DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY	ID: 81JF
MEDICARE/MEDICAID PROVIDER NO (L1) 245363 STATE VENDOR OR MEDICAID NO. (L2) 908540800 S. EFFECTIVE DATE CHANGE OF OWN).	 NAME AND ADI (L3) AICOTA HE (L4) 850 SECONI (L5) AITKIN, MN PROVIDER/SUF 	DRESS OF FACILIT ALTH CARE CE D STREET NORT N PPLIER CATEGORY	TY NTER THWEST	(L6) 56431	Facility ID: 00848 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
(L9) 04/17/ 6. DATE OF SURVEY 04/17/ 8. ACCREDITATION STATUS: 0 Unaccredited 0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	75 (L18) 75 (L17)	B. Not in Com	ce With equirements		And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 75 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS See Attached Remarks 17. SURVEYOR SIGNATURE	S (IF APPLICABLE S	HOW LTC CANCELL	LATION DATE):		18. STATE SURVEY AGENCY AF	PROVAL Date:
Teresa Ament, HFE N			04/30/2015	(L19)		, Enforcement Specialist 04/30/2015 (L20)
 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Partian 2. Facility is not Eligible 		20. COM	IPLIANCE WITH C		21. 1. Statement of Finance	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 11/17/1986 (L24)	23. LTC AGREEMI BEGINNING I (L41)		24. LTC AGREEME ENDING DATH (L25)		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension o B. Rescind Susp	of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE:	29	. INTERMEDIARY/C 03001	(L45) ARRIER NO.		30. REMARKS	
31. RO RECEIPT OF CMS-1539		. DETERMINATION (04/29/2015	DF APPROVAL DAT		Posted 05/13/2015 Co	
	(L32)			(L33)	DETERMINATION APPRO	VAL

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 Certification 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 Department of Health - Health Regulation Division • General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us *An equal opportunity employer*



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 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 245363	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/17/2015
Name	of Facility		Street Address, City, State, Zip Code	
AIC	COTA HEALTH CARE CENTER		850 SECOND STREET NORTHWE AITKIN, MN 56431	ST

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	(Y4)	Item		(Y5)	Date	(Y4)	ltem		Y5)	Date
			Correction					Correction					Correction
ID Prefix	F0225		Completed 04/17/2015		ID Prefix	E0226		Completed 04/17/2015		ID Profix			Completed
Keg. # LSC	483.13(c)(1)(ii)-(iii), (c)(2) - (4)			483.13(c)				Reg. # LSC			
										-			
			Correction					Correction					Correction
ID Prefix			Completed		ID Profix			Completed					Completed
Reg. #					Reg. #			-		Reg. #			
LSC					LSC								
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #			-					
LSC													
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
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LSC					LSC					LSC			
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			Correction Completed					Correction Completed					Correction Completed
ID Prefix			eepieted		ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			
Reviewed B	y Review	wed B	у	Da	te:	Signature o	f Surve	yor:				Date:	
State Agenc	у СС	/mn	n	04	/30/20	15		29433				04	/17/2015
Reviewed B	y Review	wed B	у	Da	te:	Signature o	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed on	:					-				Summary of		
	3/5/2015					Unc	orrecte			-2567) Sent to	o the Facility?	YES	NO

Form Approved

OMB NO. 0938-0390



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, 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

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00848	(Y2) Multiple Construction A. Building B. Wing	A. Building	
Name of Facility			Street Address, City, State, Zip Code	
AICOTA HEALTH CARE CENTER			850 SECOND STREET NORTHWE AITKIN, MN 56431	ST

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	5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y:	5) Date
		Correction			Correction			Correction
ID Drefit	04005	Completed	ID Drefit	00000	Completed			Completed
ID Prefix		04/17/2015	ID Prefix		_04/17/2015			
Reg. # LSC	MN St. Statute 626.557 St	ubd. 4	-	MN St. Statute 626.557 Su		Reg. #		
L3C		_	LOU		-			
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix			ID Prefix			ID Prefix		
Reg. #			Reg. #			Reg. #		
LSC		_	LSC		-	LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #			Reg. #			Reg. #		
		_			-	-		
		_			-			
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix		_	ID Prefix		_	ID Prefix		
Reg. #		_	Reg. #		_	Reg. #		
LSC		_	LSC		-	LSC		
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix			ID Prefix			ID Prefix		
Reg. #			Reg. #			Reg. #		
LSC		_	LSC		-	LSC		
Reviewed By	Reviewed	By	Date:	Signature of Surve				Date:
-		•	04/30/201	-	29433			04/17/2015
State Agency Reviewed By			Date:	Signature of Surve				04/1//2015
CMS RO		5,	Date.	Signature of Surve	.,			uto.
	Survey Completed on:							
	3/5/2015			-		Deficiencies. Was (CMS-2567) Sent 1		YES NO
STATE FORM	I: REVISIT REPORT ((5/99)		Page 1 of 1			Event ID: 81.	JF12

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY	ID: 81JF
 MEDICARE/MEDICAID PROVIDER NO. (L1) 245363 2.STATE VENDOR OR MEDICAID NO. (L2) 908540800 5. EFFECTIVE DATE CHANGE OF OWN).	 NAME AND ADI (L3) AICOTA HE (L4) 850 SECONI (L5) AITKIN, MN PROVIDER/SUF 	DRESS OF FACILI ALTH CARE CE D STREET NORT N PPLIER CATEGOR	TY ENTER FHWEST	(L6) 56431	Facility ID: 00848 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
(L9) 03/05/ 6. DATE OF SURVEY 03/05/ 8. ACCREDITATION STATUS: 0 Unaccredited 0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
 II. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 	75 (L18) 75 (L17)	X B. Not in Com	ce With equirements	1	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B * 15. FACILITY MEETS	6. Scope of Services Limit 7. Medical Director
18 SNF 18/19 SNF 75 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)
 16. STATE SURVEY AGENCY REMARKS See Attached Remarks 17. SURVEYOR SIGNATURE 	``````````````````````````````````````	HOW LTC CANCELL	ATION DATE):		18. STATE SURVEY AGENCY API	
Teresa Ament, HFE N			04/02/2015	(L19) EGIONAI	Mark Meeth,	(L20)
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Parti 2. Facility is not Eligible 	cipate (L21)		IPLIANCE WITH C HTS ACT:	CIVIL		ial Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 11/17/1986 (L24)	23. LTC AGREEMI BEGINNING I (L41)		24. LTC AGREEME ENDING DATI (L25)		26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemer	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE A. Suspension of	of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
	B. Rescind Sus		(L45)			
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C 03001	ARRIER NO.	(L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION (DF APPROVAL DA	TE (L33)	DETERMINATION APPRO	VAL

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.



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;

<u>Appeal Rights</u> - the facility rights to appeal imposed remedies;

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

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

<u>Informal Dispute Resolution</u> - 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:

Aicota Health Care Center March 20, 2015 Page 3

• 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. <u>If you have not already provided the</u> <u>following information, you are required to provide to this agency within ten working days of</u> <u>your receipt of this letter the name and address of the attending physician of each resident found</u> <u>to have received substandard quality of care.</u>

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.

Aicota Health Care Center March 20, 2015 Page 4

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 Aicota Health Care Center March 20, 2015 Page 6

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:

Aicota Health Care Center March 20, 2015 Page 7

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

5363s15

		AND HUMAN SERVICES			FORM	04/06/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		E SURVEY IPLETED
		245363	B. WING _		03/	05/2015
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
AICOTA	HEALTH CARE CENT	ER		850 SECOND STREET NORTHWEST AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	тѕ	F 00	00		
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will tion of compliance.				
	on-site revisit of yo validate that substa	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with				
	An extended surve Minnesota Departn 3/4/15-3/5/15.	y was conducted by the nent of Health on				
F 225 SS=E	483.13(c)(1)(ii)-(iii) INVESTIGATE/RE ALLEGATIONS/IN	PORT	F 2:	25		4/14/15
	been found guilty of mistreating resider had a finding enter registry concerning of residents or mis and report any kno court of law agains indicate unfitness f other facility staff to or licensing author					
	involving mistreatn including injuries o	nsure that all alleged violations nent, neglect, or abuse, f unknown source and f resident property are reported				
	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 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.

		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE	0938-0391 SURVEY PLETED
		245363	B. WING			03/0)5/2015
NAME OF I	PROVIDER OR SUPPLIER	L	L	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/0	
AICOTA	HEALTH CARE CENT	ER			0 SECOND STREET NORTHWEST TKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	to other officials in a through established State survey and co The facility must haviolations are thoro prevent further pote investigation is in p The results of all in to the administrator representative and with State law (inclu- certification agency incident, and if the	administrator of the facility and accordance with State law d procedures (including to the ertification agency). ave evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported	F 2	25			
FORM CMS-2	by: Based on interview facility failed to imm allegations of abus State Agency (SA) allegations for 7 of R7, R3, R28, R75) allegations of mistr Findings include: R53 alleged an inc was not reported to R53 was interview stated one staff me when assisting R53 the rough treatment	ident of mistreatment which o the SA immediately. ed on 3/2/15, at 4:17 p.m. and ember handled him roughly 3 with cares. R53 described at as "jerking" him around in e had reported the rough		Fac	F 225 The facility will ensure that all alleg violations involving mistreatment, r or abuse, including injuries of unkr source and misappropriation of resident⊡s property are reported immediately to the administrator of facility and other officials in accord with state law. On 3/3/15 R 53 reported to the sta surveyors that a staff member han him roughly when assisting with ca That afternoon, R 53 was interview the DON and Social worker and he that he hurts when he is gotten up bed in am. He was unable to give	te deled ares. ved by e stated /out of a	t Page 2 of 25

Facility ID: 00848

If continuation sheet Page 2 of 25

PRINTED: 04/06/2015

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT			MB NO. (X3) DATE	
	F CORRECTION	IDENTIFICATION NUMBER:	• •				PLETED
		245363	B. WING			03/0	5/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH CARE CENT	ER			0 SECOND STREET NORTHWEST ITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	age 2	F 2	25			
	anything more and him "roughly" conti R53's Admission R included osteoarth urinary incontinence on one side of the accident (CVA). Th (MDS) dated 1/20/ cognitively intact, a two staff for bed m two staff for bed m two staff for transfe extensive assistan hygiene. The facility individu indicated R53 was others. On 3/3/15, at 3:45 informed that R53' mistreatment were reported incidents. On 3/4/15, at 10:3- were interviewed.	 member, but hadn't heard the staff member who treated nued to work with him. tecord identified diagnoses that ritis, congestive heart failure, se and hemiplegia (weakness body) due to cerebral vascular the quarterly Minimum Data Set 15, indicated R53 was and required total assistance of obility, extensive assistance of obility, extensive assistance of ers, dressing and toileting, and ce of one staff for personal ual abuse assessment undated, at low risk of vulnerability by p.m. SW-A and the DON were s complaints of alleged e not in the facility log of 4 a.m. SW-A and the DON The DON stated they had just complaints of alleged 			specific name of staff. This alleged mistreatment was reported to OHF Aitkin County/Common Entry Point on 3/4/15. R 53 had previously talk the Social worker on 3/2/15 and sta that a staff is on a new kick stating should have larger pants. R 53 sta he preferred to lose some weight a has a closet full of clothes. He did mention being treated roughly at a during the discussion on 3/2/15. Staff was reminded to report to the leader when a resident experience pain/discomfort during transfers. R diagnosis of chronic pain related to osteoarthritis. R53 prefers to slee right side and he declines to be repositioned during night. He recei Tylenol TID and his first dose of Ty offered one hour prior to getting up morning. Going forward, a more thorough investigation will occur to include conducting interviews with other re cared for by the alleged NA as well conducting interviews with staff that	C and t (CEP) ated to ated he ted that as he not ny time team as any as any as as any as as any as as any as any as as as as any as as any as as as any as as as as as as	
	mistreatment, and SA. SW-A stated t before they report determining if som R34 was mistreate was not reported i R34's arm was gra	were not going to report to the hey always investigate first, to the SA to assist them in hething is reportable. ad by R102 and the allegation mmediately to the SA. abbed and shaken by R102 on m. Staff witnessed the incident.			with the alleged NA. Aicota □s Vulnerable Adult (VA) pc revised and updated with an emph immediately reporting to OHFC ar All staff will be in-serviced by revie our updated VA policy by April 14, with an emphasis on immediately	olicy was nasis on nd CEP. ewing	

Facility ID: 00848

If continuation sheet Page 3 of 25

		AND HUMAN SERVICES			F	ORM A	04/06/2015 PPROVED 0938-0391
STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3		SURVEY LETED
		245363	B. WING			03/0	5/2015
NAME OF PROVIDER OR S	UPPLIER	• • • • • • • • • • • • • • • • • • •		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AICOTA HEALTH CAR	RE CENT	ER			50 SECOND STREET NORTHWEST ITKIN, MN 56431		
PREFIX (EACH DI	EFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
facility's inv confused fe at 10:34 a.r investigated R34's Admi included Alz anxiety. The indicated R problems, a for daily ded decisions). having moo pleasure in overeating, The MDS io The facility 9/21/10, inc vulnerability R31 sustair were not re lacked a the abuse/mistr 1. On 12/8/ centimeter on his chess in which the by any pers not be expla- suspicious the location observed a injuries ove	filed on estigation estigation emale re- m. SW-A d before ssion R- zheimer e quarte 34 had sevent cision m The MD od proble doing th and sevent cision m The MD doing th and tro- doing tro- doing th and tro- doing	5/23/14 (time unknown). The on determined R102 often esidents as his wife. On 3/4/15, A stated the facility always a they reported to the SA. ecord identified diagnoses that is disease, chronic pain, and erly MDS dated 1/21/15, short and long term memory erely impaired cognitive skills haking (never/rarely made DS further identified R34 as ems of little interest or hings, poor appetite or uble concentrating on things. no behaviors. al Abuse Assessment dated R34 was at high risk of ers. uries of unknown origin which o the SA immediately, and nvestigation to determine if t occurred. was discovered to have a 6.7 6 cm bruise of unknown origin is one of the injury was not observed e source of the injury could of the resident; and the injury is e of the extent of the injury or njury or the number of injuries int in time or the incidence of The facility originally did not the SA, however, on 12/10/14,	F2	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 we 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 visio was ambulatory and was often looking his wife. He was kind, easily redirecte and did not mean any harm. The incide was reported to the OHFC and CEP of 5/23/14 even though R 34 did not app in any distress over the incident. Staff was reminded to do an initial rep immediately to OHFC and CEP. A fol up report will continue to be complete 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 reviewin our updated VA policy by April 14, 201 with an emphasis on immediately reporting to OHFC and CEP. 	h vill be d d on, g for ed dent on bear boort llow ed	

Facility ID: 00848

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO.	0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMF	SURVEY
		245363	B. WING			03/0	5/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
AICOTA	HEALTH CARE CENT	ER			50 SECOND STREET NORTHWEST ITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 225	his hands/fists nea facility then reporte 12/10/14 (time unk investigated, and d have been done by could have been so a result of being re- investigation was r possible abuse/mis 2. On 2/4/15, at 3: a 4.2 cm by 3.8 cm his chest. The facilithe SA. Although th origin, there was n 3. On 2/9/15, R31 2.3 cm bruise of un The facility's Resid Report/Investigition incident to be: "Re growth. question t shaving may have also identified "Re- cup independently have bumped jaw. bruise to the state investigation. R31's Admission F	r his chest was accurate. The ed the bruise to the SA on mown). The facility further letermined the injury could y another resident or staff, elf-inflicted, or could have been esistive to cares. However, the not thorough enough to rule out streatment. 15 p.m. R31 was noted to have n bruise of unknown origin on lity did not report the bruise to he injury remained an unknown o further investigation. was noted to have a 2 cm by nknown origin on his right jaw.		225	Social worker or designee will conc audits of incident reports to ensure immediate reporting and that thoro investigations occurred. VA reports monitored to ensure that we are in compliance with State regulations a report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 31 sustained three bruises of un origin, two bruises on his chest and on his chin. Social worker and Res Care Coordinator (RCC) interviewe R 31 swife and daughter and felt there was sufficient reasoning for t bruising related to R 31 sresistive rigidity, clenching fists and holding his chest, hanging onto items durin transfers and his skin bruising eas nursing staff who have been caring recently for R 31 were interviewed care plan was followed and bruisin be self- inflicted. All unexplained bruising/bruise of unknown origin will be reported immediately to OHFC and CEP. A thorough investigation will be comp as soon as possible and a follow u	ugh s will be and known d one ident ed R 31, that he eness, against ng ily. All g could	
	impairment, and h bad about self or a down. The MDS f extensive assistan and transfers, exte for toileting, and to	d R31 had severe cognitive ad mood indicators of feeling a failure or have let your family further identified R31 required note of two staff with bed mobility ensive assistance of one staff otal assistance of one staff for nd personal hygiene. The MDS			 will continue to be completed withi working days of the incident. Aicota s VA policy was revised an updated with an emphasis on imm reporting to OHFC and CEP. All staff will be in serviced by revie 	id iediately	

Facility ID: 00848

If continuation sheet Page 5 of 25

					FORMA	04/06/2015 APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
	245363	B. WING			03/0	5/2015
PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HEALTH CARE CENT	ER					
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
	-	F 2	225		F	
The facility Individu undated, indicated	al Abuse Assessment R31 was at moderate risk of			an emphasis on immediate reportin bruising of an unknown origin to OF and CEP.	g of IFC	
were interviewed. S investigated alleged abuse/neglect/mist unable to come up	SW-A stated they always d incidents of reatment, and if they are with any explanation, they			audits of incident reports to ensure immediate reporting and that thorou investigations occurred. VA reports monitored to ensure that we are in	ugh will be	
not reported to the investigation. R7's annual MDS d had no cognitive im delirium, psychosis cares. R7 required	SA, and lacked a thorough lated 12/4/14, indicated R7 pairments. R7 had no , behaviors or rejection of the extensive assistance of			the interdisciplinary team on 3/3/15 her care conference. She stated sh treated rough by a big guy NA, while was turned/repositioned. DON atter	during e was e she mpted	
male NA who was r bed. R7 stated, "He aware he's rough w she had bruises on NA's hands when h further the NA had did say the bruises not told anyone. R7 often and I just put of handling." On 3/3/15, at 3:45 p were informed of R treatment. The SW because R7 reported	rough when he turned her in a's big and I don't think he's when he moves me." R7 stated her upper inner legs from the ne moved her. R7 stated been more careful because he matched his hands. R7 had 7 stated, "He's not here very up with it. It's just his manner p.m. the DON and the SW-A 7's allegation of rough 5 stated she was aware ed it during her care			afternoon, but R 7 had a visitor, tha participated in activities and decline having skin assessment completed these times. At HS, the LPN on dut checked R 7 s skin and found a fa bruise on the inside of her left thigh small round newer looking bruise w noticed on the left outer thigh. Due 7 s request to have her bed position her right side against the wall (as it more comfortable and feels safe for R 7 is always turned towards her left and assisted by staff using a turning sheet. The big guy NA was interview Social worker and DON. He stated	n at y ding and a vas to R on with is r her), ft side g wed by I that	
	RS FOR MEDICARE OF DEFICIENCIES DF CORRECTION PROVIDER OR SUPPLIER HEALTH CARE CENT SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From paritic identified no behavit The facility Individu undated, indicated vulnerability by other On 3/04/15, at 10:3 were interviewed. Sinvestigated alleged abuse/neglect/mistin unable to come up report to the SA. inter- R7 alleged rough tr not reported to the investigation. R7's annual MDS of had no cognitive im delirium, psychosis cares. R7 required one staff with bed r On 3/3/15, at 10:00 male NA who was re bed. R7 stated, "He aware he's rough w she had bruises on NA's hands when he further the NA had did say the bruises not told anyone. R7 often and I just put of handling." On 3/3/15, at 3:45 p were informed of R treatment. 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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	RS FOR MEDICARE & MEDICAID SERVICES rof DEFICIENCIES PCORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245363 B. WING PROVIDER OR SUPPLIER HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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It's just his manner of	RS FOR MEDICARE & MEDICAID SERVICES COF DEFICIENCIES COT DEFICIENCIES CALL PROVIDER OR SUPPLIER HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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WING (X3) MUTTIPLE REALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE S50 SECOND STREET NORTHWEST ATTKIN, NN 56431 037 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (ACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY ON LSC DENTFINING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION POLD BE (EACH CORRECTIVE ACTION POLD DE (EACH CO

Facility ID: 00848

		& MEDICAID SERVICES				MB NO.		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY	
		245363	B. WING			03/0	5/2015	
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
AICOTA I	HEALTH CARE CENT	ER			0 SECOND STREET NORTHWEST TKIN, MN 56431			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 225	Continued From pa	age 6	F2	225				
	by the DON indicat conference R7 reprilegs. The facility's Report Abuse/Neglect con R7 reported the indi- conference at 2:00 bruising on her upp long time ago from didn't know his own R7 was not upset a improved. The reprilicensed practical r legs and found thread the LPN that the "b her. The incident report blue discolored aread measured 2.5 by 3 cm darker blue aread incident report's in the incident) includ were very pale and further stated the b caused by removing the commode or to	ent Fall/Incident n report completed on 3/4/15, ed on 3/3/15, during a care orted bruising on her upper rt of Alleged Incident of npleted by the SW indicated cident on 3/3/15, during a care p.m. R7 reported she had ber legs/thighs. R7 reported a a male staff member who "just n strength" when handling her. and indicated things had ort indicated on 3/5/15, a nurse (LPN) observed R7's ee old bruises. R7 reported to big guy with the beard" turns t indicated R7 had two light eas on the left inner thigh which centimeters (cm) and a 1 by 1 ea on the left outer thigh. The vestigative findings (cause of led the bruises on the left thigh d appeared old. The findings pruises were "more likely ng incontinent briefs while on bilet and the bruises on the probably from items in R7's			 Staff would not hold onto left inner while turning R 7 for cares. Reside to have multiple items on the insid wheel chair and recliner. She brui easily related to monoclonal gamm During interview with R 7, she indit that she has not been hurt by the has no problem with that NA conticare for her. An incident report was filed and reto 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 com as soon as possible and a follow will continue to be completed with working days of the incident. Goin forward, a more thorough investig occur to include conducting interviews with staff that work with alleged NA. Aicota S VA policy was revised a updated with an emphasis on imminetation of the incident. Ali staff will be in serviced by revised 	ent likes e of her ses nopathy. cated NA and nuing to ported pleted up report in 5 9 ation will iews he n the nd nediately		
	had reported the b treatment. There v investigation. The rough treatment as	n R7 was cognitively intact and pruises were from rough vas no evidence of any further incident report indicated the nd bruises were not reported to ent report's department review			our updated VA policy by April 14, emphasis on immediate reporting bruising with unknown origin. DON or designee will complete N observations of ADLs to ensure th) of A		

	OF DEFICIENCIES	E & MEDICAID SERVICES			OMB NO.	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED	
		245363	B. WING		03/0)5/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AICOTA	HEALTH CARE CEN	TER		850 SECOND STREET NORTHWEST AITKIN, MN 56431			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE OPRIATE	COMPLETIO DATE	
F 225	Continued From pa	age 7	F 225	5			
		ed easily and had multiple					
	items in the wheel			Social worker or designee will co	onduct		
				audits of incident reports to ensu			
		6 a.m. the DON stated the tained all of the information		immediate reporting and that the			
		eatment." The DON further		investigations occurred. VA reprint monitored to ensure that we are			
		ot going to report the incident.		compliance with State regulation			
	,	5 5 1		report unusual findings to the Q			
		jury following an incident		committee quarterly.			
		follow the plan of care. The					
		s not reported immediately to		Completion Date: April 14, 2015			
		l a thorough investigation. the floor during a staff		R 3 was transferred by two nurs	ina		
		n 10/6/14, at 5:00 a.m. Staff		assistants at 05:00 on 10/6/14 fi			
		g R3 as directed by the care		to commode without using a trai			
		was not reported right away by		The resident lost her footing and	l was		
		ent was reported to the facility		eased to the floor to avoid injury			
	by R3 on 10/6/14,	at 2:30 p.m.		incident was reported by the res			
	R3's quarterly MD9	S dated 11/14/14, indicated R3		during the day at 14:30. An initia was made online to OHFC and			
		term memory problems but		10/6/14. Calls were made to the			
		the season, the location of her		nursing assistants to conduct fu			
	room, staff names	and faces and that she was in		investigation and both verified th			
		3 had modified independence		resident was transferred without			
		/ in new situations when		belt and lowered to floor when s			
		R3 had no behaviors or R3 needed the extensive		footing to avoid injury/prevent fa	11.		
		staff with bed mobility and		Both nursing assistants (NA) we	aro fairly		
		not ambulatory. The Activities		new in their positions. The NA			
	of Daily Living (AD	L) care plan revised on 8/7/14,		educated on the importance of f			
		insfer R3 with the EZ		resident⊡s plan of care and usir			
	(mechanical) lift ar	nd two staff.		transfer belt while transferring re			
	The facility's Pacid	lant Fall/Incident		They were also educated on the			
	The facility's Resid	ient Fail/Incident on report completed on 10/6/14,		of falls/incidents and the importation immediately reporting incidents			
		ent occurred on 10/6/14, at		nurse in charge.			
		not reported until 2:30 p.m. by					
	R3. R3 reported th	e staff dropped her to the floor		Going forward, a more thorough	Ì		
	while transferring h	ner to the commode. Although		investigation will occur to include			

	OF DEFICIENCIES	E & MEDICAID SERVICES	(Y2) MULT			(3) DATE	0938-039 SUBVEY
	F CORRECTION	IDENTIFICATION NUMBER:					LETED
		245363	B. WING _			03/0	5/2015
AME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH CARE CEN	TER		85 Al			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 225	Continued From p	age 8	F 2:	25			
F 223	the care plan direct staff utilized a pivot belt. The incident included staff was lowered to the flood lost her footing and avoid injury. On 10 size bruise was for right wrist had swee forearm which me half inches. The in- indicated staff was reported to the sta However, no further R28 alleged mistra- to the SA, and lac R28's MDS dated cognitive impairme- extensive assistant mobility, transfers The facility's Repor Abuse/Neglect for indicated a NA rep the call light when	ted staff to use an E-Z Lift, of transfer without a transfer report's investigative findings contacted and verified R3 was or while being transferred. R3 d was lowered to the floor to D/6/14, at 6:30 p.m. a penny und on R3's left hand, R3's elling and a bruise on the right asured five inches by one and a neident report's follow up is counseled. The incident was ate agency on 10/6/14. er investigation was conducted. eatment which was not reported ked a thorough investigation. 11/18/14, indicated R28 had no ent and R28 required the nce of one staff with bed		25	 conducting interviews with other resident cared for by the alleged NAs as well conducting interviews with staff that with the alleged NAs to ensure that of plans are followed. Aicota S VA policy was revised and updated with an emphasis on immediated vA policy and the internation incident report form by April 14, 2015 an emphasis on immediately reporting OHFC and CEP and the importance following a resident scare plan. DON or designee will monitor/completed and that resident care plaare followed. Social worker or designee will conducated with an emports to ensure immediate reporting and that thorout investigations occurred. VA reports 	as work care diately ing al 5 with ng to of lete her are ans uct gh	
	R28 calling for he call light and said 8:50 a.m. R28 rep "gentleman pulled when I needed to make sure this do The incident repo indicated the SW indicated the NA r light when he wall	Ip and stated, "he unplugged my I couldn't use the bathroom." At ported to a registered nurse a I my call light out of the wall go to the bathroom. I want to bes not happen to anyone else." rt's follow up at 10:20 a.m. spoke with the NA. The report must have unplugged the call ked out of the room and tripped. the SW he had been "behind"			 monitored to ensure that we are in compliance with State regulations ar 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 pro the assistance he unplugged my call 	nd is wided	

Facility ID: 00848

		HAND HUMAN SERVICES E & MEDICAID SERVICES			FORM / OMB NO.	APPROVE 0938-039
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245363	B. WING		03/0)5/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
AICOTA	HEALTH CARE CEN	TER		850 SECOND STREET NORTHWEST AITKIN, MN 56431		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	PECTION	(XE)
PREFIX TAG	(EACH DEFICIENC	SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 225	Continued From p	age 9	F 225	5		
	20 minutes." The I and should have g plugged the call lig	NA stated it was not intentional one back right away and one back in. The NA understood over be unplugged.		the Resident Care Coordinat 08:50 after the resident was RCC went to discuss the rep with R 28. R 28 stated that a	toileted, the orted incident gentleman	
	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.			pulled my call light out of the internal incident report was fi was interviewed. He stated th have tripped on the cord whe 28 s room. He stated that un call light was not intentional. needs were met, she was no and no mental anguish was r	led. The NA nat he must en leaving R nplugging the R 28⊡s t distressed	
	following the plan lacked a thorough	injury as a result of staff not of care. The neglect of care investigation, and the 't was not reported to the SA		was assisted to toilet (able to during day) and it was not re OHFC and CEP. A call light r ran for the wing that caregive to ensure that other residents cords were not unplugged.	o toilet self ported to report was er worked on	
	timely. R75's MDS dated diagnosed with de hypotension, and fi indicated she requ transfers, toileting	10/13/14, indicated she was mentia, orthostatic racture. The MDS also ired extensive assist with , locomotion on and off the unit, ncontinent of bowel and		Through the investigation of was determined that a call lig turned off, even if it is discon the wall outlet. The call light since been reprogrammed so light cannot be turned off or disconnected from wall in a r room. If a call light is unplug wall, it will now activate the c	yht can be nected from system has o that a call silenced when esident⊡s ged from the	
	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.			Staff was counseled/educate feel they may have tripped o to make sure to go back imn check to ensure nothing has disconnected and that every	ed that if they n something, nediately and been	
	2:25 a.m. revealed floor near her walk result of the fall, R	lent report dated 10/14/14, at d R75 was found sitting on the ker (unwitnessed fall). As a t75 received a small cut inside		place and safe for the reside report will be filed immediate reports that staff unplugged	nt. Initial Iy if resident call light.	
	her bottom lip. The	e incident report indicated,		An immediate report will be r	nade to	

		AND HUMAN SERVICES				FORMA	04/06/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245363	B. WING			03/0	5/2015
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
ΑΙCOTA	HEALTH CARE CENT	ER			50 SECOND STREET NORTHWEST ITKIN, MN 56431		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	fall mat was support and toileting sched administrator and S However, the facilit investigation into the addition, the invest	age 10 s not being followed, as the sed to be placed near the bed ule may also be a factor. The SA were notified on 10/14/14. y failed to complete a thorough he possible neglect of care. In igation was not reported to the 7 days after the incident.	F	225	 OHFC and CEP if a resident has a of neglect. A thorough investigation completed as soon as possible and follow up report will continue to be completed within 5 working days of incident. Going forward, a more thinvestigation will occur to include conducting interviews with other rescared for by the alleged NA as well conducting interviews with staff that with the alleged NA. Aicota□s VA policy was revised and updated with an emphasis on immereporting to OHFC and CEP. All staff will be in-serviced by review our updated VA policy and the interincident report form by April 14, 20 an emphasis on immediately report OHFC and CEP. Social worker or designee will concaudits of incident reports to ensure immediate reporting and that thoro investigations occurred. VA reports monitored to ensure that we are in compliance with State regulations areport unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 75 was admitted on 9/16/14 for sterm rehab after a fall at home results of incident a fall at home results of cVA and dementia. R 75 had a lof being more restless on afternoor of the point of the point. 	will be l a the borough sidents as t work d ediately wing nal 15 with ting to duct ugh s will be and short ulting in ncluded istory history	

Event ID: 81JF11

Facility ID: 00848

If continuation sheet Page 11 of 25

		AND HUMAN SERVICES			FORM	04/06/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	
		245363	B. WING	·	03/0	5/2015
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, ST	ATE, ZIP CODE	
	HEALTH CARE CENT	FR		850 SECOND STREET NO	RTHWEST	
AIGOIA				AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 225	Continued From pa	age 11	F	 225 nights. She got up a poorly possibly related talking to husband in not unusual for her. R 75 was found in the bed, sitting on fasmall cut inside her bed, sitting on faster viewed and the assisted R 75 to bar prior to fall stated the forgotten to place the following the plan corresident. Staff was reminded immediately to OHI incident with injury was not followed. A continue to be come days of the incident more thorough invesion include conducting that work with the at that care plans are Aicota S VA policy updated with an error and so the source of th	at night and slept ted to dementia. When he stated that this was . On 10/14/14 at 02:25 her room, across from loor and had sustained er bottom lip. The floor t of bed on floor an of care. An internal t was filed. The caring for R 75 were e nursing assistant who athroom several times hat she must have he mat after she went rlier that night. R 75 home on 10/28/14. Working that night were d on the importance of of care for each d to do an initial report FC and CEP for any where the plan of care A follow up report will pleted within 5 working t. Going forward, a estigation will occur to interviews with other by the alleged NAs as interviews with staff alleged NAs to ensure followed.	
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID:81J		reporting to OHFC	and CEP. If continuation sheet	Page 12 of 25

TATEMENT	OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
			N	NG		
		245363	B. WING		03/0)5/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AICOTA	HEALTH CARE CEN	ſER		850 SECOND STREET NORTHWEST AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETIO DATE
F 225	Continued From p	age 12	F 22	25		
				All staff will be in-serviced by reviour updated VA policy by April 14, with an emphasis on immediately reporting to OHFC and CEP and importance of following a resident plan.	2015 the	
				DON or designee will monitor/cor NA observations to ensure that re care plans are followed.		
				Social worker or designee will con audits of incident reports to ensur immediate reporting and that thor investigations occurred. VA repor monitored to ensure that we are i compliance with State regulations report unusual findings to the QA committee quarterly.	e ough rts will be n and	
F 226 SS=F	483.13(c) DEVEL ABUSE/NEGLEC	OP/IMPLMENT T, ETC POLICIES	F 2	Completion Date: April 14, 2015		4/14/15
	policies and proce mistreatment, neg	evelop and implement written dures that prohibit lect, and abuse of residents ion of resident property.				
	by: Based on intervie facility failed to de prohibition policy v	ENT is not met as evidenced w and document review, the velop and implement an abuse which required immediate State Agency (SA) allegations		F 226 Aicota Health Care Center (Aicot have a policy and procedure that		

Facility ID: 00848

If continuation sheet Page 13 of 25

		AND HUMAN SERVICES				FORM	04/06/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245363	B. WING			03/0)5/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AICOTA I	HEALTH CARE CENT	ER			50 SECOND STREET NORTHWEST NTKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	of abuse/neglect/m investigations. The allegations of timely conduct thorough in residents (R53, R3 reviewed for potent abuse/neglect/mist the potential to affet the facility. Findings include: The facility policy a Adult Abuse Preven directed staff to rep abuse/neglect/mist exceed 24 hours. T to initiate an invest later explained that to determine if the The policy explained procedure was to b of only those incide reported. The repo defined as immedia team leader (TL)/n possible, but no lat day, the TL was to The incident report happened but also completed, findings to consult the polic determine if a repo attention shall be n exceed 24-hour tim weekends."	istreatment prior to conducting facility failed to report y to the SA and/or failed to nvestigations for 7 of 10 4, R31, R7, R3, R28, R75)		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 hand him roughly when assisting with car That afternoon, R 53 was interviewed the DON and Social worker and he that he hurts when he is gotten up/o bed in am. He was unable to give a specific name of staff. This alleged mistreatment was reported to OHFO Aitkin County/Common Entry Point on 3/4/15. R 53 had previously talket the Social worker on 3/2/15 and sta that a staff is on a new kick stating I should have larger pants. R 53 state he preferred to lose some weight as has a closet full of clothes. He did n mention being treated roughly at an during the discussion on 3/2/15. Staff was reminded to report to the leader when a resident experiences pain/discomfort during transfers. R5 diagnosis of chronic pain related to osteoarthritis. R53 prefers to sleep right side and he declines to be repositioned during night. He receiv Tylenol TID and his first dose of Tyle offered one hour prior to getting up morning. Our Vulnerable Adult (VA) policy an internal incident report form have be revised and updated. The reporting frame was redefined to remove with	e lled res. ed by stated out of C and (CEP) ed to ted he ed that s he not ty time team s any 53 has on his ves enol is in the d our een time	
		nursing (DON) were			hours and changed to immediately.	All	

Facility ID: 00848

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
		245363	B. WING			03/0	5/2015
	PROVIDER OR SUPPLIER	240000		STE	REET ADDRESS, CITY, STATE, ZIP CODE	00/0	572015
	HEALTH CARE CENT	ER	850 SECOND STREET NORTHWEST AITKIN, MN 56431				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	 interviewed. SW-A investigated alleger mistreatment/abus unable to come up reported it to the SJ abuse/neglect/mist immediately and th to be conducted. R53 alleged an inc was not reported to R53 was interviewed stated one staff me when assisting R53 the rough treatment bed. R53 stated he treatment to a staff anything more and him "roughly" contit R53's Admission F included osteoarth urinary incontinent on one side of the accident (CVA). Th (MDS) dated 1/20/ cognitively intact, at two staff for bed m two staff for bed m two staff for bed m two staff for transfe extensive assistant hygiene. The facility individe indicated R53 was others. On 3/3/15, at 3:45 informed that R53 	stated they always	F 22	26	alleged reports of mistreatment, ne abuse and misappropriation of res property will be made to OHFC and immediately. A thorough investigat be completed as soon as possible follow up report will continue to be completed within 5 working days o incident. The Administrator will also continue to be notified immediately All staff will be in-serviced by revie our updated VA policy by April 14, with an emphasis on immediately reporting to OHFC and CEP and to residents gently. DON or designee will complete NA observations of ADLs to ensure the residents are treated gently. Social worker or designee will con audits of incident reports to ensure immediate reporting and that thoro investigations occurred. VA report monitored to ensure that we are in compliance with State regulations report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 R 34□s arm was shaken by R 102 5/22/14 at 17:15. R 102 had poor was ambulatory and was often loof his wife. He was kind, easily redire and did not mean any harm. The was reported to the OHFC and CI 5/23/14 even though R 34 did not in any distress over the incident.	ident d CEP ion will and a f the o /. wing 2015 reating A at duct e bugh ts will be and 2 on vision, oking for ected incident EP on	

Facility ID: 00848

If continuation sheet Page 15 of 25

CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO.	APPROVE 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		245363	B. WING		03/0	05/2015	
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>	STREET ADDRESS, CITY, STATE, ZIP CODE				
	HEALTH CARE CEN	TED	;	850 SECOND STREET NORTHWEST			
AICOTA	REALTH CARE CEN	IER		AITKIN, MN 56431			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)		COMPLETIO DATE	
F 226	Continued From p	age 15	F 226	3			
	reported incidents						
	0.0445			Staff was reminded to do an ini			
	On 3/4/15, at 10:3	4 a.m. SW-A and the DON The DON stated they had just		immediately to OHFC and CEP			
		complaints of alleged		up report will continue to be cor within 5 working days of the inc			
		were not going to report to the		within 5 working days of the me	ident.		
		hey always investigate first,		Our Vulnerable Adult (VA) polic	y and our		
		to the SA to assist them in		internal incident report form have			
	determining if som	ething is reportable.		revised and updated. The report			
	R34 was mistreate	ed by R102 and the allegation		frame was redefined to remove hours and changed to immedia			
	was not reported i	mmediately to the SA.		alleged reports of mistreatment			
	R34's arm was grabbed and shaken by			abuse and misappropriation of			
		m. Staff witnessed the incident.		property will be made to OHFC	and CEP		
		immediately report the alleged		immediately. A thorough investi			
		itment to the state agency; a 1 5/23/14 (time unknown). The		be completed as soon as possi follow up report will continue to			
		ion determined R102 often		completed within 5 working day			
		esidents as his wife. On 3/4/15,		incident. The Administrator will			
	at 10:34 a.m. SW-	A stated the facility always reported to the SA.		continue to be notified immedia	itely.		
	_			All staff will be in-serviced by re			
		Record identified diagnoses that		our updated VA policy by April 1			
		r's disease, chronic pain, and		with an emphasis on immediate	ely		
		erly MDS dated 1/21/15, short and long term memory		reporting to OHFC and CEP.			
		verely impaired cognitive skills		Social worker or designee will o	conduct		
		making (never/rarely made		audits of incident reports to ens			
		DS further identified R34 as		immediate reporting and that th	orough		
		lems of little interest or		investigations occurred. VA rep			
		things, poor appetite or ouble concentrating on things.		monitored to ensure that we are compliance with State regulation			
	The MDS identifie			report unusual findings to the C			
				committee quarterly.	.		
		ual Abuse Assessment dated					
	9/21/10, indicated vulnerability by oth	R34 was at high risk of ners.		Completion Date: April 14, 201	5		
				R 31 sustained three bruises of			
	R31 sustained 3 ir	njuries of unknown origin which		origin, two bruises on his chest	and one		

				0		
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
	245363	B. WING			03/0)5/2015
PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HEALTH CARE CENT	ER					
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETIO DATE
were not reported to lacked a thorough in abuse/mistreatment 1. On 12/8/14, R31 centimeter (cm) by on his chest. [An in- in which the source by any person or the not be explained by suspicious because the location of the in observed at one po- injuries over time.] report the bruise to R31's spouse was explanation that R32 his hands/fists near facility then reporte 12/10/14 (time unk investigated, and dhave been done by could have been set a result of being re- investigation was no possible abuse/mise 2. On 2/4/15, at 3:1 a 4.2 cm by 3.8 cm his chest. The facili the SA. Although thorigin, there was no 3. On 2/9/15, R31 was 2.3 cm bruise of ur The facility's Resid Report/Investigtion incident to be: "Resident context and the set of the set of the set of the set of the set of the result of the set of the s	o the SA immediately, and nvestigation to determine if t occurred. was discovered to have a 6.7 6 cm bruise of unknown origin jury of unknown origin is one of the injury was not observed e source of the injury could v the resident; and the injury or njury or the number of injuries of the extent of the injury or njury or the number of injuries int in time or the incidence of The facility originally did not the SA, however, on 12/10/14, uncertain if the facility's 4 bruised himself by clenching r his chest was accurate. The d the bruise to the SA on nown). The facility further etermined the injury could another resident or staff, elf-inflicted, or could have been sistive to cares. However, the ot thorough enough to rule out streatment. 5 p.m. R31 was noted to have bruise of unknown origin on ity did not report the bruise to be injury remained an unknown of further investigation. was noted to have a 2 cm by aknown origin on his right jaw. ent Fall/Incident identified the cause of sident with strong facial hair	F 2	226	 on his chin. Social worker and Rescare Coordinator (RCC) interviewer R 31 □s wife and daughter and felt there was sufficient reasoning for the bruising related to R 31 □s resistive rigidity, clenching fists and holding his chest, hanging onto items during transfers and his skin bruising eas nursing staff who have been caring recently for R 31 were interviewed. Care plan was followed and bruising be self- inflicted. All unexplained bruising/bruise of unknown origin will be reported immediately to OHFC and CEP. A thorough investigation will be compas soon as possible and a follow u will continue to be completed within working days of the incident. Our Vulnerable Adult (VA) policy and internal incident report form have be revised and updated. The reporting frame was redefined to remove withours and changed to immediately alleged reports of mistreatment, not abuse and misappropriation of responerty will be made to OHFC and immediately. A thorough investigation investigation is completed within 5 working days of the incident. 	ed R 31, that he eness, against g ily. All g The g could bleted p report n 5 nd our been g time thin 24 y. All eglect, ident d CEP ion will and a f the o y. wing	
	RS FOR MEDICARE OF DEFICIENCIES FORRECTION PROVIDER OR SUPPLIER HEALTH CARE CENT SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA Continued From pat were not reported to lacked a thorough i abuse/mistreatmen 1. On 12/8/14, R31 centimeter (cm) by on his chest. [An in in which the source by any person or th not be explained by suspicious because the location of the i observed at one poi injuries over time.] report the bruise to R31's spouse was explanation that R3 his hands/fists near facility then reporte 12/10/14 (time unkui investigated, and di have been done by could have been se a result of being rea investigation was n possible abuse/mise 2. On 2/4/15, at 3:1 a 4.2 cm by 3.8 cm his chest. The facili the SA. Although th origin, there was no 3. On 2/9/15, R31 v 2.3 cm bruise of un The facility's Resid Report/Investigtion incident to be: "Resigned to be the set of the growth. question to	OF CORRECTION IDENTIFICATION NUMBER: 245363 PROVIDER OR SUPPLIER HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	RS FOR MEDICARE & MEDICAID SERVICES Image: Construction of Deficiencies Image: Constres Image	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL Network 245363 B. WING PROVIDER OR SUPPLIER 245363 B. WING HEALTH CARE CENTER S SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 16 F 226 were not reported to the SA immediately, and lacked a thorough investigation to determine if abuse/mistreatment occurred. F 226 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 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 2/9/15, 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	RES FOR MEDICARE & MEDICAID SERVICES OI OF DEFICIENCIES FORMECTION (x1) PROVIDERSUPPLERCLIA JUBINITY (x2) MULTIPLE CONSTRUCTION A BUILDING PROVIDER OR SUPPLIER 245363 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 860 SECOND STREET NORTHWEST AITKIN, MN 56431 SUMMARY STATEMENT OF DEFICIENCIES (REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER SPLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER SPLAN OF CORRECTION (EACH ORECTIVE ACTION SHOULD (EACH ORECTI	RS FOR MEDICARE & MEDICAID SERVICES OMB NO. Or DEFICIENCIES FOORECTION (X) PROVEERSUPPLIERCLA BEWING (X) MULTIPLE CONSTRUCTION A BUILDING (X) DUCTIPLE COMP COMP COMP COMP COMP COMP COMP COMP

		AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM A	04/06/2015 PPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			3) DATE	SURVEY LETED	
		245363	B. WING			03/05/2015		
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIP CODE					
ΑΙCOTA	HEALTH CARE CENT	ER			50 SECOND STREET NORTHWEST ITKIN, MN 56431			
					PROVIDER'S PLAN OF CORRECTION		(YE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 226	Continued From pa	age 17	F	226				
1 220	· · · · · · · · · · · · · · · · · · ·	sident does use a lidded sippy	1 4	220	reporting to OHFC and CEP.			
		at times with meals and may						
		The facility did not report the			Social worker or designee will conduc	ct		
		agency, nor was there an			audits of incident reports to ensure immediate reporting and that thoroug	uh		
	investigation.				investigations occurred. VA reports w			
	R31's Admission R	ecord identified diagnoses that			monitored to ensure that we are in			
		The annual MDS dated			compliance with State regulations and	d		
		R31 had severe cognitive			report unusual findings to the QA			
		ad mood indicators of feeling failure or have let your family			committee quarterly.			
		urther identified R31 required			Completion Date: April 14, 2015			
	extensive assistant	ce of two staff with bed mobility						
		nsive assistance of one staff			D.7 reported by Joing on her Upper lo	an to		
		tal assistance of one staff for id personal hygiene. The MDS			R 7 reported bruising on her upper le the interdisciplinary team on 3/3/15 d			
	identified no behav				her care conference. She stated she			
					treated rough by a big guy NA, while			
		al Abuse Assessment			was turned/repositioned. DON attemp			
	vulnerability by oth	R31 was at moderate risk of			to investigate the alleged bruising that afternoon, but R 7 had a visitor, than			
		615.			participated in activities and declined			
	On 3/04/15, at 10:3	34 a.m. SW-A and the DON			having skin assessment completed a	at		
		SW-A stated they always			these times. At HS, the LPN on duty			
	investigated allege	d incidents of treatment, and if they are			checked R 7⊡s skin and found a fadi bruise on the inside of her left thigh a			
		with any explanation, they			small round newer looking bruise was			
	report to the SA. in				noticed on the left outer thigh. Due to	DR		
		-			7⊡s request to have her bed position			
		reatment by staff which was			her right side against the wall (as it is			
	investigation.	SA, and lacked a thorough			more comfortable and feels safe for l R 7 is always turned towards her left			
		dated 12/4/14, indicated R7			and assisted by staff using a turning			
	had no cognitive in	npairments. R7 had no			sheet. The big guy NA was interviewe			
		s, behaviors or rejection of			Social worker and DON. He stated t			
	one staff with bed	I the extensive assistance of			he followed the plan of care and alware repositions/turns with a turning sheet			
		moonity.			Staff would not hold onto left inner th			
	On 3/3/15, at 10:0	0 a.m. R7 stated there was one			while turning R 7 for cares. Resident			

Facility ID: 00848

				י יחוד	MB NO. 0938-039 (X3) DATE SURVEY			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245363			(X2) MUL A. BUILD		COMPLETED			
		B. WING		03/05/2015				
NAME OF PROVIDER OR SUPPLIER				ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
AICOTA HEALTH CARE CENTER				850 SECOND STREET NORTHWEST AITKIN, MN 56431				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 226	Continued From p	age 18	F 2	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			.20	to have multiple items on the inside wheel chair and recliner. She bruis easily related to monoclonal gamm During interview with R 7, she indic that she has not been hurt by the N has no problem with that NA contin- care for her. An incident report was filed and rep 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 comp as soon as possible and a follow u will continue to be completed within working days of the incident. Going forward, a more thorough investiga occur to include conducting interview with other residents cared for by th alleged NA as well as conducting interviews with staff that work with alleged NA. Our Vulnerable Adult (VA) policy ar internal incident report form have the	ses opathy. cated IA and uing to borted preport n 5 g ation will ews le the the		
	long time ago from didn't know his ow R7 was not upset improved. The rep licensed practical legs and found thr	pper legs/thighs. R7 reported a n a male staff member who "just /n strength" when handling her. and indicated things had port indicated on 3/5/15, a nurse (LPN) observed R7's ree old bruises. R7 reported to big guy with the beard" turns			revised and updated. The reporting frame was redefined to remove with hours and changed to immediately alleged reports of mistreatment, ne abuse and misappropriation of res property will be made to OHFC an immediately. A thorough investigat be completed as soon as possible follow up report will continue to be completed within 5 working days of	thin 24 c. All eglect, ident d CEP tion will and a		

Facility ID: 00848

STATEMENT OF DEPREENCIES AND PLAN LIP CONTENSION PLEAR IDENTIFICATION MARGER. (p2) NULTPLE CONSTRUCTION A BULDING (p3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245363 IN WINC 03/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, GITY, STATE, 2IP CODE 80 SECOND STREET NORTHWEST 00/05/2015 ALCOTA HEALTH CARE CENTER STREET ADDRESS, GITY, STATE, 2IP CODE 80 SECOND STREET NORTHWEST 0/0 MARKEN TARGEN TO DEPROENCIES TAG SUMMARY STREET OF DEPROENCIES 80 SECOND STREET NORTHWEST ATTAC 0/0 PREFIX TAG SUMMARY STREET OF DEPROENCIES REAL OPERCENTIVE ACTION SHOULDBE COMPLITION TAG 0/0 PREFIX TAG SUMMARY STREET ADDRESS BY FILL RECOVER OF DEPROENCIES 0 PREFIX TAG SUMMARY STREET ADDRESS BY FILL RECOVER OF DEPROENCIES 0 PREFIX TAG SUMMARY STREET ADDRESS BY FILL RECOVER OF DEPROENCIES 0 F 226 Continued From page 19 measured 2.5 by 3 centimeters (cm) and a 1 by 1 incident reports investigation for thigh. The incident report investigation for the findings further stated the bruises were from rough threatment. There was no evidence of any further revery pale and appeared (oil. The findings further stated the bruises were from rough threatment. There was no evidence of any further rough treatment. There was no revery the date stated they were not going to report the incident. Social worker or designee will compute threatment. There			AND HUMAN SERVICES				FORM	04/06/2015 APPROVED 0938-0391		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CTY, STATE, ZIP CODE Out of Vol ALCOTA HEALTH CARE CENTER STREET ADDRESS, CTY, STATE, ZIP CODE B60 SECOND STREET NORTHWEST MAIN DEPENDENT OF DEFICIENCIES In PRETX, NM 16 5431 PROVIDER'S PLAN OF CORRECTION ACTION SINULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY DM PRETX, TAG SUMMARY STATEMENT OF DEFICIENCIES In PRETX, NM 16 34431 PRETX, NM 16 34431 TAG SUMMARY STATEMENT OF DEFICIENCIES In PRETX, NM 16 34431 PRETX, NM 16 34431 TAG SUMMARY STATEMENT OF DEFICIENCIES PRETX, TAG PRETX, NM 16 34431 TAG SUMMARY STATEMENT OF DEFICIENCIES PRETX, TAG PRETX, TAG PRETX, NM 16 3441 TAG SUMMARY STATEMENT OF DEFICIENCIES PRETX, TAG PRETX, TAG PRETX, TAG F 226 Continued From tage 19 F 226 All staff will be in-serviced by reviewing our updated VA policy by April 14, 2015 winter tage and the druises were from rough treatment reports department review and interventions discussed dated 3/4/15, indicated R7 butises were from rough treatment reports department review and interventions discussed dated 3/4/15, indicated R7 butise deasily and had multiple items in the wheelchair. Social worker or designee will conduct audits of incident reports to ensure that weare in comportan	STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STRE, IP CODE ALCOTA HEALTH CARE CENTER STREET ADDRESS, CITY, STRE, IP CODE (%1) ID PREFIX TAG SUMMARY STREMENT OF DEFICIENCIES (EACH OFFICENCY AND ST & FRECEDED BY FILL (EACH OFFICENCY AND ST & FRECEDED BY FILL (EACH OFFICENCY) IP F 226 Continued From page 19 (measured 2.5 by 3 centimeters (cm) and a 1 by 1 (micident incident) included the bruises on the Ido ulter thigh. The incident reports investigative findings (cause of the incident) included the bruises on the Ido thigh were very pale and appeared oid. The findings further stated the bruises on the Ido the bruises on the Ido 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 nor reported to the S.The incident report state and multiple items in the wheelchair. DON or designee will complete NA observations of ADLs to ensure that resident reports denorming to the QA committee quartery. On 3/4/15, at 10:36 am. the DON stated the incident report to incident report to incident and where staff did not follow the pian of care. R3 was transferred by two nursing assistants at 05:00 on 10/6/14, at 2:30 p.m. Social worker or designee will conduct audits of indicate the the reported by monitored to ensure that therorough investigation. The incident report to incident was not transferring R3 as directed by the care pian. The incident was not reported inmediately the staff then incident was not reported integrations and report unusual findings to the QA committee quartery. Social worker or designee will conduct audits of indicate the the care incident was reported by the residentitater during the day at 14:30. An initial report was	245363		245363	B. WI	B. WING			03/05/2015		
AICTA HEALTH CARE CENTER AITKIN, MN 56431 (%1) ID PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY ON USE DEVEMPTING INFORMATION) ID PRETX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION BAUGUE DE CROSS-REFERENCE DIT THE APPROPRATE DEFICIENCY Comment (Comment) 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 reports investigative findings (cause of the incident probably from items in R7's chair" even though R7 was cognitively intact and had reported the bruises on the left thigh were very pale and appeared of L.The findings further stated the bruises were from rough threament. There was no evidence of any further indicated R7 bruised easily and had multiple items in the wheelchair. F 226 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 wes not veloced immediately to the SA, and lacked a 3/4/15, indicated R7 bruised easily and had multiple items in the wheelchair. Social worker or designee will conduct audits of incident reports department review and interventions discussed dated 3/4/15, indicated R7 bruised easily and had multiple items at the vene to the goor during a staff assisted transfer on 10/6/14, at 5:00 a.m. Staff was not transfering R3 as directed by the care plan. The incident was not reported immediately to the SA, and lacked at through investigation. R3 was transferred WIDS dated 111/4/14, indicated R3 had short and long term memory problems but was able to recall the season, the location of ther room, staff names and faces and that she was in AITKIN, MN 56431	NAME OF F	NAME OF PROVIDER OR SUPPLIER								
PRETX TAGCEACH DEFICIENCY MUST BE PRECEDED OF YPULL REGULTION OR LSC IDENTIFYING INFORMATION)PRETX TAGCEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATECOMBATF 226Continued From page 19 measured 2.5 by 3 centimeters (cm) and a 1 by 1 measured by the calible on the footing incombines brifts measured and report of the bruises were from rough treatment and bruises were not reported to the foot proving a transfer belt. The resident lost her footing and was eased to the foot or lost of any further investigation. The bON further stated they were not going to report the incident. R3 sustained an injury following an incident was solved not to the foot or loring a transfer belt. The resident later during the astift and the footing and was easistant transferm belt. The solut thersing R3	AICOTA	HEALTH CARE CENT	ER							
 measured 2.5 by 3 centimeters (cm) and a 1 by 1 cm darker blue area on the left outer thigh. The incident reports findings (cause of the incident) included the bruises on the left thigh were very pale and appeared old. The findings further stated the bruises on the left thigh were very pale and appeared old. The findings (caused by removing incontinent briefs while on the commode or tollet 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 incommation about the "rough treatment." The port so 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. The incident was not reported inmediately to the SA, and lacked a thorough investigation. R3 was lowered to the floor during a staff assisted transferring R3 as directed by the care plan. The incident was not reported inght assisted transferring R3 as directed by the care plan. The incident was not reported inght assisted transferring R3 as directed by the care plan. The incident was not reported inght assisted transferring R3 as directed by the care plan. The incident was not reported inght asso by the scaled 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 	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION		
room, staff names and faces and that she was in new in their positions. The NADs were	F 226	measured 2.5 by 3 cm darker blue are incident report's inv the incident) includ- were very pale and further stated the b caused by removin the commode or to outer thighs were p chair" even though had reported the br treatment. There w investigation. The i rough treatment an the SA. The incider and interventions d indicated R7 bruise items in the wheeld On 3/4/15, at 10:36 incident report cont about the "rough tre stated they were no R3 sustained an in where staff did not neglect of care was the SA, and lacked R3 was lowered to assisted transfer in plan. The incident of by R3 on 10/6/14, a R3's quarterly MDS had short and long	centimeters (cm) and a 1 k a on the left outer thigh. The vestigative findings (cause of ed the bruises on the left the appeared old. The findings ruises were "more likely g incontinent briefs while o ilet and the bruises on the probably from items in R7's R7 was cognitively intact a ruises were from rough ras no evidence of any furth ncident report indicated the d bruises were not reportent report's department revise liscussed dated 3/4/15, ed easily and had multiple chair. 6 a.m. the DON stated the tained all of the information eatment." The DON further of going to report the incide jury following an incident follow the plan of care. The s not reported immediately a thorough investigation. the floor during a staff n 10/6/14, at 5:00 a.m. Staff g R3 as directed by the car was not reported right away ent was reported to the fac at 2:30 p.m.	e of iigh of i i i i i i i i i i i i i i i i i i	F 226	All staff will be in-serviced by our updated VA policy by Apr with an emphasis on immedi reporting to OHFC and CEP residents gently. DON or designee will complet observations of ADLs to ensu- residents are treated gently. Social worker or designee will audits of incident reports to e- immediate reporting and that investigations occurred. VA monitored to ensure that we compliance with State regula report unusual findings to the committee quarterly. Completion Date: April 14, 24 R 3 was transferred by two m assistants at 05:00 on 10/6/1 to commode without using a The resident lost her footing eased to the floor to avoid in incident was reported by the during the day at 14:30. An in was made online to OHFC a 10/6/14. Calls were made to nursing assistants to conduct investigation and both verifier resident was transferred with belt and lowered to floor whe footing to avoid injury/prever	il 14, 2015 ately and treating ete NA ure that ill conduct ensure t thorough reports will be are in ations and e QA 015 ursing 14 from chair transfer belt. and was jury/fall. This resident later nitial report nd to CEP on the night shift t further ed that nout a transfer en she lost her at fall.			
	FORM CMS-2	room, staff names	and faces and that she wa	s in	F	new in their positions. The N	A⊡s were	Page 20 of 25		
IND PLAN OF CORRECTION IDE NAME OF PROVIDER OR SUPPLIER AICOTA HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT (EACH DEFICIENCY MUST B REGULATORY OR LSC IDENT F 226 Continued From page 20 a nursing home. R3 had m with some difficulty in new making decisions. R3 had rejection of cares. R3 nee	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER: 245363 OF DEFICIENCIES E PRECEDED BY FULL FIFYING INFORMATION)	A. BUILDI B. WING B. WING D PREFI TAG	ING		(X3) DATE COMF 03/0	0938-039 SURVEY LETED 5/2015				
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AICOTA HEALTH CARE CENTER (X4) ID PREFIX TAG F 226 Continued From page 20 a nursing home. R3 had m with some difficulty in new making decisions. R3 had rejection of cares. R3 nee	OF DEFICIENCIES E PRECEDED BY FULL TIFYING INFORMATION)	ID PREFI TAG	ST 85 A!	REET ADDRESS, CITY, STATE, ZIP CODE 50 SECOND STREET NORTHWEST ITKIN, MN 56431 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	I BE	(X5)				
AICOTA HEALTH CARE CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT (EACH DEFICIENCY MUST B REGULATORY OR LSC IDENT F 226 Continued From page 20 a nursing home. R3 had m with some difficulty in new making decisions. R3 had rejection of cares. R3 nee	E PRECEDED BY FULL FIFYING INFORMATION)	PREFIZ TAG	85 Al	0 SECOND STREET NORTHWEST ITKIN, MN 56431 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE					
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F 226 Continued From page 20 a nursing home. R3 had m with some difficulty in new making decisions. R3 had rejection of cares. R3 nee	E PRECEDED BY FULL FIFYING INFORMATION)	PREFIZ TAG		(EACH CORRECTIVE ACTION SHOULD	BE					
a nursing home. R3 had n with some difficulty in new making decisions. R3 had rejection of cares. R3 nee	nodified independence	F2		DEFICIENCY)		DATE				
a nursing home. R3 had n with some difficulty in new making decisions. R3 had rejection of cares. R3 nee	nodified independence		226							
assistance of two staff with transfers. R3 was not amb of Daily Living (ADL) care directed staff to transfer R (mechanical) lift and two s The facility's Resident Fal Report/Investigation repor indicated the incident occu 5:00 a.m. and was not rep R3. R3 reported the staff of while transferring her to th the care plan directed staff staff utilized a pivot transfe belt. The incident report's included staff was contact lowered to the floor while lost her footing and was lo avoid injury. On 10/6/14, a size bruise was found on right wrist had swelling an forearm which measured half inches. The incident r indicated staff was counse reported to the state ager However, no further inves R28 alleged mistreatment to the SA, and lacked a th R28's MDS dated 11/18/1 cognitive impairment and extensive assistance of o mobility, transfers and toil	no behaviors or ded the extensive h bed mobility and pulatory. The Activities plan revised on 8/7/14, 3 with the EZ staff. //Incident t completed on 10/6/14, at ported until 2:30 p.m. by dropped her to the floor ne commode. Although ff to use an E-Z Lift, er without a transfer investigative findings ted and verified R3 was being transferred. R3 owered to the floor to at 6:30 p.m. a penny R3's left hand, R3's d a bruise on the right five inches by one and a report's follow up eled. The incident was acy on 10/6/14. tigation was conducted. t which was not reported horough investigation. 4, indicated R28 had no R28 required the ne staff with bed		226	 educated on the importance of follor resident s plan of care and using a transfer belt while transferring reside They were also educated on the det of falls/incidents and the importance immediately reporting incidents to the nurse in charge. Our Vulnerable Adult (VA) policy an internal incident report form have b revised and updated. The reporting frame was redefined to remove with hours and changed to immediately alleged reports of mistreatment, ner abuse and misappropriation of resign property will be made to OHFC and immediately. A thorough investigation be completed as soon as possible follow up report will continue to be completed within 5 working days of incident. The Administrator will also continue to be notified immediately. All staff will be in-serviced by review our updated VA policy by April 14, 2 with an emphasis on immediately reporting to OHFC and CEP and the importance of following a resident plan. DON or designee will monitor/com NA observations of transfers and can abuse and that resident care pare followed. Social worker or designee will contained to ensure the transfers to ensure that safe transfers and can abuse of incident reports to ensure that safe transfers and can be abuse and that resident care pare followed. 	a lents. finition e of he d our een time hin 24 All glect, dent d CEP on will and a f the 2015 he s care plete other are olans duct					

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			P		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OI		0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY
		245363	B. WING			03/0	5/2015
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				8	50 SECOND STREET NORTHWEST		
	HEALTH CARE CENT	ER		A	AITKIN, MN 56431		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
F 226	Continued From pa	ae 21	F2	226			
		n dated 1/19/15, at 8:10 a.m.		-20	investigations occurred. VA reports	s will be	
		orted another NA unplugged			monitored to ensure that we are in		
		R28 put the call light on for			compliance with State regulations a	and	
		he bathroom. The NA heard			report unusual findings to the QA		
		and stated, "he unplugged my couldn't use the bathroom." At			committee quarterly.		
	8:50 a.m. R28 repo	rted to a registered nurse a my call light out of the wall			Completion Date: April 14, 2015		
		o to the bathroom. I want to			R 28 yelled out for help to use the		
		s not happen to anyone else."			bathroom at 08:10 on 1/19/15. At th	nis	
		s follow up at 10:20 a.m.			time, R 28 stated to the NA who pro-		
		poke with the NA. The report			the assistance he unplugged my ca		
		ust have unplugged the call			The NA who assisted R 28 reported		
		ed out of the room and tripped.			the Resident Care Coordinator (RC	CC). At	
	The NA informed th	e SW he had been "behind"			08:50 after the resident was toilete	d, the	
		using the call light "every 15 to			RCC went to discuss the reported		
		A stated it was not intentional			with R 28. R 28 stated that a gentle		
		one back right away and			pulled my call light out of the wall.		
		nt back in. The NA understood			internal incident report was filed. T		
	call lights should ne	ever be unplugged.			was interviewed. He stated that he		
	On 2/4/15 at 10:24				have tripped on the cord when leav		
		a.m. the DON stated the NA d stated he accidentally			28 s room. He stated that unpluge		
		ight. The DON stated she felt			call light was not intentional. R 280 needs were met, she was not distri		
		need to be reported to the			and no mental anguish was noticed		
		ever, the incident was not			was assisted to toilet (able to toilet		
		ated to determine possible			during day) and it was not reported		
	neglect of care.	······			OHFC and CEP. A call light report		
					ran for the wing that caregiver worl		
		njury as a result of staff not			to ensure that other residents call I		
		f care. The neglect of care			cords were not unplugged.		
		nvestigation, and the					
		was not reported to the SA			Through the investigation of the inc		
	timely.				was determined that a call light can		
		10/13/14, indicated she was			turned off, even if it is disconnected		
	diagnosed with der				the wall outlet. The call light system		
		acture. The MDS also			since been reprogrammed so that		
		red extensive assist with locomotion on and off the unit,			light cannot be turned off or silence disconnected from wall in a reside		
	i ansiers, iolieung,	iocomotion on and on the unit,			usconnected from wall in a reside	nu⊔s	

Facility ID: 00848

PRINTED: 04/06/2015

	OF DEFICIENCIES	& MEDICAID SERVICES				(X3) DATE	0938-039
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245363	B. WING _			03/0	5/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH CARE CENT	ER			0 SECOND STREET NORTHWEST TKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 226	Continued From pa	age 22	F 22	26	-		
		continent of bowel and			room. If a call light is unplugged from wall, it will now activate the call light		
	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			Staff was counseled/educated that feel they may have tripped on some to make sure to go back immediate check to ensure nothing has been disconnected and that everything is place and safe for the resident. Initi	ething, ly and in		
2 f	2:25 a.m. revealed floor near her walk	R75 was found sitting on the er (unwitnessed fall). As a			report will be filed immediately if res reports that staff unplugged call ligh	sident nt.	
	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			Our Vulnerable Adult (VA) policy an internal incident report form have b revised and updated. The reporting frame was redefined to remove with hours and changed to immediately. alleged reports of mistreatment, ne abuse and misappropriation of resi- property will be made to OHFC and immediately. A thorough investigati	een time hin 24 All glect, dent t CEP on will		
	SA until 10/20/14,	7 days after the incident.			be completed as soon as possible a follow up report will continue to be completed within 5 working days of incident. The Administrator will also continue to be notified immediately	the)	
					All staff will be in-serviced by review our updated VA policy by April 14, 2 with an emphasis on immediately reporting to OHFC and CEP.	-	
					Social worker or designee will conc audits of incident reports to ensure immediate reporting and that thoro investigations occurred. VA reports monitored to ensure that we are in compliance with State regulations a report unusual findings to the QA	ugh s will be	

Facility ID: 00848

If continuation sheet Page 23 of 25

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	04/06/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		245363	B. WING)		03/0	5/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ΑΙCOTA	HEALTH CARE CENT	ER			50 SECOND STREET NORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	Continued From pa	ge 23	F	226			
					committee quarterly.		
					Completion Date: April 14, 2015		
					R 75 was admitted on 9/16/14 for sterm rehab after a fall at home reship fracture. Admission diagnosis is status post-surgical repair of hip, h of CVA and dementia. R 75 had a of being more restless on afternoor nights. She got up at night and sle poorly possibly related to dementia talking to husband he stated that t not unusual for her. On 10/14/14 a R 75 was found in her room, acrosher bed, sitting on floor and had su a small cut inside her bottom lip. T mat was not in front of bed on floo according to the plan of care. An in initial incident report was filed. The nursing assistants caring for R 75 interviewed and the nursing assist assisted R 75 to bathroom severa prior to fall stated that she must hat forgotten to place the mat after she to the bathroom earlier that night. was discharged to home on 10/28 Nursing assistants working that ni counseled/educated on the import following the plan of care for each	ulting in ncluded history history ns and pt a. When his was at 02:25 ss from ustained he floor r nternal were ant who I times ave e went R 75 /14. ght were ance of	
					resident. Staff was reminded to do an initial immediately to OHFC and CEP fo incident with injury where the plan was not followed. A follow up repo continue to be completed within 5 days of the incident.	r any of care ort will working	
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID:81	JF11	Fa	icility ID: 00848 If continua	tion sheet	Page 24 of 25

TATEMENT	OF DEFICIENCIES F CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
		245363	B. WING		0.210	5/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		00/2010
	NOVIDER OR OUT LIER	×		850 SECOND STREET NORTH		
AICOTA	HEALTH CARE CEN	TER		AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 226	Continued From p	age 24	F 2	226		
				 Our Vulnerable Adult (internal incident report revised and updated. frame was redefined to hours and changed to alleged reports of mist abuse and misapprop property will be made immediately. A thoroug be completed as soon follow up report will co completed within 5 wo incident. The Administ continue to be notified All staff will be in-servi our updated VA policy with an emphasis on i reporting to OHFC and importance of followin plan. DON or designee will NA observations to en care plans are followe 	t form have been The reporting time o remove within 24 immediately. All treatment, neglect, riation of resident to OHFC and CEP gh investigation will as possible and a ontinue to be orking days of the trator will also I immediately. iced by reviewing by April 14, 2015 mmediately d CEP and the ig a resident⊡s care monitor/complete nsure that resident ed.	
				audits of incident report immediate reporting a investigations occurre monitored to ensure th compliance with State report unusual finding committee quarterly.	and that thorough ed. VA reports will be hat we are in e regulations and	
				Completion Date: Apr	il 14, 2015	

Facility ID: 00848

DEPART CENTER	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV		53630	324	FORM	03/06/2015 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			PLE CONSTRUCTION 3 01 - AICOTA NURSING HOME	(X3) DATE SU COMPLE	
		245363		B. WING		03/04	4/2015
					ITATE, ZIP CODE REET NORTHWEST		
AICUTA	HEALTH CARE CEN	NIER		, MN 5643			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S		K 000			
		Survey was conduct					
	time of this survey, was found in subst	ent of Public Safety. Aicota Health Care (antial compliance wi	Center				
	483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the Fire Protection Assoc 01, Life Safety Code	ciation				
	with no basement. constructed in 1969 Type II(111) constru- constructed to the b be of Type II(111) co assisted living facili properly 2 hour fire original building and construction type al	Center, is a 1-story l The original building and was determine action. In 1983 an ad puilding that was deter onstruction. In 2007 ty was attached, that rated separated. Be d its additions meet t lowed for existing built reyed as a single built	was d to be of dition was ermined to an t is ecause the he uildings,				
	facility has a fire ala detection in the corr corridors that is mo department notifica have either heat de that are on the fire a with the Minnesota	sprinklered through arm system with smo ridors and spaces op nitored for automatic tion. Other hazardou tection or smoke def alarm system in acco State Fire Code. The 5 beds and had a cen urvey.	ke ben to the c fire is areas rection ordance e facility				
	The requirement at MET.	42 CFR, Subpart 48	3.70(a) is	2			
LABORATO	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESE	ENTATIVE'S SIG	INATURE	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 <u>only a suggestion</u> 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.

Minnesota Department of Health • Health Regulation Division • General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us *An equal opportunity employer*

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, 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

5363s15lic

Minnesc	ota Department of He	alth					
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
		00848	B. WING		ION SHOULD BE COMPLETE HE APPROPRIATE DATE		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ΑΙCOTA	HEALTH CARE CENT	ER 850 SECC AITKIN, M		NORTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE	
2 000	Initial Comments		2 000				
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been					
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.					
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are					
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 03/30/15	

Electronically Signed

STATE FORM

If continuation sheet 1 of 23

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00848	B. WING		03/	05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
AICOTA	HEALTH CARE CENT	IFR	OND STREET MN 56431	NORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	you electronically. is necessary for St enter the word "cor text. You must ther State licensure pro completion date, th corrected prior to e Minnesota Departm	alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for n indicate in the electronic cess, under the heading ne date your orders will be electronically submitting to the nent of Health. 15, surveyors of this				
	Department's staff, the following correct Please indicate in y correction that you and identify the dat	, visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, te when they will be completed nent of Health is documenting				
	federal software. T	Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "IE statute/rule out of o "Summary Stateme and replaces the "T correction order. T findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE.				

Minnesc	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00848	B. WING		03/0	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AICOTA	HEALTH CARE CENT	ER 850 SECC AITKIN, M		T NORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
21995	MN St. Statute 626. Maltreatment of Vul	557 Subd. 4a Reporting - nerable Adults	21995			4/14/15
	(a) Each facility sha ongoing written pro applicable licensing of suspected maltre facility has an interr mandated reporter requirements of this internally. However	reporting of maltreatment. all establish and enforce an ocedure in compliance with rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting s section by reporting r, the facility remains plying with the immediate ents of this section.				
	by: Based on interview facility failed to imm allegations of abuse State Agency (SA) a allegations for 7 of R7, R3, R28, R75) allegations of mistre Findings include: R53 alleged an inci- was not reported to R53 was interviewe stated one staff me when assisting R53 the rough treatment	ent is not met as evidenced and document review, the rediately report potential e/neglect/mistreatment to the and thoroughly investigate 10 residents (R53, R34, R31, reviewed for potential eatment. dent of mistreatment which the SA immediately. d on 3/2/15, at 4:17 p.m. and mber handled him roughly with cares. R53 described t as "jerking" him around in had reported the rough		The facility will establish and enform ongoing written procedure in comp with applicable licensing rules to en- that all cases of suspected maltreat are reported. On 3/3/15 R 53 reported to the stat surveyors that a staff member han him roughly when assisting with ca That afternoon, R 53 was interview the DON and Social worker and he that he hurts when he is gotten up/ bed in am. He was unable to give a specific name of staff. This alleged mistreatment was reported to OHF Aitkin County/Common Entry Point on 3/4/15. R 53 had previously talk	liance nsure atment te dled ures. ved by e stated out of a fC and t (CEP)	

6899

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00848	B. WING		03/0	5/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AICOTA	HEALTH CARE CENT	TER 850 SECC AITKIN, M		TNORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21995	Continued From pa	age 3	21995			
	Continued From page 3 reatment to a staff member, but hadn't heard anything more and the staff member who treated nim "roughly" continued to work with him. R53's Admission Record identified diagnoses that ncluded 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 wo staff for bed mobility, extensive assistance of wo staff for transfers, dressing and toileting, and extensive assistance of one staff for personal hygiene. The facility individual abuse assessment undated, ndicated R53 was at low risk of vulnerability by others.			 the Social worker on 3/2/15 at that a staff is on a new kick s should have larger pants. R 5 he preferred to lose some we has a closet full of clothes. He mention being treated roughly during the discussion on 3/2/ Staff was reminded to report leader when a resident expert pain/discomfort during transfer diagnosis of chronic pain related osteoarthritis. R53 prefers to right side and he declines to larger site one hour prior to gettimorning. Aicota s Vulnerable Adult (V. 	tating he 53 stated that eight as he e did not y at any time 15. to the team iences any ers. R53 has ted to o sleep on his be receives of Tylenol is ing up in the	
	informed that R53's mistreatment were reported incidents. On 3/4/15, at 10:34 were interviewed. T investigated R53's mistreatment, and SA. SW-A stated th before they report t determining if some R34 was mistreated was not reported in R34's arm was gra 5/22/14, at 5:15 p.r The facility did not	n 3/4/15, at 10:34 a.m. SW-A and the DON ere interviewed. The DON stated they had just vestigated R53's complaints of alleged istreatment, and were not going to report to the A. SW-A stated they always investigate first, efore they report to the SA to assist them in etermining if something is reportable. 34 was mistreated by R102 and the allegation as not reported immediately to the SA. 34's arm was grabbed and shaken by R102 on 22/14, at 5:15 p.m. Staff witnessed the incident. he facility did not immediately report the alleged		revised and updated with an immediately reporting to OHF All staff will be in-serviced by our updated VA policy by Apri with an emphasis on immedia reporting to OHFC and CEP. Social worker or designee wi VA reports to ensure that we compliance with State regula report unusual findings to the committee quarterly. Completion Date: April 14, 20 R 34 s arm was shaken by F 5/22/14 at 17:15. R 102 had	emphasis on FC and CEP. reviewing il 14, 2015 ately Il monitor all are in tions and QA 015 R 102 on poor vision,	
	incident of mistreat	5/23/14 (time unknown). The		was ambulatory and was offe his wife. He was kind, easily	n looking for	

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00848	B. WING		03/05	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AICOTA	HEALTH CARE CENT	ER 850 SECC		TNORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
21995	Continued From pa	age 4	21995			
21000	 ⁵⁵ Continued From page 4 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 			and did not mean any harn was reported to the OHFC 5/23/14 even though R 34 in any distress over the inc Staff was reminded to do a immediately to OHFC and up report will continue to be within 5 working days of the Aicota s VA policy was rev updated with an emphasis reporting to OHFC and CE All staff will be in-serviced our updated VA policy by A with an emphasis on imme reporting to OHFC and CE	and CEP on did not appear ident. an initial report CEP. A follow e completed e incident. <i>v</i> ised and on immediately P. by reviewing pril 14, 2015 ediately	
9/21/10, ind vulnerability R31 sustain were not rep lacked a tho abuse/mistr 1. On 12/8/1 centimeter (on his chest	vulnerability by othe R31 sustained 3 in were not reported t lacked a thorough abuse/mistreatmer 1. On 12/8/14, R31 centimeter (cm) by on his chest. [An in	juries of unknown origin which o the SA immediately, and investigation to determine if		Social worker or designee VA reports to ensure that w compliance with State regu report unusual findings to t committee quarterly. Completion Date: April 14, R 31 sustained three bruise origin, two bruises on his c	ve are in Ilations and he QA 2015 es of unknown	
not be explained b suspicious becaus the location of the observed at one po injuries over time.] report the bruise to R31's spouse was explanation that R his hands/fists near		the injury was not observed be source of the injury could y the resident; and the injury is e of the extent of the injury or njury or the number of injuries bint in time or the incidence of The facility originally did not the SA, however, on 12/10/14, uncertain if the facility's 34 bruised himself by clenching r his chest was accurate. The d the bruise to the SA on		on his chin. Social worker a Care Coordinator (RCC) in R 31 s wife and daughter there was sufficient reason bruising related to R 31 s rigidity, clenching fists and his chest, hanging onto iter transfers and his skin bruis nursing staff who have bee recently for R 31 were inter care plan was followed and	and Resident terviewed R 31, and felt that ing for the resistiveness, holding against ms during sing easily. All en caring rviewed. The	

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPL	
		00848	B. WING		03/0	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AICOTA	HEALTH CARE CENT	TER 850 SECC		TNORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21995	Continued From pa	age 5	21995			
		nown). The facility further		be self- inflicted.		
	 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 			All unexplained bruising/brui unknown origin will be repor- immediately to OHFC and C thorough investigation will be as soon as possible and a for will continue to be completed working days of the incident. Aicota s VA policy was revis updated with an emphasis of reporting to OHFC and CEP All staff will be in serviced by updated VA policy by April 14 emphasis on immediate rep	ted EP. A e completed ollow up report d within 5 sed and n immediately y reviewing our 4, 15 with an orting of	
	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.		bruising of an unknown origi and CEP. Social worker or designee w VA reports to ensure that we compliance with State regula report unusual findings to the committee quarterly. Completion Date: April 14, 2	rill monitor all are in ations and e QA		
R31's Admission Record identified diagnos included dementia. The annual MDS dated 11/26/14, indicated R31 had severe cogniti impairment, and had mood indicators of fee bad about self or a failure or have let your f down. The MDS further identified R31 requested extensive assistance of two staff with bed r and transfers, extensive assistance of one for toileting, and total assistance of one sta dressing, eating and personal hygiene. The identified no behaviors issues. The facility Individual Abuse Assessment nesota Department of Health	I R31 had severe cognitive ad mood indicators of feeling failure or have let your family urther identified R31 required ce of two staff with bed mobility ensive assistance of one staff tal assistance of one staff for nd personal hygiene. The MDS viors issues.		R 7 reported bruising on her the interdisciplinary team on her care conference. She sta treated rough by a big guy N was turned/repositioned. DC to investigate the alleged bru afternoon, but R 7 had a visi participated in activities and having skin assessment con these times. At HS, the LPN checked R 7 s skin and fou bruise on the inside of her le	ated she was 3/3/15 during ated she was IA, while she DN attempted using that itor, than declined npleted at on duty und a fading		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00848	B. WING		03/0	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AICOTA	HEALTH CARE CEN	TER 850 SECC		TNORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLET DATE
21995	Continued From pa	age 6	21995			
51992	undated, indicated vulnerability by oth On 3/04/15, at 10:3 were interviewed. 3 investigated allege abuse/neglect/misi unable to come up report to the SA. in R7 alleged rough t not reported to the investigation. R7's annual MDS of had no cognitive in delirium, psychosis cares. R7 required one staff with bed On 3/3/15, at 10:00 male NA who was bed. R7 stated, "H aware he's rough w she had bruises or NA's hands when I further the NA had did say the bruises not told anyone. R often and I just put of handling." On 3/3/15, at 3:45 were informed of F treatment. The SW because R7 report conference on 3/3/ The facility's Resid	R31 was at moderate risk of ers. B4 a.m. SW-A and the DON SW-A stated they always d incidents of treatment, and if they are with any explanation, they westigated. reatment by staff which was SA, and lacked a thorough dated 12/4/14, indicated R7 npairments. R7 had no s, behaviors or rejection of the extensive assistance of mobility. D a.m. R7 stated there was one rough when he turned her in e's big and I don't think he's when he moves me." R7 stated her upper inner legs from the ne moved her. R7 stated been more careful because he matched his hands. R7 had 7 stated, "He's not here very up with it. It's just his manner p.m. the DON and the SW-A R7's allegation of rough <i>I</i> stated she was aware ed it during her care 15.	21992	 small round newer looking bruise noticed on the left outer thigh. Du 7 s request to have her bed posi her right side against the wall (as more comfortable and feels safe R 7 is always turned towards her and assisted by staff using a turni sheet. The big guy NA was intervi Social worker and DON. He state followed the plan of care and alware positions/turns with a turning should not hold onto left inner thigh turning R 7 for cares. Resident like have multiple items on the inside wheel chair and recliner. She brue easily related to monoclonal game. An incident report was filed and reto 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 comras soon as possible and a follow will continue to be completed with working days of the incident. Aicota s VA policy was revised at updated with an emphasis on immediate reporting bruising with unknown origin. Social worker or designee will motional working days of the incident. 	e to R tion with it is for her), left side ing ewed by ed that he ays heet. Staff h while es to of her hises mopathy. eported A hpleted up report in 5 nd nediately ewing our with of	
innesota D	conference on 3/3/ The facility's Resid Report/Investigatio	15.	6900	bruising with unknown origin.	nitor all n	

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	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3	DATE SURVEY COMPLETED
		00848	B. WING		03/05/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
AICOTA	HEALTH CARE CENT	TER 850 SECC		TNORTHWEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
21995	Continued From pa	age 7	21995		
	conference R7 repo legs.	orted bruising on her upper		report unusual findings to the QA committee quarterly.	
	Abuse/Neglect com R7 reported the ind conference at 2:00 bruising on her upp long time ago from didn't know his own R7 was not upset a improved. The repor- licensed practical m legs and found threat the LPN that the "b her. The incident report blue discolored are measured 2.5 by 3 cm darker blue are incident report's inv the incident) includ were very pale and further stated the b caused by removin the commode or to outer thighs were p chair" even though had reported the br treatment. There w investigation. The i rough treatment and the SA. The incider and interventions d indicated R7 bruise items in the wheeld On 3/4/15, at 10:36	t of Alleged Incident of npleted by the SW indicated sident on 3/3/15, during a care p.m. R7 reported she had per legs/thighs. R7 reported a a male staff member who "just n strength" when handling her. and indicated things had port indicated on 3/5/15, a nurse (LPN) observed R7's ee old bruises. R7 reported to ig guy with the beard" turns trans indicated R7 had two light eas on the left inner thigh which centimeters (cm) and a 1 by 1 a on the left outer thigh. The vestigative findings (cause of ed the bruises on the left thigh appeared old. The findings wruises were "more likely g incontinent briefs while on ilet and the bruises on the probably from items in R7's R7 was cognitively intact and ruises were from rough ras no evidence of any further ncident report indicated the nd bruises were not reported to nt report's department review liscussed dated 3/4/15, ed easily and had multiple chair.		Completion Date: April 14, 2015 R 3 was transferred by two nursing assistants at 05:00 on 10/6/14 from cl to commode without using a transfer b The resident lost her footing and was eased to the floor to avoid injury/fall. T incident was reported by the resident during the day at 14:30. An initial repor- was made online to OHFC and to CEI 10/6/14. Calls were made to the night nursing assistants to conduct further investigation and both verified that resident was transferred without a tran- belt and lowered to floor when she lose footing to avoid injury/prevent fall. Both nursing assistants (NA) were fair new in their positions. The NA s were educated on the importance of followi resident s plan of care and using a transfer belt while transferring residen They were also educated on the defin 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 immedia reporting to OHFC and CEP. All staff will be in-serviced by reviewin our updated VA policy and the internal incident report form by April 14, 2015 an emphasis on immediately reporting OHFC and CEP.	pelt. This later on shift on shift ther ther ty e ng a ts. ition of ately

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X:	3) DATE SURVEY COMPLETED
		00848	B. WING		03/05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
AICOTA	HEALTH CARE CENT	FR	OND STREE /IN 56431	TNORTHWEST	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
21995	Continued From pa	age 8	21995		
		e "rough treatment." The DON further ney were not going to report the incident. Social worker or designee will monitor all VA reports to ensure that we are in compliance with State regulations and			
	where staff did not	jury following an incident follow the plan of care. The s not reported immediately to		report unusual findings to the QA committee quarterly.	u .
	the SA, and lacked R3 was lowered to	a thorough investigation. the floor during a staff		Completion Date: April 14, 2015	
	was not transferring plan. The incident	n 10/6/14, at 5:00 a.m. Staff g R3 as directed by the care was not reported right away by		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 prov	ided
	by R3 on 10/6/14, a			the assistance he unplugged my call The NA who assisted R 28 reported t the Resident Care Coordinator (RCC	his to). At
	had short and long	S dated 11/14/14, indicated R3 term memory problems but he season, the location of her		08:50 after the resident was toileted, RCC went to discuss the reported ind with R 28. R 28 stated that a gentlem	cident
	a nursing home. R	and faces and that she was in 3 had modified independence r in new situations when		pulled my call light out of the wall. An internal incident report was filed. The was interviewed. He stated that he m	NA
	making decisions. rejection of cares.	R3 had no behaviors or R3 needed the extensive staff with bed mobility and		have tripped on the cord when leavin 28 s room. He stated that unpluggin call light was not intentional. R 28 s	g R g the
	transfers. R3 was r of Daily Living (ADI	not ambulatory. The Activities L) care plan revised on 8/7/14,		needs were met, she was not distres and no mental anguish was noticed.	sed She
	directed staff to tra (mechanical) lift an	nsfer R3 with the EZ d two staff.		was assisted to toilet (able to toilet se during day) and it was not reported to OHFC and CEP.	
		ent Fall/Incident n report completed on 10/6/14, ent occurred on 10/6/14, at		Through the investigation of the incid was determined that a call light can be	
	5:00 a.m. and was R3. R3 reported the	not reported until 2:30 p.m. by e staff dropped her to the floor		turned off, even if it is disconnected f the wall outlet. The call light system h	rom nas
	the care plan direct staff utilized a pivot	er to the commode. Although ted staff to use an E-Z Lift, t transfer without a transfer eport's investigative findings		since been reprogrammed so that a light cannot be turned off or silenced disconnected from wall in a resident room.	when
	included staff was lowered to the floor	contacted and verified R3 was r while being transferred. R3 I was lowered to the floor to		Staff was counseled/educated that if feel they may have tripped on somet	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00848	B. WING		03/0	5/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	HEALTH CARE CENT	ER 850 SECC	ND STREE	T NORTHWEST		
		AITKIN, M	IN 56431			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	ige 9	21995			
	avoid injury. On 10/ size bruise was fou right wrist had swel forearm which mea half inches. The inci indicated staff was reported to the state However, no further R28 alleged mistrea to the SA, and lack R28's MDS dated 1 cognitive impairment extensive assistance mobility, transfers a The facility's Report Abuse/Neglect form indicated a NA report the call light when F assistance to use th R28 calling for help call light and said I 8:50 a.m. R28 report "gentleman pulled r when I needed to g make sure this doe The incident report" indicated the SW spi indicated the NA mailight when he walke The NA informed the and R28 had been 20 minutes." The N	 /6/14, at 6:30 p.m. a penny nd on R3's left hand, R3's ling and a bruise on the right usured five inches by one and a cident report's follow up counseled. The incident was e agency on 10/6/14. r investigation was conducted. atment which was not reported ed a thorough investigation. 1/18/14, indicated R28 had no nt and R28 required the be of one staff with bed and toilet use. t of Alleged Incident of n dated 1/19/15, at 8:10 a.m. orted another NA unplugged R28 put the call light on for he bathroom. The NA heard o and stated, "he unplugged my couldn't use the bathroom." At orted to a registered nurse a my call light out of the wall o to the bathroom. I want to s not happen to anyone else." 's follow up at 10:20 a.m. poke with the NA. The report ust have unplugged the call ed out of the room and tripped. he SW he had been "behind" using the call light "every 15 to IA stated it was not intentional 		to make sure to go back im check to ensure nothing ha disconnected and that ever place and safe for the reside report will be filed immedia reports that staff unplugged An immediate report will be OHFC and CEP if a resider of neglect. A thorough inves completed as soon as poss follow up report will continue completed within 5 working incident. Aicota s VA policy was revue updated with an emphasis reporting to OHFC and CEI All staff will be in-serviced to our updated VA policy and to incident report form by Apria an emphasis on immediate OHFC and CEP. Social worker or designee we VA reports to ensure that we compliance with State regue report unusual findings to the committee quarterly. Completion Date: April 14, R 75 was admitted on 9/16	s been ything is in lent. Initial tely if resident d call light. a made to nt has a claim stigation will be sible and a e to be days of the ised and on immediately P. by reviewing the internal I 14, 2015 with ly reporting to will monitor all e are in lations and ne QA 2015 /14 for short	
	plugged the call ligh call lights should ne			term rehab after a fall at ho hip fracture. Admission dia status post-surgical repair o CVA and dementia. R 75 ha	gnosis included of hip, history of ad a history of	
		a.m. the DON stated the NA d stated he accidentally		being more restless on after nights. She got up at night		

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE : COMPL	
		00848	B. WING		03/0	5/2015
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	HEALTH CARE CENT	TER 850 SECC AITKIN, M		TNORTHWEST		
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLE DATE
21995	Continued From pa	age 10	21995			
	the incident did not state agency. How thoroughly investig neglect of care. R75 sustained an i following the plan of lacked a thorough investigative report timely. R75's MDS dated 1 diagnosed with der hypotension, and fra indicated she requi transfers, toileting, and occasionally in bladder. R75's care plan init had a fall with a res	light. The DON stated she felt is need to be reported to the ever, the incident was not ated to determine possible njury as a result of staff not of care. The neglect of care investigation, and the twas not reported to the SA 10/13/14, indicated she was mentia, orthostatic acture. The MDS also ired extensive assist with locomotion on and off the unit, icontinent of bowel and tiated 9/23/14, indicated R75 sulting left hip fracture. R75's lentified she had impaired		possibly related to dementia to husband he stated that the unusual for her. On 10/14/1 75 was found in her room, a bed, sitting on floor and had small cut inside her bottom mat was not in front of bed according to the plan of car initial incident report was file assistants caring for R 75 w interviewed and the nursing assisted R 75 to bathroom s prior to fall stated that she r forgotten to place the mat a to the bathroom earlier that was discharged to home on Nursing assistants working counseled/educated on the following the plan of care for resident.	his was not 4 at 02:25 R across from her I sustained a lip. The floor on floor e. An internal ed. The nursing vere assistant who several times nust have fter she went night. R 75 10/28/14. that night were importance of	
	physical mobility, re toileting and incont Review of an incide 2:25 a.m. revealed	equiring assist with transfers, inence cares. ent report dated 10/14/14, at R75 was found sitting on the er (unwitnessed fall). As a		Staff was reminded to do an immediately to OHFC and C incident with injury where th was not followed. A follow to continue to be completed w days of the incident. Please	CEP for any e plan of care up report will ithin 5 working	
	result of the fall, R7 her bottom lip. The R75's care plan wa fall mat was suppo and toileting sched administrator and S	75 received a small cut inside incident report indicated, as not being followed, as the sed to be placed near the bed ule may also be a factor. The SA were notified on 10/14/14. ty failed to complete a thorough		investigative report for R 75 completed seven days after However, two of those days weekend days, so the inves reporting guidelines were m working days.	was the incident. were tigative	
	investigation into th addition, the invest	to complete a thorough the possible neglect of care. In igation was not reported to the 7 days after the incident.		Aicota s VA policy was revi updated with an emphasis of reporting to OHFC and CEF	on immediately	
	SUGGESTED MET	THOD OF CORRECTION:		All staff will be in-serviced b	w reviewing	

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STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00848	B. WING		03/0	05/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
AICOTA	HEALTH CARE CENT	ER 850 SECO AITKIN, M		T NORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
21995	Continued From pa	ge 11	21995			
	policies and proced of mistreatment. Th a monitoring system compliance.	ould educate all staff on lures regarding alleged reports le administrator could develop in to ensure ongoing R CORRECTION: Twenty-one		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		
22000	MN St Statute 626	6.557 Subd. 14 (a)-(c)	22000	committee quarterly. Completion Date: April 14, 2015		4/14/15
	Subd. 14. Abuse facility, except hom personal care atten establish and enfor prevention plan. Th assessment of the environment, and it factors which may e and a statement of to minimize the risk comply with any rul promulgated by the (b) Each facility, agency and person providers, shall dev prevention plan for residing there or ree The plan shall conta assessment of: (1) abuse by other indiv vulnerable adults; (other vulnerable ad specific measures t	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00848	B. WING		03/0	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AICOTA	HEALTH CARE CENT	FR	OND STREE [®] AN 56431	TNORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
22000	Continued From pa adults. For the pur term "abuse" include	poses of this paragraph, the	22000			
	and personal care knows that the vulr violent crime or an toward others, the plan must detail the minimize the risk th reasonably be expe facility and persons unsupervised. Unc of a vulnerable adu misconduct or phy such information fr authority or through another facility, and	except home health agencies attendant services providers, herable adult has committed a act of physical aggression individual abuse prevention e measures to be taken to hat the vulnerable adult might ected to pose to visitors to the soutside the facility, if der this section, a facility knows ult's history of criminal rsical aggression if it receives om a law enforcement in a medical record prepared by other health care provider, or g assessments of the				
	by: Based on interview facility failed to dev prohibition policy w notification to the S of abuse/neglect/m investigations. The allegations of timel conduct thorough in residents (R53, R3 reviewed for potent abuse/neglect/mist	ent is not met as evidenced r and document review, the relop and implement an abuse thich required immediate state Agency (SA) allegations sistreatment prior to conducting facility failed to report y to the SA and/or failed to nvestigations for 7 of 10 4, R31, R7, R3, R28, R75) tial allegations of reatment. This practice had ect all 57 residents residing in		Aicota Health Care Center I and enforces an ongoing w prevention plan. The plan c the rules governing the plar by the licensing agency. Our Vulnerable Adult (VA) p internal incident report form revised and updated. The ru frame was redefined to rem hours and changed to imme alleged reports of mistreatn	ritten abuse omplies with promulgated policy and our have been eporting time love within 24 ediately. All	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00848	B. WING		03/0	5/2015
IAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	HEALTH CARE CENT	ER 850 SECC AITKIN, M		TNORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
22000	Continued From pa	ge 13	22000			
	Findings include: The facility policy a Adult Abuse Prever directed staff to rep abuse/neglect/mist exceed 24 hours. T to initiate an investi later explained that to determine if the i The policy explaine procedure was to b of only those incide reported. The repor defined as immedia team leader (TL)/m possible, but no late day, the TL was to The incident report happened but also completed, findings to consult the policy determine if a repor attention shall be m exceed 24-hour tim weekends." On 3/4/15, at 10:34 and the director of interviewed. SW-A investigated alleged mistreatment/abuse unable to come up reported it to the S/ abuse/neglect/mist	nd procedure on Vulnerable ntion Plan dated 5/21/12, ort a suspected incident of reatment immediately, not to he policy further directed staff gation immediately. The policy investigation was necessary ncident should be reported. d the internal reporting e followed to ensure reporting nts which are required to be ting procedure was then ately making a report to the urse in charge. As soon as er than leaving work for the complete an incident report. should not only define what explain the investigation and action taken. The TL was y and decision tree to rt needed to be made. "Special hade to the immediately, not to e frames, especially on a.m. social worker (SW)-A nursing (DON) were stated they always d incidents of e/neglect, and if they are with any explanation, they A. However, allegations of reatment are to be reported en a thorough investigation is		property will be made to OHFC immediately. A thorough invest be completed as soon as poss follow up report will continue to completed within 5 working day incident. The Administrator will continue to be notified immedia All staff will be in-serviced by re our updated VA policy by April with an emphasis on immediat reporting to OHFC and CEP. Social worker or designee will VA reports to ensure that we ar compliance with State regulation report unusual findings to the C committee quarterly. Completion Date: April 14, 201 Our Vulnerable Adult (VA) police internal incident report form that revised and updated. The report frame was redefined to remove hours and changed to immedia alleged reports of mistreatment abuse and misappropriation of property will be made to OHFC immediately. A thorough invest be completed as soon as poss follow up report will continue to completed within 5 working day incident. The Administrator will continue to be notified immedia All staff will be in-serviced by re our updated VA policy by April with an emphasis on immediatt reporting to OHFC and CEP.	igation will ible and a be ys of the also ately. eviewing 14, 2015 ely monitor all re in ons and QA 5 sy and our ve been rting time e within 24 ately. All t, neglect, resident c and CEP igation will ible and a be ys of the also ately.	
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STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		00848	B. WING		03/05/2	015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	HEALTH CARE CENT	TER 850 SECO AITKIN, M		TNORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) OMPLET DATE
22000	•	-	22000			
	R53 was interviewed stated one staff me when assisting R53 the rough treatment bed. R53 stated he treatment to a staff anything more and	the SA immediately. ed on 3/2/15, at 4:17 p.m. and ember handled him roughly with cares. R53 described at as "jerking" him around in had reported the rough member, but hadn't heard the staff member who treated nued to work with him.		Social worker or designee will mo VA reports to ensure that we are compliance with State regulations report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 Our Vulnerable Adult (VA) policy a	in s and	
	included osteoarthu urinary incontinenc on one side of the accident (CVA). Th (MDS) dated 1/20/ ⁻ cognitively intact, a two staff for bed may two staff for transfe	ecord identified diagnoses that ritis, congestive heart failure, e and hemiplegia (weakness body) due to cerebral vascular le quarterly Minimum Data Set 15, indicated R53 was and required total assistance of obility, extensive assistance of ers, dressing and toileting, and ce of one staff for personal		internal incident report form have revised and updated. The reportin frame was redefined to remove w hours and changed to immediate alleged reports of mistreatment, r abuse and misappropriation of re property will be made to OHFC a immediately. A thorough investiga be completed as soon as possible follow up report will continue to be completed within 5 working days incident. The Administrator will all	ng time vithin 24 ly. All neglect, sident nd CEP ation will e and a e of the	
	indicated R53 was others. On 3/3/15, at 3:45 informed that R53's	al abuse assessment undated, at low risk of vulnerability by p.m. SW-A and the DON were s complaints of alleged not in the facility log of		continue to be notified immediate All staff will be in-serviced by revi our updated VA policy by April 14, with an emphasis on immediately reporting to OHFC and CEP.	ly. ewing , 2015	
	reported incidents. On 3/4/15, at 10:34 were interviewed. T investigated R53's mistreatment, and SA. SW-A stated th before they report t	A a.m. SW-A and the DON The DON stated they had just complaints of alleged were not going to report to the ney always investigate first, to the SA to assist them in ething is reportable.		Social worker or designee will mo VA reports to ensure that we are compliance with State regulations report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015 Our Vulnerable Adult (VA) policy a	in s and and our	
	R34 was mistreate	d by R102 and the allegation		internal incident report form have revised and updated. The reporting		

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STATEME	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00848	B. WING		03/0	5/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
ΑΙCOTA	HEALTH CARE CENT	ER 850 SECO AITKIN, M		NORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
22000	was not reported in R34's arm was gral 5/22/14, at 5:15 p.m The facility did not i incident of mistreat report was filed on facility's investigatio confused female re at 10:34 a.m. SW-A investigated before R34's Admission R included Alzheimer anxiety. The quarter indicated R34 had s problems, and seve for daily decision m decisions). The MD having mood proble pleasure in doing th overeating, and troo The MDS identified The facility Individu 9/21/10, indicated F vulnerability by othe R31 sustained 3 inj were not reported t lacked a thorough i abuse/mistreatmen 1. On 12/8/14, R31 centimeter (cm) by on his chest. [An in in which the source by any person or th not be explained by suspicious because	hmediately to the SA. bbed and shaken by R102 on n. Staff witnessed the incident. immediately report the alleged ment to the state agency; a 5/23/14 (time unknown). The on determined R102 often esidents as his wife. On 3/4/15, A stated the facility always the they reported to the SA. ecord identified diagnoses that 's disease, chronic pain, and erly MDS dated 1/21/15, short and long term memory erely impaired cognitive skills taking (never/rarely made DS further identified R34 as ems of little interest or nings, poor appetite or uble concentrating on things. I no behaviors. al Abuse Assessment dated R34 was at high risk of ers.	22000	frame was redefined to rehours and changed to im alleged reports of mistrea abuse and misappropriat property will be made to 0 immediately. A thorough is be completed as soon as follow up report will contin completed within 5 workin incident. The Administrate continue to be notified im All staff will be in-serviced our updated VA policy by with an emphasis on immediately. A All staff will be in-serviced our updated VA policy by with an emphasis on immediately of the Social worker or designed VA reports to ensure that compliance with State reg- report unusual findings to committee quarterly. Completion Date: April 14 Our Vulnerable Adult (VA internal incident report for revised and updated. The frame was redefined to re- hours and changed to im- alleged reports of mistrea abuse and misappropriat property will be made to 0 immediately. A thorough is be completed as soon as follow up report will contin completed within 5 workin incident. The Administrate continue to be notified im-	emove within 24 mediately. All atment, neglect, ion of resident DHFC and CEP investigation will possible and a nue to be ng days of the or will also mediately. d by reviewing April 14, 2015 nediately EP. e will monitor all we are in gulations and o the QA 4, 2015) policy and our rm have been e reporting time emove within 24 mediately. All atment, neglect, ion of resident DHFC and CEP investigation will possible and a nue to be ng days of the or will also	

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	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00848	B. WING		03/05/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
AICOTA	HEALTH CARE CENT	ER 850 SECC		TNORTHWEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLE
22000	Continued From pa	age 16	22000		
	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.			All staff will be in-serviced by revie our updated VA policy by April 14, with an emphasis on immediately reporting to OHFC and CEP. Social worker or designee will mo VA reports to ensure that we are in compliance with State regulations report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015	2015 nitor all n
	2. On 2/4/15, at 3:1 a 4.2 cm by 3.8 cm his chest. The facili the SA. Although th origin, there was no 3. On 2/9/15, R31 v 2.3 cm bruise of un The facility's Reside Report/Investigtion incident to be: "Res growth. question to shaving may have of also identified "Res cup independently have bumped jaw."	estigation was not thorough enough to rule out ssible abuse/mistreatment. On 2/4/15, at 3:15 p.m. R31 was noted to have 2.2 cm by 3.8 cm bruise of unknown origin on chest. The facility did not report the bruise to a SA. Although the injury remained an unknowr gin, there was no further investigation. On 2/9/15, R31 was noted to have a 2 cm by a cm bruise of unknown origin on his right jaw. e facility's Resident Fall/Incident port/Investigtion identified the cause of ident to be: "Resident with strong facial hair owth. question to whether resident's daily aving may have caused brusing." The report o identified "Resident does use a lidded sippy o independently at times with meals and may we bumped jaw." The facility did not report the uise to the state agency, nor was there an		Our Vulnerable Adult (VA) policy a internal incident report form have revised and updated. The reportin frame was redefined to remove w hours and changed to immediatel alleged reports of mistreatment, n abuse and misappropriation of res property will be made to OHFC ar immediately. A thorough investiga be completed as soon as possible follow up report will continue to be completed within 5 working days of incident. The Administrator will als continue to be notified immediatel All staff will be in-serviced by revie our updated VA policy by April 14, with an emphasis on immediately reporting to OHFC and CEP.	been g time ithin 24 y. All eglect, sident nd CEP tion will e and a of the so y. ewing 2015
	included dementia. 11/26/14, indicated impairment, and ha bad about self or a down. The MDS fu	ecord identified diagnoses that The annual MDS dated R31 had severe cognitive ad mood indicators of feeling failure or have let your family inther identified R31 required ce of two staff with bed mobility		Social worker or designee will mo VA reports to ensure that we are in compliance with State regulations report unusual findings to the QA committee quarterly. Completion Date: April 14, 2015	n

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		00848	B. WING		03/0	05/2015
	PROVIDER OR SUPPLIER	ER 850 SEC	OND STREE	STATE, ZIP CODE T NORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLE DATE
22000	and transfers, exte for toileting, and toi dressing, eating an identified no behav The facility Individu undated, indicated vulnerability by othe On 3/04/15, at 10:3 were interviewed. S investigated allege abuse/neglect/mist unable to come up report to the SA. in R7 alleged rough the not reported to the investigation. R7's annual MDS of had no cognitive im delirium, psychosis cares. R7 required one staff with bed r On 3/3/15, at 10:00 male NA who was bed. R7 stated, "He aware he's rough w she had bruises on NA's hands when h further the NA had did say the bruises not told anyone. R7 often and I just put of handling."	nsive assistance of one staff tal assistance of one staff for id personal hygiene. The MDS iors issues. All Abuse Assessment R31 was at moderate risk of ers. All a.m. SW-A and the DON SW-A stated they always d incidents of reatment, and if they are with any explanation, they vestigated. The attent by staff which was SA, and lacked a thorough dated 12/4/14, indicated R7 the attensive assistance of mobility. D a.m. R7 stated there was one rough when he turned her in e's big and I don't think he's when he moves me." R7 stated ther upper inner legs from the matched his hands. R7 had 7 stated, "He's not here very up with it. It's just his manner p.m. the DON and the SW-A R7's allegation of rough		Our Vulnerable Adult (VA) internal incident report forr revised and updated. The frame was redefined to ren hours and changed to immalleged reports of mistreat abuse and misappropriatio property will be made to O immediately. A thorough in be completed as soon as p follow up report will contine completed within 5 working incident. The Administrato continue to be notified imm All staff will be in-serviced our updated VA policy by A with an emphasis on immed reporting to OHFC and CE Social worker or designee VA reports to ensure that w compliance with State regu- report unusual findings to committee quarterly. Completion Date: April 14,	policy and our m have been reporting time move within 24 nediately. All ment, neglect, on of resident PHFC and CEP nyestigation will possible and a ue to be g days of the r will also nediately. by reviewing April 14, 2015 ediately EP. will monitor all we are in ulations and the QA	

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED		
	00848		B. WING		03/	03/05/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
AICOTA	HEALTH CARE CENT	FR	OND STREET	NORTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
22000	because R7 reporte conference on 3/3/ The facility's Reside Report/Investigation by the DON indicat	ed it during her care 15.	22000				
	Abuse/Neglect com R7 reported the inc conference at 2:00 bruising on her upp long time ago from didn't know his own R7 was not upset a improved. The repo licensed practical n legs and found three	t of Alleged Incident of ppleted by the SW indicated ident on 3/3/15, during a care p.m. R7 reported she had er legs/thighs. R7 reported a a male staff member who "jus a strength" when handling her. and indicated things had ort indicated on 3/5/15, a urse (LPN) observed R7's e old bruises. R7 reported to ig guy with the beard" turns	t				
	blue discolored are measured 2.5 by 3 cm darker blue are incident report's inv the incident) includ were very pale and further stated the b caused by removin the commode or to outer thighs were p chair" even though had reported the br treatment. There w investigation. The in	indicated R7 had two light as on the left inner thigh which centimeters (cm) and a 1 by 1 a on the left outer thigh. The restigative findings (cause of ed the bruises on the left thigh appeared old. The findings ruises were "more likely g incontinent briefs while on ilet and the bruises on the robably from items in R7's R7 was cognitively intact and uises were from rough as no evidence of any further ncident report indicated the d bruises were not reported to					

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00848			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED 03/05/2015	
		00848	B. WING	B. WING		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AICOTA	HEALTH CARE CEN	IFR	OND STREET MN 56431	NORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From pa	age 19	22000			
		discussed dated 3/4/15, ed easily and had multiple chair.				
	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.					
	where staff did not neglect of care wa the SA, and lacked R3 was lowered to assisted transfer o was not transferrin plan. The incident	jury following an incident follow the plan of care. The s not reported immediately to d a thorough investigation. the floor during a staff n 10/6/14, at 5:00 a.m. Staff g R3 as directed by the care was not reported right away by ent was reported to the facility at 2:30 p.m.				
	had short and long was able to recall t room, staff names a nursing home. R with some difficulty making decisions. rejection of cares. assistance of two s transfers. R3 was of Daily Living (AD	S dated 11/14/14, indicated R3 term memory problems but the season, the location of her and faces and that she was in 3 had modified independence in new situations when R3 had no behaviors or R3 needed the extensive staff with bed mobility and not ambulatory. The Activities L) care plan revised on 8/7/14, insfer R3 with the EZ and two staff.				
	indicated the incide 5:00 a.m. and was R3. R3 reported th	lent Fall/Incident on report completed on 10/6/14 ent occurred on 10/6/14, at not reported until 2:30 p.m. by e staff dropped her to the floor her to the commode. Although				

		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	00848		B. WING		03/	03/05/2015	
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
		850 SEC		NORTHWEST			
ICOTA	HEALTH CARE CENT	AITKIN,	MN 56431				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
22000	Continued From pa	age 20	22000				
	staff utilized a pivot belt. The incident re- included staff was of lowered to the floor lost her footing and avoid injury. On 10, size bruise was four right wrist had swel forearm which mea- half inches. The indi- indicated staff was reported to the stat However, no furthe R28 alleged mistre to the SA, and lack R28's MDS dated to cognitive impairme extensive assistant mobility, transfers a The facility's Repor Abuse/Neglect form indicated a NA repor the call light when I assistance to use to R28 calling for help call light and said I 8:50 a.m. R28 repor "gentleman pulled to when I needed to g make sure this doe The incident report indicated the SW s indicated the SW s indicated the NA m light when he walke The NA informed th	ted staff to use an E-Z Lift, t transfer without a transfer eport's investigative findings contacted and verified R3 was r while being transferred. R3 I was lowered to the floor to /6/14, at 6:30 p.m. a penny ind on R3's left hand, R3's lling and a bruise on the right asured five inches by one and a cident report's follow up counseled. The incident was e agency on 10/6/14. er investigation was conducted. atment which was not reported ed a thorough investigation. 11/18/14, indicated R28 had no nt and R28 required the ce of one staff with bed and toilet use. et of Alleged Incident of n dated 1/19/15, at 8:10 a.m. orted another NA unplugged R28 put the call light on for he bathroom. The NA heard o and stated, "he unplugged my couldn't use the bathroom." At orted to a registered nurse a my call light out of the wall jo to the bathroom. I want to es not happen to anyone else." 's follow up at 10:20 a.m. poke with the NA. The report ust have unplugged the call ed out of the room and tripped. he SW he had been "behind" using the call light "every 15 to					

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
	00848		B. WING		03/	03/05/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
AICOTA	HEALTH CARE CEN	IFR	OND STREET MN 56431	NORTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
22000	Continued From pa	200 21	22000	DEFICIEN	CY)		
22000	and should have g plugged the call lig	one back right away and ht back in. The NA understood ever 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.						
	following the plan of lacked a thorough investigative report timely. R75's MDS dated diagnosed with der hypotension, and fr indicated she requ transfers, toileting,	injury as a result of staff not of care. The neglect of care investigation, and the t was not reported to the SA 10/13/14, indicated she was mentia, orthostatic acture. The MDS also ired extensive assist with locomotion on and off the unit, incontinent of bowel and					
nnesota Do	had a fall with a reacted a fall with a reacted by a fall with a reacted by a further identified by a function of the second sec	tiated 9/23/14, indicated R75 sulting left hip fracture. R75's lentified she had impaired equiring assist with transfers, tinence cares.					
	2:25 a.m. revealed floor near her walk result of the fall, R' her bottom lip. The R75's care plan wa fall mat was suppo and toileting sched	ent report dated 10/14/14, at I R75 was found sitting on the er (unwitnessed fall). As a 75 received a small cut inside e incident report indicated, as not being followed, as the used to be placed near the bed dule may also be a factor. The SA were notified on 10/14/14.					

STATE MENT OF DEFICIENCIES (X1) PROVIDERSUPPLIER CULA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING:	Minnesota Department of Health						
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 DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OERRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) COMPLETE DATE 22000 Continued From page 22 22000 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. 22000 SUGGESTED METHOD OF CORRECTION: The administrator could develop policies and procedures regarding reporting and investigating all alleged abuse/neglect/mistreatment. The administrator could deucate all staff on those policies and procedures. Theadministrator could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one							
AICOTA HEALTH CARE CENTER Stature in the second statute in the s			00848	B. WING		03/0	5/2015
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