHFC and to CEP on 10/6/14. Calls were made to the night shift nursing assistants to conduct further investigation and both verified that resident was transferred without a transfer belt and lowered to floor when she lost her footing to avoid injury/prevent fall. Both nursing assistants (NA) were fairly new in their positions. The NA□s were educated on the importance of following a resident□s plan of care and using a transfer belt while transferring residents. They were also educated on the definition of falls/incidents and the importance of immediately reporting incidents to the nurse in charge. Aicota□s VA policy was revised and updated with an emphasis on immediately reporting to OHFC and CEP. All staff will be in-serviced by reviewing our updated VA policy and the internal incident report form by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP.	

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21995	Continued From page 8 about the "rough treatment." The DON further stated they were not going to report the incident. R3 sustained an injury following an incident where staff did not follow the plan of care. The neglect of care was not reported immediately to the SA, and lacked a thorough investigation. R3 was lowered to the floor during a staff assisted transfer on 10/6/14, at 5:00 a.m. Staff was not transferring R3 as directed by the care plan. The incident was not reported right away by the staff. The incident was reported to the facility by R3 on 10/6/14, at 2:30 p.m. R3's quarterly MDS dated 11/14/14, indicated R3 had short and long term memory problems but was able to recall the season, the location of her room, staff names and faces and that she was in a nursing home. R3 had modified independence with some difficulty in new situations when making decisions. R3 had no behaviors or rejection of cares. R3 needed the extensive assistance of two staff with bed mobility and transfers. R3 was not ambulatory. The Activities of Daily Living (ADL) care plan revised on 8/7/14, directed staff to transfer R3 with the EZ (mechanical) lift and two staff. The facility's Resident Fall/Incident Report/Investigation report completed on 10/6/14, indicated the incident occurred on 10/6/14, at 5:00 a.m. and was not reported until 2:30 p.m. by R3. R3 reported the staff dropped her to the floor while transferring her to the commode. Although the care plan directed staff to use an E-Z Lift, staff utilized a pivot transfer without a transfer belt. The incident report's investigative findings included staff was contacted and verified R3 was lowered to the floor while being transferred. R3 lost her footing and was lowered to the floor to	21995	Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 28 yelled out for help to use the bathroom at 08:10 on 1/19/15. At this time, R 28 stated to the NA who provided the assistance he unplugged my call light. The NA who assisted R 28 reported this to the Resident Care Coordinator (RCC). At 08:50 after the resident was toileted, the RCC went to discuss the reported incident with R 28. R 28 stated that a gentleman pulled my call light out of the wall. An internal incident report was filed. The NA was interviewed. He stated that he must have tripped on the cord when leaving R 28□s room. He stated that unplugging the call light was not intentional. R 28□s needs were met, she was not distressed and no mental anguish was noticed. She was assisted to toilet (able to toilet self during day) and it was not reported to OHFC and CEP. Through the investigation of the incident, it was determined that a call light can be turned off, even if it is disconnected from the wall outlet. The call light system has since been reprogrammed so that a call light cannot be turned off or silenced when disconnected from wall in a resident□s room. Staff was counseled/educated that if they feel they may have tripped on something,	

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avoid injury. On 10/6/14, at 6:30 p.m. a penny size bruise was found on R3's left hand, R3's right wrist had swelling and a bruise on the right forearm which measured five inches by one and a half inches. The incident report's follow up indicated staff was counseled. The incident was reported to the state agency on 10/6/14. However, no further investigation was conducted.

R28 alleged mistreatment which was not reported to the SA, and lacked a thorough investigation. R28's MDS dated 11/18/14, indicated R28 had no cognitive impairment and R28 required the extensive assistance of one staff with bed mobility, transfers and toilet use.

The facility's Report of Alleged Incident of Abuse/Neglect form dated 1/19/15, at 8:10 a.m. indicated a NA reported another NA unplugged the call light when R28 put the call light on for assistance to use the bathroom. The NA heard R28 calling for help and stated, "he unplugged my call light and said I couldn't use the bathroom." At 8:50 a.m. R28 reported to a registered nurse a "gentleman pulled my call light out of the wall when I needed to go to the bathroom. I want to make sure this does not happen to anyone else." The incident report's follow up at 10:20 a.m. indicated the SW spoke with the NA. The report indicated the NA must have unplugged the call light when he walked out of the room and tripped. The NA informed the SW he had been "behind" and R28 had been using the call light "every 15 to 20 minutes." The NA stated it was not intentional and should have gone back right away and plugged the call light back in. The NA understood call lights should never be unplugged.

On 3/4/15, at 10:34 a.m. the DON stated the NA was interviewed and stated he accidentally

to make sure to go back immediately and check to ensure nothing has been disconnected and that everything is in place and safe for the resident. Initial report will be filed immediately if resident reports that staff unplugged call light.

An immediate report will be made to OHFC and CEP if a resident has a claim of neglect. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident.

Aicota□s VA policy was revised and updated with an emphasis on immediately reporting to OHFC and CEP.

All staff will be in-serviced by reviewing our updated VA policy and the internal incident report form by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP.

Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly.

Completion Date: April 14, 2015

R 75 was admitted on 9/16/14 for short term rehab after a fall at home resulting in hip fracture. Admission diagnosis included status post-surgical repair of hip, history of CVA and dementia. R 75 had a history of being more restless on afternoons and nights. She got up at night and slept poorly

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21995	Continued From page 10 tripped on the call light. The DON stated she felt the incident did not need to be reported to the state agency. However, the incident was not thoroughly investigated to determine possible neglect of care. R75 sustained an injury as a result of staff not following the plan of care. The neglect of care lacked a thorough investigation, and the investigative report was not reported to the SA timely. R75's MDS dated 10/13/14, indicated she was diagnosed with dementia, orthostatic hypotension,and fracture. The MDS also indicated she required extensive assist with transfers, toileting, locomotion on and off the unit, and occasionally incontinent of bowel and bladder. R75's care plan initiated 9/23/14, indicated R75 had a fall with a resulting left hip fracture. R75's care plan further identified she had impaired physical mobility, requiring assist with transfers, toileting and incontinence cares. Review of an incident report dated 10/14/14, at 2:25 a.m. revealed R75 was found sitting on the floor near her walker (unwitnessed fall). As a result of the fall, R75 received a small cut inside her bottom lip. The incident report indicated, R75's care plan was not being followed, as the fall mat was supposed to be placed near the bed and toileting schedule may also be a factor. The administrator and SA were notified on 10/14/14. However, the facility failed to complete a thorough investigation into the possible neglect of care. In addition, the investigation was not reported to the SA until 10/20/14, 7 days after the incident. SUGGESTED METHOD OF CORRECTION:	21995	possibly related to dementia. When talking to husband he stated that this was not unusual for her. On 10/14/14 at 02:25 R 75 was found in her room, across from her bed, sitting on floor and had sustained a small cut inside her bottom lip. The floor mat was not in front of bed on floor according to the plan of care. An internal initial incident report was filed. The nursing assistants caring for R 75 were interviewed and the nursing assistant who assisted R 75 to bathroom several times prior to fall stated that she must have forgotten to place the mat after she went to the bathroom earlier that night. R 75 was discharged to home on 10/28/14. Nursing assistants working that night were counseled/educated on the importance of following the plan of care for each resident. Staff was reminded to do an initial report immediately to OHFC and CEP for any incident with injury where the plan of care was not followed. A follow up report will continue to be completed within 5 working days of the incident. Please also note the investigative report for R 75 was completed seven days after the incident. However, two of those days were weekend days, so the investigative reporting guidelines were met within five working days. Aicota□s VA policy was revised and updated with an emphasis on immediately reporting to OHFC and CEP. All staff will be in-serviced by reviewing	

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21995	Continued From page 11 The administrator could educate all staff on policies and procedures regarding alleged reports of mistreatment. The administrator could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995	our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP. Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015	
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable	22000		4/14/15

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22000	Continued From page 12 adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement an abuse prohibition policy which required immediate notification to the State Agency (SA) allegations of abuse/neglect/mistreatment prior to conducting investigations. The facility failed to report allegations of timely to the SA and/or failed to conduct thorough investigations for 7 of 10 residents (R53, R34, R31, R7, R3, R28, R75) reviewed for potential allegations of abuse/neglect/mistreatment. This practice had the potential to affect all 57 residents residing in the facility.	22000	Aicota Health Care Center has established and enforces an ongoing written abuse prevention plan. The plan complies with the rules governing the plan promulgated by the licensing agency. Our Vulnerable Adult (VA) policy and our internal incident report form have been revised and updated. The reporting time frame was redefined to remove within 24 hours and changed to immediately. All alleged reports of mistreatment, neglect, abuse and misappropriation of resident	

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22000	Continued From page 13 Findings include: The facility policy and procedure on Vulnerable Adult Abuse Prevention Plan dated 5/21/12, directed staff to report a suspected incident of abuse/neglect/mistreatment immediately, not to exceed 24 hours. The policy further directed staff to initiate an investigation immediately. The policy later explained that investigation was necessary to determine if the incident should be reported. The policy explained the internal reporting procedure was to be followed to ensure reporting of only those incidents which are required to be reported. The reporting procedure was then defined as immediately making a report to the team leader (TL)/nurse in charge. As soon as possible, but no later than leaving work for the day, the TL was to complete an incident report. The incident report should not only define what happened but also explain the investigation completed, findings and action taken. The TL was to consult the policy and decision tree to determine if a report needed to be made. "Special attention shall be made to the immediately, not to exceed 24-hour time frames, especially on weekends." On 3/4/15, at 10:34 a.m. social worker (SW)-A and the director of nursing (DON) were interviewed. SW-A stated they always investigated alleged incidents of mistreatment/abuse/neglect, and if they are unable to come up with any explanation, they reported it to the SA. However, allegations of abuse/neglect/mistreatment are to be reported immediately and then a thorough investigation is to be conducted. R53 alleged an incident of mistreatment which	22000	property will be made to OHFC and CEP immediately. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. The Administrator will also continue to be notified immediately. All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP. Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 Our Vulnerable Adult (VA) policy and our internal incident report form have been revised and updated. The reporting time frame was redefined to remove within 24 hours and changed to immediately. All alleged reports of mistreatment, neglect, abuse and misappropriation of resident property will be made to OHFC and CEP immediately. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. The Administrator will also continue to be notified immediately. All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP.	

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22000	Continued From page 14 was not reported to the SA immediately. R53 was interviewed on 3/2/15, at 4:17 p.m. and stated one staff member handled him roughly when assisting R53 with cares. R53 described the rough treatment as "jerking" him around in bed. R53 stated he had reported the rough treatment to a staff member, but hadn't heard anything more and the staff member who treated him "roughly" continued to work with him. R53's Admission Record identified diagnoses that included osteoarthritis, congestive heart failure, urinary incontinence and hemiplegia (weakness on one side of the body) due to cerebral vascular accident (CVA). The quarterly Minimum Data Set (MDS) dated 1/20/15, indicated R53 was cognitively intact, and required total assistance of two staff for bed mobility, extensive assistance of two staff for transfers, dressing and toileting, and extensive assistance of one staff for personal hygiene. The facility individual abuse assessment undated, indicated R53 was at low risk of vulnerability by others. On 3/3/15, at 3:45 p.m. SW-A and the DON were informed that R53's complaints of alleged mistreatment were not in the facility log of reported incidents. On 3/4/15, at 10:34 a.m. SW-A and the DON were interviewed. The DON stated they had just investigated R53's complaints of alleged mistreatment, and were not going to report to the SA. SW-A stated they always investigate first, before they report to the SA to assist them in determining if something is reportable. R34 was mistreated by R102 and the allegation	22000	Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 Our Vulnerable Adult (VA) policy and our internal incident report form have been revised and updated. The reporting time frame was redefined to remove within 24 hours and changed to immediately. All alleged reports of mistreatment, neglect, abuse and misappropriation of resident property will be made to OHFC and CEP immediately. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. The Administrator will also continue to be notified immediately. All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP. Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 Our Vulnerable Adult (VA) policy and our internal incident report form have been revised and updated. The reporting time	

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22000	Continued From page 15 was not reported immediately to the SA. R34's arm was grabbed and shaken by R102 on 5/22/14, at 5:15 p.m. Staff witnessed the incident. The facility did not immediately report the alleged incident of mistreatment to the state agency; a report was filed on 5/23/14 (time unknown). The facility's investigation determined R102 often confused female residents as his wife. On 3/4/15, at 10:34 a.m. SW-A stated the facility always investigated before they reported to the SA. R34's Admission Record identified diagnoses that included Alzheimer's disease, chronic pain, and anxiety. The quarterly MDS dated 1/21/15, indicated R34 had short and long term memory problems, and severely impaired cognitive skills for daily decision making (never/rarely made decisions). The MDS further identified R34 as having mood problems of little interest or pleasure in doing things, poor appetite or overeating, and trouble concentrating on things. The MDS identified no behaviors. The facility Individual Abuse Assessment dated 9/21/10, indicated R34 was at high risk of vulnerability by others. R31 sustained 3 injuries of unknown origin which were not reported to the SA immediately, and lacked a thorough investigation to determine if abuse/mistreatment occurred. 1. On 12/8/14, R31 was discovered to have a 6.7 centimeter (cm) by 6 cm bruise of unknown origin on his chest. [An injury of unknown origin is one in which the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one point in time or the incidence of	22000	frame was redefined to remove within 24 hours and changed to immediately. All alleged reports of mistreatment, neglect, abuse and misappropriation of resident property will be made to OHFC and CEP immediately. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. The Administrator will also continue to be notified immediately. All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP. Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 Our Vulnerable Adult (VA) policy and our internal incident report form have been revised and updated. The reporting time frame was redefined to remove within 24 hours and changed to immediately. All alleged reports of mistreatment, neglect, abuse and misappropriation of resident property will be made to OHFC and CEP immediately. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. The Administrator will also continue to be notified immediately.	

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22000	Continued From page 16 injuries over time.] The facility originally did not report the bruise to the SA, however, on 12/10/14, R31's spouse was uncertain if the facility's explanation that R34 bruised himself by clenching his hands/fists near his chest was accurate. The facility then reported the bruise to the SA on 12/10/14 (time unknown). The facility further investigated, and determined the injury could have been done by another resident or staff, could have been self-inflicted, or could have been a result of being resistive to cares. However, the investigation was not thorough enough to rule out possible abuse/mistreatment. 2. On 2/4/15, at 3:15 p.m. R31 was noted to have a 4.2 cm by 3.8 cm bruise of unknown origin on his chest. The facility did not report the bruise to the SA. Although the injury remained an unknown origin, there was no further investigation. 3. On 2/9/15, R31 was noted to have a 2 cm by 2.3 cm bruise of unknown origin on his right jaw. The facility's Resident Fall/Incident Report/Investigtion identified the cause of incident to be: "Resident with strong facial hair growth. question to whether resident's daily shaving may have caused brusing." The report also identified "Resident does use a lidded sippy cup independently at times with meals and may have bumped jaw." The facility did not report the bruise to the state agency, nor was there an investigation. R31's Admission Record identified diagnoses that included dementia. The annual MDS dated 11/26/14, indicated R31 had severe cognitive impairment, and had mood indicators of feeling bad about self or a failure or have let your family down. The MDS further identified R31 required extensive assistance of two staff with bed mobility	22000	All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP. Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 Our Vulnerable Adult (VA) policy and our internal incident report form have been revised and updated. The reporting time frame was redefined to remove within 24 hours and changed to immediately. All alleged reports of mistreatment, neglect, abuse and misappropriation of resident property will be made to OHFC and CEP immediately. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. The Administrator will also continue to be notified immediately. All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP. Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015	

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22000	Continued From page 17 and transfers, extensive assistance of one staff for toileting, and total assistance of one staff for dressing, eating and personal hygiene. The MDS identified no behaviors issues. The facility Individual Abuse Assessment undated, indicated R31 was at moderate risk of vulnerability by others. On 3/04/15, at 10:34 a.m. SW-A and the DON were interviewed. SW-A stated they always investigated alleged incidents of abuse/neglect/mistreatment, and if they are unable to come up with any explanation, they report to the SA. investigated. R7 alleged rough treatment by staff which was not reported to the SA, and lacked a thorough investigation. R7's annual MDS dated 12/4/14, indicated R7 had no cognitive impairments. R7 had no delirium, psychosis, behaviors or rejection of cares. R7 required the extensive assistance of one staff with bed mobility. On 3/3/15, at 10:00 a.m. R7 stated there was one male NA who was rough when he turned her in bed. R7 stated, "He's big and I don't think he's aware he's rough when he moves me." R7 stated she had bruises on her upper inner legs from the NA's hands when he moved her. R7 stated further the NA had been more careful because he did say the bruises matched his hands. R7 had not told anyone. R7 stated, "He's not here very often and I just put up with it. It's just his manner of handling." On 3/3/15, at 3:45 p.m. the DON and the SW-A were informed of R7's allegation of rough treatment. The SW stated she was aware	22000	Our Vulnerable Adult (VA) policy and our internal incident report form have been revised and updated. The reporting time frame was redefined to remove within 24 hours and changed to immediately. All alleged reports of mistreatment, neglect, abuse and misappropriation of resident property will be made to OHFC and CEP immediately. A thorough investigation will be completed as soon as possible and a follow up report will continue to be completed within 5 working days of the incident. The Administrator will also continue to be notified immediately. All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 with an emphasis on immediately reporting to OHFC and CEP. Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015	

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22000	Continued From page 18 because R7 reported it during her care conference on 3/3/15. The facility's Resident Fall/Incident Report/Investigation report completed on 3/4/15, by the DON indicated on 3/3/15, during a care conference R7 reported bruising on her upper legs. The facility's Report of Alleged Incident of Abuse/Neglect completed by the SW indicated R7 reported the incident on 3/3/15, during a care conference at 2:00 p.m. R7 reported she had bruising on her upper legs/thighs. R7 reported a long time ago from a male staff member who "just didn't know his own strength" when handling her. R7 was not upset and indicated things had improved. The report indicated on 3/5/15, a licensed practical nurse (LPN) observed R7's legs and found three old bruises. R7 reported to the LPN that the "big guy with the beard" turns her. The incident report indicated R7 had two light blue discolored areas on the left inner thigh which measured 2.5 by 3 centimeters (cm) and a 1 by 1 cm darker blue area on the left outer thigh. The incident report's investigative findings (cause of the incident) included the bruises on the left thigh were very pale and appeared old. The findings further stated the bruises were "more likely caused by removing incontinent briefs while on the commode or toilet and the bruises on the outer thighs were probably from items in R7's chair" even though R7 was cognitively intact and had reported the bruises were from rough treatment. There was no evidence of any further investigation. The incident report indicated the rough treatment and bruises were not reported to the SA. The incident report's department review	22000		

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22000	Continued From page 19 and interventions discussed dated 3/4/15, indicated R7 bruised easily and had multiple items in the wheelchair. On 3/4/15, at 10:36 a.m. the DON stated the incident report contained all of the information about the "rough treatment." The DON further stated they were not going to report the incident. R3 sustained an injury following an incident where staff did not follow the plan of care. The neglect of care was not reported immediately to the SA, and lacked a thorough investigation. R3 was lowered to the floor during a staff assisted transfer on 10/6/14, at 5:00 a.m. Staff was not transferring R3 as directed by the care plan. The incident was not reported right away by the staff. The incident was reported to the facility by R3 on 10/6/14, at 2:30 p.m. R3's quarterly MDS dated 11/14/14, indicated R3 had short and long term memory problems but was able to recall the season, the location of her room, staff names and faces and that she was in a nursing home. R3 had modified independence with some difficulty in new situations when making decisions. R3 had no behaviors or rejection of cares. R3 needed the extensive assistance of two staff with bed mobility and transfers. R3 was not ambulatory. The Activities of Daily Living (ADL) care plan revised on 8/7/14, directed staff to transfer R3 with the EZ (mechanical) lift and two staff. The facility's Resident Fall/Incident Report/Investigation report completed on 10/6/14, indicated the incident occurred on 10/6/14, at 5:00 a.m. and was not reported until 2:30 p.m. by R3. R3 reported the staff dropped her to the floor while transferring her to the commode. Although	22000		

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22000	Continued From page 20 the care plan directed staff to use an E-Z Lift, staff utilized a pivot transfer without a transfer belt. The incident report's investigative findings included staff was contacted and verified R3 was lowered to the floor while being transferred. R3 lost her footing and was lowered to the floor to avoid injury. On 10/6/14, at 6:30 p.m. a penny size bruise was found on R3's left hand, R3's right wrist had swelling and a bruise on the right forearm which measured five inches by one and a half inches. The incident report's follow up indicated staff was counseled. The incident was reported to the state agency on 10/6/14. However, no further investigation was conducted. R28 alleged mistreatment which was not reported to the SA, and lacked a thorough investigation. R28's MDS dated 11/18/14, indicated R28 had no cognitive impairment and R28 required the extensive assistance of one staff with bed mobility, transfers and toilet use. The facility's Report of Alleged Incident of Abuse/Neglect form dated 1/19/15, at 8:10 a.m. indicated a NA reported another NA unplugged the call light when R28 put the call light on for assistance to use the bathroom. The NA heard R28 calling for help and stated, "he unplugged my call light and said I couldn't use the bathroom." At 8:50 a.m. R28 reported to a registered nurse a "gentleman pulled my call light out of the wall when I needed to go to the bathroom. I want to make sure this does not happen to anyone else." The incident report's follow up at 10:20 a.m. indicated the SW spoke with the NA. The report indicated the NA must have unplugged the call light when he walked out of the room and tripped. The NA informed the SW he had been "behind" and R28 had been using the call light "every 15 to 20 minutes." The NA stated it was not intentional	22000		

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 _____	03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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22000	Continued From page 21 and should have gone back right away and plugged the call light back in. The NA understood call lights should never be unplugged. On 3/4/15, at 10:34 a.m. the DON stated the NA was interviewed and stated he accidentally tripped on the call light. The DON stated she felt the incident did not need to be reported to the state agency. However, the incident was not thoroughly investigated to determine possible neglect of care. R75 sustained an injury as a result of staff not following the plan of care. The neglect of care lacked a thorough investigation, and the investigative report was not reported to the SA timely. R75's MDS dated 10/13/14, indicated she was diagnosed with dementia, orthostatic hypotension,and fracture. The MDS also indicated she required extensive assist with transfers, toileting, locomotion on and off the unit, and occasionally incontinent of bowel and bladder. R75's care plan initiated 9/23/14, indicated R75 had a fall with a resulting left hip fracture. R75's care plan further identified she had impaired physical mobility, requiring assist with transfers, toileting and incontinence cares. Review of an incident report dated 10/14/14, at 2:25 a.m. revealed R75 was found sitting on the floor near her walker (unwitnessed fall). As a result of the fall, R75 received a small cut inside her bottom lip. The incident report indicated, R75's care plan was not being followed, as the fall mat was supposed to be placed near the bed and toileting schedule may also be a factor. The administrator and SA were notified on 10/14/14.	22000		

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22000	Continued From page 22 However, the facility failed to complete a thorough investigation into the possible neglect of care. In addition, the investigation was not reported to the SA until 10/20/14, 7 days after the incident. SUGGESTED METHOD OF CORRECTION: The administrator could develop policies and procedures regarding reporting and investigating all alleged abuse/neglect/mistreatment. The administrator could educate all staff on those policies and procedures. Theadministrator could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	22000		