

Protecting, Maintaining and Improving the Health of All Minnesotans

November 27, 2018

Ms. Michelle Hanneken, Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, MN 56431

Subject: Aitkin Health Services - IDR CMS Certification Number (CCN) 245119 Project # S5119026

Dear Ms. Hanneken:

This is in response to your letter of September 14, 2018, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F580, F641 and F760 issued pursuant to the survey event 9KMY11, completed on August 23, 2018.

The information presented with your letter, the CMS 2567 dated August 23, 2018, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F580-483.109(g)(14) S/S-D Notification of change

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is—
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment);

The facility has requested an IDR of this tag as they state, the condition that was present at the time of the survey exited on 8/23/18 was not a significant change or a new form of treatment for R42. The facility argues that R42 had this similar condition and treatment in the recent past.

Summary of facts include:

The 2567 for the survey exit date of 8/23/18, indicated the facility failed to ensure the resident representative was informed of a new skin condition that was present at the time of survey and further indicated the representative had stated she had not been informed of the sore on R42's left leg.

R42's skin condition progress note dated 3/4/18, indicated R42 had edema, redness and open sore of the left lower shin and required a dressing change. Skin condition progress note dated 5/29/18, indicated this wound had healed. R42's skin condition progress note dated 7/10/18, indicated a scabbed area to left lower shin. R42's progress note dated 7/21/18, indicated R42 had a scab and edema to left lower shin.

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R42's progress note dated 8/17/18, indicated a closed blister on left lower shin.

R42's Skin and Wound Log for Selected Site indicated, R42 had redness to left lower shin, from 3/4/18 through 5/29/18 a scabbed area to left lower shin from 7/10/18 to 7/31/18, and a closed blister to left lower shin from 8/17/18 to 8/19/18.

R42's care conference note dated 7/30/18, indicated family (POA) and resident were present and updated on wound status.

Per the Statement of Operations manual the definition of a need to alter treatment significantly includes: DEFINITIONS §483.10(g)(14)

"A need to alter treatment significantly "means a need to stop a form of treatment because of adverse consequences (such as an adverse drug reaction), or commence a new form of treatment to deal with a problem (for example, the use of any medical procedure, or therapy that has not been used on that resident before).

Summary of findings include:

Based on the above progress notes, the wound status and treatment for R42's left shin would not meet the definition of a significant change in condition or a need to alter treatment significantly. The progress notes and the wound logs indicated that R42 had this condition of the left lower shin for some time and that the sore that was noted at the time of survey in this area was not a significant change in condition nor did it require a new form of treatment in terms of a procedure that had not been used on that resident before.

This is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies.

F641- 483.20 (g)- S/S-D Accuracy of Assessment

The assessment must accurately reflect the resident's status.

The facility has requested that this tag be removed as while the Minimum Data Set (MDS) was coded in error, and coding of a deep tissue injury was not included on the MDS, it did not pose any potential for harm as this information was included in the resident care plan and interventions were in place.

Summary of facts include:

The 2567 for the survey exited on 8/23/18, indicated the facility failed to accurately code the MDS for R24 to include deep tissue injury. The 2567 further stated R24's quarterly MDS with a completion date of 7/3/18, which included observation dates of 6/20/18 through 6/26/18 failed to identify a deep tissue injury.

R24's current care plan dated 4/09/18, indicated R24 had a pressure ulcer to the left heel.

R24's wound progress notes from 1/8/19 through 6/26/18, indicated a deep tissue injury of the left heel including assessment and treatment of the deep tissue injury of the heel.

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The registered nurse that was interviewed on 8/23/18 and was identified on the 2567 as RN-D, verified the quarterly assessment with a completion date of 7/3/18, indicated the resident did have the deep tissue injury at the time of the last quarterly assessment and that the coding of the deep tissue injury was missed on the MDS.

The SOM indicates the assessment must accurately reflect the resident's status.

Summary of findings include:

The coding of the deep issue was not included on the quarterly MDS with a completion date of 7/3/18. Based on the care plan, progress notes and interviews, the deep tissue injury was present at the time of the observation period of 6/2018 to 6/26/18, therefore should have been included on the quarterly MDS assessment dated 7/3/18.

This is a valid deficiency at this tag and will remain as stated on the CMS-2567.

F760-483.45(f)(2)-S/S-D Residents are free from significant medication error.

"Significant medication error" means one which causes the resident discomfort or jeopardizes his or her health and safety.

Summary of facts include:

The SOM provides the following guiding principles:

The relative significance of medication errors is a matter of professional judgment. Follow three general guidelines in determining whether a medication error is significant or not:

- Resident Condition The resident's condition is an important factor to take into consideration. For example, a diuretic (fluid pill) erroneously administered to a dehydrated resident may have serious consequences, but if administered to a resident with a normal fluid balance may not. If the resident's condition requires rigid control, such as with strict intake and output measurement, daily weights, or monitoring of lab values, a single missed or wrong dose can be highly significant;
- Drug Category If the medication is from a category that usually requires the resident to be titrated to a specific blood level, a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. This is especially important with a medication that has a Narrow Therapeutic Index (NTI) (i.e., a medication in which the therapeutic dose is very close to the toxic dose). Examples of medications with NTI include: phenytoin (Dilantin), carbamazepine (Tegretol); warfarin (Coumadin); digoxin (Lanoxin); theophylline (TheoDur); lithium salts (Eskalith, Lithobid); and
- Frequency of Error If an error is occurring repeatedly, there may be more reason to classify the error as significant. For example, if a resident's medication was omitted several times, it may be appropriate, depending on consideration of resident condition and medication category, to classify that error as significant

The 2567 for the survey exited on 8/23/18, indicated the facility failed to insure appropriate dosing of insulin was administered due to the nurse not priming the insulin pen prior to administration for R14. The 2567 further indicated R14 had an order to receive 8 units of Novolog (short acting) insulin at 4:30 p.m.

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prior to her evening meal. The 2567 also stated that during the medication pass on 8/20/18, at 4:56 p.m. the nurse administered 8 units of Novolog insulin, however, failed to prime the pen prior to administering insulin. (Priming the pen is often recommended to ensure air is removed from the needle hub and the correct dose of insulin is administered).

Following the administration of the insulin, the nurse was asked about the process of priming the pen. She stated she forgot to prime the pen but should have.

In reviewing the blood glucose levels following the lack of priming the pen, there was no evidence that the lack of priming the pen affected the condition of the resident, that the dosing was significantly altered or that this was a pattern of medication errors.

Review of the Novolog package insert does not direct that priming of the pen must be completed every time a needle is changed.

Summary of finding include:

Lack of priming the pen prior to a dose of Novolog insulin did not meet the criteria of a significant medication error as indicated at F760.

This is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Ka-Tu

Kathy Lucas, Unit Supervisor Licensing and Certification Program Health Regulation Division Telephone: 320-223-7343 Fax: 320-223-7348

cc: Office of Ombudsman for Long-Term Care Pam Kerssen, Assistant Program Manager Licensing and Certification File Terri Ament, Duluth District Office Unit Supervisor

		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245119	B. WING			08/	23/2018
NAME OF F	PROVIDER OR SUPPLIER						
AITKIN H	EALTH SERVICES				1 MINNESOTA AVENUE SOUTH TKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLET I ON DATE
E 000	Initial Comments		E 00	00			
F 000	Emergency Prepare conducted 8/20/18, recertification surve with the Appendix Z Requirements. INITIAL COMMENT On 8/20/18, throug	ance with CMS Appendix Z edness Requirements, was through 8/23/18, during a ey. The facility is in compliance C Emergency Preparedness TS h 8/23/18, a standard survey our facility by the Minnesota	F 0(00			
	Department of Heal was in compliance	Ith to determine if your facility with the requirements of 42 part B, and Requirements for					
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.	0	5			
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with			Q		
	and as a result the from the 2567, F58	e Resolution was requested following tags will be removed 0-Notification of change and e free of significant medication					
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4)	F 58	85			10/2/18
	director's or provid	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 09/14/2018

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/27/2018

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING			08/:	23/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH NTKIN, MN 56431		
(X4) I D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	§483.10(j) Grievano §483.10(j)(1) The ro grievances to the fa- that hears grievano reprisal and without reprisal. Such griev respect to care and furnished as well as furnished, the beha- residents, and othe facility stay. §483.10(j)(2) The ro facility must make p resolve grievances accordance with thi §483.10(j)(3) The fa on how to file a grie to the resident. §483.10(j)(4) The fa grievance policy to of all grievances re- contained in this pa provider must give to the resident. The include: (i) Notifying residen postings in promine facility of the right to (meaning spoken) of grievance offican be filed, that is, address (mailing ar number; a reasonal	ces. esident has the right to voice acility or other agency or entity es without discrimination or ances include those with treatment which has been s that which has not been vior of staff and of other r concerns regarding their LTC esident has the right to and the prompt efforts by the facility to the resident may have, in	F 5	585			

Facility ID: 00002

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING	;		08/2	23/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	IEALTH SERVICES				301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
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F 585	to obtain a written d grievance; and the independent entities be filed, that is, the Quality Improvement Agency and State L program or protectii (ii) Identifying a Grie responsible for over receiving and trackii conclusions; leading by the facility; main information associa example, the identifi grievances submitte written grievance de coordinating with st necessary in light o (iii) As necessary, ta prevent further pote right while the alleg investigated; (iv) Consistent with reporting all alleged abuse, including inj and/or misappropria anyone furnishing s provider, to the adm as required by State (v) Ensuring that all include the date the summary of the per regarding the reside as to whether the g confirmed, any corr	lecision regarding his or her contact information of s with whom grievances may pertinent State agency, nt Organization, State Survey ong-Term Care Ombudsman on and advocacy system; evance Official who is rseeing the grievance process, ing grievances through to their g any necessary investigations taining the confidentiality of all ited with grievances, for ty of the resident for those ed anonymously, issuing ecisions to the resident; and ate and federal agencies as f specific allegations; aking immediate action to ential violations of any resident ed violation is being §483.12(c)(1), immediately I violations involving neglect, uries of unknown source, ation of resident property, by pervices on behalf of the ninistrator of the provider; and	F	585			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION (E SURVEY PLETED
		245119	B. WING			08/2	23/2018
NAME OF I			<u> </u>	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH SERVICES				MINNESOTA AVENUE SOUTH FKIN, MN 56431		
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F 585	and the date the wi (vi) Taking appropri accordance with St of the residents' rig or if an outside entit the State Survey A Organization, or loc confirms a violation rights within its are (vii) Maintaining ev result of all grievan 3 years from the ist decision. This REQUIREME by: Based on observa review, the facility f concerns for 1 of 2	age 3 ritten decision was issued; iate corrective action in tate law if the alleged violation white is confirmed by the facility ity having jurisdiction, such as gency, Quality Improvement cal law enforcement agency in for any of these residents' a of responsibility; and idence demonstrating the ces for a period of no less than suance of the grievance NT is not met as evidenced tion, interview, and document failed to act upon reported residents (R5) reviewed for	F 5		R5- met with representative to follow on the concern related removal of la Offered personal padded lap desk a	ip tray. s an	
	diagnoses included behaviors and scol R5's General Nurse 8/8/18, indicated R impairment.	rinted 8/22/18, indicated R5's d unspecified dementia without iosis (curvature of the spine). e's Observation note dated 5 had severe cognitive 4 p.m. R5's family member	C		alternative or tray table to accommo Resident representative satisfied wit alternative. A letter was sent out to all resident's and/or representatives that included grievance policy as a way to make resident's/representatives aware of I voice concerns as well as how to file grievance. Staff responsible for reviewing the	the how to	
	(FM)-A was intervie using a lap tray on removed it, stating he had spoken to the concern with remove the lap tray for place stuffed animal for F	wed, and stated R5 had been her wheelchair, but the facility it was a restraint. FM-A stated he facility staff about his ving it. FM-A stated R5 used cement of an activity blanket or R5 to touch. FM-A stated the ressed his concern to his			admission packet on admission will document that the grievance policy v reviewed. All staff were re-educated on the grievance policy and how to docume concern SS/designee will follow up concerns	ent a	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		245119	B. WING			08/2	23/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLET I ON DATE
F 585	Encounter note date tray on R5's wheeld and also provided a or stuffed animal to activities and tactile Summary note date tray encouraged ere R5's social engager an activity blanket of Evaluation and Plar indicated R5's famil displeased with the R5's OT Evaluation 7/18/18, indicated F appropriate, and dio tray. On 8/22/18, at 2:08 (OT)-A was intervie was a padded tray, straps and replaced additional veloro fas wheelchair which al removed quickly. O improved R5's abilit other people, and F placed on the tray to OT-A stated the lap in the wheelchair, b improve posture. O using a tilting wheel continued to request On 8/22/18, at 2:23 (DON) was interview tray was removed a	ge 4 Therapy (OT) Treatment ed 3/12/18, indicated the lap thair improved R5's posture, a place for an activity blanket assist R5 with sensory estimulation. An OT Discharge ed 3/22/18, indicated R5's lap ect posture and increased ment by providing a place for or stuffed animal to sit. An OT n of Treatment dated 5/23/18, y member (FM)-A was removal of the full lap tray. and Plan of Treatment dated R5's wheelchair was no longer a not address use of the lap p.m. occupational therapist wed and stated R5's lap tray and OT had removed the them with velcro fastener. An stener was placed on R5's lowed the lap tray to be T-A stated the lap tray ty to make eye contact with R5 was able to have objects o provide tactile stimulation. tray was not used to keep R5 ut to facilitate positioning and T-A stated R5 was currently ichair. OT-A stated FM-A st the lap tray be resumed. p.m. the director of nursing wed. The DON stated the lap ifter discussion about it being N stated the corporate	F	585	are brought forward to ensure the of has been addressed to the complati satisfaction. Will audit all concerns 2x/week for 1 month then 2x/month months and then monthly thereafter results will be brought to the QAPI committee for review and further recommendations Completion date: 10/2/18	inant's n for 2	

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AITKIN HEALTH SERVICES 301 MINNESOTA AVENUE SOUTH (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C F 585 Continued From page 5 compliance officer thought the lap tray was a restraint, and needed to be removed. The DON stated R5's lap tray was used for positioning and activities. F 585 The facility Grievance policy dated 1/9/17, directed a grievance included those regarding care or treatment, the behavior of staff or other individuals receiving services, and other concerns regarding a resident stay. If a grievance was voiced by an individual, the facility would promptly investigate and resolve the grievance. F 585	SURVEY
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F 641 Accuracy of Assessments F 641 SS=D CFR(s): 483.20(g) §483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately code the Minimum Data Set (MDS) to identify a deep tissue injury for 1 of 3 residents (R24) reviewed for pressure ulcers. R24- a modification of the MDS ARD 6/26/18 was corrected to reflect the deep tissue injury (DTI). Findings include: Pressure ulcer stages defined by the National Pressure Ulcer Advisory Panel: All residents will be reviewed to ensure that the MDS is coded accurately. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Staff involved in coding the MDS were re-educated on ensuring the coding of the MDS is accurate and reflects the assessment. DON/designee will complete random chart audits of the MDS. A total of 2 records will be audited weekly for 4 weeks and then 1	10/2/18

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		E CONSTRUCTION		E SURVEY PLETED
		245119	B. WING	;		08/2	23/2018
NAME OF PROVIDER OR SUP	PLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN HEALTH SERVIC	ES				01 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
PREFIX (EACH DEFI	CIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLET I ON DATE
differently in d results from ir and shear ford The wound m actual extent of without tissue subcutaneous muscle or oth this indicates (Unstageable, DTPI to descr neuropathic, of R24's Physicia included diage diabetic neuro kidney diseas R24's Genera 6/20/18, and of R24 was at lo a deep tissue was dry and ir R24's quarter reference data completion da moderately im identified R24 staff with activ MDS also indi ulcers, and ha present on the lacked identifi	bisc larkly tense ces at ay ev of tiss loss. tissue a full Stag ibe va or der an's C opathy e. I Nurs or der injury tact. ly MD e (AR te of paire tense ta a full stag or der injury tact. to set to s	ge 6 coloration may appear pigmented skin. This injury e and/or prolonged pressure the bone-muscle interface. olve rapidly to reveal the ue injury, or may resolve If necrotic tissue, e, granulation tissue, fascia, derlying structures are visible, thickness pressure injury e 3 or Stage 4). Do not use ascular, traumatic, matologic conditions. Order Sheet printed 8/23/18, of type two diabetes with a, and stage four chronic se's Observation started on eted on 6/26/18, indicated for pressure ulcers, and had (DTI) on the left heel which S with an assessment D) of 6/26/18, and a 7/3/18, indicated R24 had d cognition. The MDS red extensive assistance from of daily living (ADLs). The R24 was at risk for pressure e any unhealed pressure e any unhealed pressure e any unhealed pressure e any unhealed pressure assessment. The MDS n of R24's deep tissue injury. a.m. R24 was observed to c on the left foot, and a shoe	F	541	Completion date: 10/2/18		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		245119	B. WING	i		08/2	23/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	EALTH SERVICES				01 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	the back of her foot on it that morning, b On 8/23/18, at 10:3 observed with licen R24's DTI was obse heel on the Achilles approximately the s brown in color with R24 had the DTI fo stated she had the stated she had the stated she thought shoe. On 8/23/18, at 12:4 (RN)-D (the facility DTI was not identifi MDS, and stated it assessment referent through 6/26/18, and the assessment per R24's MDS should DTI. On 8/23/18, at 1:01 (DON) stated she w be accurate. The facility's MDS 3 4/6/15, directed the residents were asses needs, develop an it to ensure the MDS the interdisciplinary	24 stated she had a sore on 4, they had used scissors to cut 5 out it did not hurt. 6 a.m. R24's DTI was sed practical nurse (LPN)-A. erved located above the left	F	541			
F 761		and Biologicals	F 7	761			10/2/18

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		AND HUMAN SERVICES			F	NTED: 11/27/201 ORM APPROVE NO. 0938-039	D
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			3) DATE SURVEY COMPLETED	Ì
		245119	B. WING	i		08/23/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH NTKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		1
F 761 SS=D		-	F	761			
	Drugs and biological labeled in accordan professional princip appropriate access instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In ac Federal laws, the fa- biologicals in locked temperature control personnel to have a §483.45(h)(2) The f locked, permanent storage of controlle the Comprehensive	e expiration date when of Drugs and Biologicals cordance with State and acility must store all drugs and d compartments under proper ls, and permit only authorized access to the keys. facility must provide separately y affixed compartments for d drugs listed in Schedule II of e Drug Abuse Prevention and		\$			
	abuse, except when package drug distri quantity stored is m be readily detected.	and other drugs subject to the facility uses single unit bution systems in which the inimal and a missing dose can NT is not met as evidenced					
	Based on observat review, the facility f drops were not in u	tion, interview, and document ailed to ensure expired eye se and were removed from in 1 of 2 medication carts ation storage.			R42 s Cosopt eye drops were remove from the medication cart. All residents have the potential to be affected.	ved	
	Findings include:				All medications were check for viability	у.	
		p.m. during inspection of the licensed practical nurse			All licensed nursing staff and Trained Medication Aides (TMA⊡s) were		

Facility ID: 00002

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		AND HUMAN SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING	i		08/2	23/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431		
(X4) I D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	to R42 were noted t 5/18. LPN-A stated check the expiration prior to administrative expired it was to be received the Cosop day. LPN-A stated F of the eye drops in the was unable to tell w currently being used R42's Face Sheet p diagnosis of dry eye lacrimal gland. R42 7/24/18, directed Co each eye twice a dat On 8/22/18, at 2:23 (DON) was interview supposed to check medication prior to a DON stated if a mere expired, it was to be medication cart and was ordered. The D	⁶ Cosopt eye drops belonging to have an expiration date of the facility protocol was to in date on the medications on, and if the medication was ordered. LPN-A stated R42 at drops to both eyes twice a R42 had two additional bottles the medication cart, and she which bottle of eyedrops were d for R42. orinted 8/23/18, identified a e syndrome of unspecified 's Physician Orders dated osopt eyedrops, one drop to ay. p.m. the director of nursing wed and stated staff was the expiration date of administering medication. The dication was found to be	F	761	re-educated on the Medication Stora Policy as it relates to expired medica DON/designee will perform random observational audits 3x/week for 4 w and then 2x/month for 2 months the monthly thereafter. Audit results will brought to the QAPI committee for r and further recommendations Completion date: 10/2/18	ations veeks n II be	
F 812 SS=F	7/26/17, directed the discontinued, outda biologicals. Food Procurement, CFR(s): 483.60(i)(1		F٤	312			10/2/18
	§483.60(i) Food saf The facility must -	ety requirements.					

Facility ID: 00002

If continuation sheet Page 10 of 22

PREFIX (EACH DEFICIENCY	245119 TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	:	I STREET ADDRESS, CITY, STATE, ZIP CODE 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431	08/23/2018
AITKIN HEALTH SERVICES (X4) ID SUMMARY STAT PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431	
(X4) ID SUMMARY STAT PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID	AITKIN, MN 56431	
PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL			
		TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETIC DATE
F 812 Continued From page	ge 10	F 812	2	
approved or conside state or local author (i) This may include from local producers and local laws or reg (ii) This provision do facilities from using gardens, subject to safe growing and for (iii) This provision do from consuming foo §483.60(i)(2) - Store serve food in accord standards for food s This REQUIREMEN by: Based on observati review, the facility fa hygiene and use of a during food service cross-contamination R31, R42, R36, R2, Bear's Den dining ro failed to ensure prop to serving to preven residents (R1, R31) addition, the facility fa pans were dry and f washed, stored, and food-borne illness. T all 43 residents who kitchen. Findings include:	food items obtained directly s, subject to applicable State gulations. bes not prohibit or prevent produce grown in facility compliance with applicable od-handling practices. bes not preclude residents bds not procured by the facility. e, prepare, distribute and dance with professional service safety. IT is not met as evidenced ion, interview, and document ailed to ensure proper hand utensils for handling of food	S	Dietary staff involved in meal service were re-educated on proper hand hygiene, proper use of utensils for handling of food during food service, a also on the procedure for heating up fo Dietary staff were also re-educated on process for washing and drying pans a other utensils. All residents have the potential to be affected by a deficient practice in this area. All dietary, nursing, and activity staff were re-educated on proper hand hygiene a use of gloves during meal service. All dietary, nursing, and activity staff were instructed on proper food handling dur meal service, and the procedure for heating up food. Dietary staff were also	od. the nd ere nd

Facility ID: 00002

If continuation sheet Page 11 of 22

STATEMEN	OF DEFICIENCIES	KINGER SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245119	B. WING		08/	23/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
AITKIN I	IEALTH SERVICES			301 MINNESOTA AVENUE SOUTH 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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET I O DATE
F 812	disease, dysphagia diabetes. R31's Face Sheet p R31's diagnoses in hypertension. R42's Face Sheet p R42's diagnoses in colitis, dementia, at R36's Face Sheet p R36's diagnoses in (stroke), hypertens and dysphagia. R2's Face Sheet pr diagnoses included hypertension. R32's Face Sheet pr diagnoses included hypertension. R32's Face Sheet pr diagnoses included atrial fibrillation. R1's Face Sheet pr diagnoses included atrial fibrillation. R1's Face Sheet pr diagnoses included abnormal weight lo On 8/20/18, during dietary aide (DA)-A food from the stear her hands. DA-A to cupboards, and opt	cluded severe chronic kidney a (swallowing problems), and brinted 8/23/18, indicated cluded atrial fibrillation and brinted 8/23/18, indicated cluded diabetes, ulcerative nd anemia. brinted 8/21/18, indicated cluded cerebral infarction ion, gastro-esophageal reflux, rinted 8/23/18, indicated R2's I heart failure, and brinted 8/23/18, indicated cluded dementia, heart	F 81	2 re-educated on the process for w and drying pans and other utens T he Assistant Dietary Manager/de will perform random audits. 3 ra observational audits for hand hys during meal service will be comp weekly for 4 weeks, then 2 audit for 2 months and then monthly th to ensure ongoing compliance. 3 observational audits will be comp weekly for 4 weeks to ensure pa other utensils are clean and dry storage will be completed then 2 audits/month for 2 months, then monthly thereafter will be comple ensure ongoing compliance. 3 ra audits of food temps will be com weekly for 4 weeks, then 2 audits for 2 months, then monthly there ensure ongoing compliance. Au results will be brought to the QAI committee for review and further recommendations Completion date: 10/2/18	Is. signee ndom giene leted s/month hereafter 3 random bleted ns and brior to 1 audit eted to andom bleted s/month after to idit Pl	

	ARTMENT OF HEALTH AND HUMAN SERVICES					RINTED: 11 FORMAP MB NO. 09	PROVED	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION		(X3) DATE SU COMPLE	JRVEY	
		245119	B. WING		_	08/23/2018		
NAME OF I	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE			
	IEALTH SERVICES			301 MINNESOTA AVENUE S AITKIN, MN 56431	OUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECTIVE CROSS-REFERENCED		BE CO	(X5) DMPLET I ON DATE	
F 812	preparing foods to bread from the bag them in the toaster, down, then remove touching and openi donned clean glove DA-A pushed the to took the toast out of gloved hands, and R24. The toast was the microwave to h The soup had beer sat in ice in a bin of soup, warmed it lor served the soup wit temperature of the steaming at the tim ate the soup. The and a creamy soup On 8/20/18, at 5:28 comes up cold, and days. DA-A stated to and verified she did the soup prior to set On 8/20/18, at 5:49 her gloved hands to she usually tried to meal service, after refrigerator, but she verified she used s or sanitize her hand during the supper r On 8/21/18, at 4:16 check the temperat	serve. DA-A took 2 pieces of with her gloved hands, placed pushed the toaster lever ad her soiled gloves after ng packets of sauces. DA-A es without washing her hands. baster lever down again, and of the toaster with the same placed the toast on a plate for a served to R24. DA-A used eat soup in individual bowls. In taken from a serving dish that in the cart. DA-A stirred the nger, stirred it again, and thout checking the soup. The soup was not e. R31 and R1 received and soup of the day was beef stew, was served. B.p.m. DA-A stated the soup d is on the cold cart for up to 3 they warm it in the microwave, d not check the temperature of erving it. D.p.m. DA-A verified she used b handle the bread, and stated change her gloves throughout touching the microwave and e did not always do it. DA-A oiled gloves, and did not wash ds between glove changes neal. D.p.m. DA-C stated he would ture of soups prior to serving. are prepared, and go into the k, they are taken out to be						
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 9KMY1	1	Facility ID: 00002	If continuation	on sheet Pag	e 13 of 22	

		AND HUMAN SERVICES				FORM	: 11/27/2018 APPROVED . 0938-0391	
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		245119	B. WINC	G_		08/23/2018		
NAME OF	PROVIDER OR SUPPLIER			Τ	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
	IEALTH SERVICES				301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 812	thawed the day befit the soup of the day on the cold cart, in individual bowl, and reheated, are broug On 8/23/18, at 11:4 lunch. DA-B washe gloves. DA-B open soup, put it into a b soup and put some in a plastic containe gloved hands, pour gloves, and sanitize soup in the microwa donned clean glove On 8/23/18, at 11:4 using utensils. At 1 nursing assistant (N microwave and che temperature was 90 the soup was place when checked agai DA-B stated the sou degrees. At 11:53 a steaming soup was and the temperatur soup was served. in the microwave for checked the temper 115 degrees F. The in the microwave and Che S/22/18, at 11:5 out of the bag with ham sandwich for F At 11:55 a.m. DA-B	ore serving, and then used for . The soups are brought up ice, and heated by the d left-overs that have not been ght down to the cooler. 1 a.m. DA-B was setting up for ed her hands and donned hed the fridge, took out some owl, got another container of in a bowl, took out corn dogs er, and put two on a plate with ed milk into pudding, removed ed her hands. DA-B then put ave, sanitized her hands, and es. 6, DA-B started serving food 1:47 a.m. DA-B asked a NA) to take the soup out of the eck the temperature. The D degrees Fahrenheit (F), and in, it was 115 degrees F. up should be 150-160 a.m. the soup was boiling. The removed from the microwave, e of the soup was 177. The The NA then put the corn dogs or 1 minute and at 11:53 a.m. rature. The temperature was e corn dogs were placed back	F	81				

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING	;		08/;	23/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ld PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLET I ON DATE
F 812	Continued From pa was 176 degrees F	•	F٤	812			
	of the container with and placed the lettu plate was served to microwave and che bowl of soup. At 11 of the bag with sam plate and it was ser DA-B took a piece of gloved hands and if p.m. DA-B took a piece of gloved hands and if p.m. DA-B took a piece of R32's family memb served the corn dog Prior to the meal ar nursing assistants h the food service kito pour liquids and cot in the kitchen area. On 8/22/18, at 12:0 forgot to use tongs lettuce. DA-B state temperature of the also stated she che and if wet or had fo rewashed. On 8/20/18, at 2:09 assistant dietary ma pans were wet and pans were wet and	6 a.m. DA-B took lettuce out a same gloved hands, tore it, ice on a plate for R36. The R36. DA-B opened the cked the temperature of a :59 a.m., DA-B took bread out ie gloved hands, put it on a ved to R31. At 12:01 p.m. of bread out with the same : was served to R2. At 12:02 iece of bread out of the bag ed hands and it was given to er seated next to him. R4 was gs. ad during the meal service, had been observed to enter chen, open the refrigerator, fee, and touch various items 7 p.m. DA-B verified she for the bread, corn dogs and d she always checked the soup after microwaving. DA-B cked the pans before using, od debris, will have them p.m. during a tour with anager (ADM), 3 medium food 2 had residue. 21 medium d. ADM stated they are used is, and such foods. 2 of 10 it, and 1 of 10 pans had food ed the larger pans were used isagne. 2 of 12 scoops had		Ś			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING	;		08/2	23/2018
NAME OF	PROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AITKIN	HEALTH SERVICES				301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	food residue on the dishwasher to be by verified the pans ar and were ready for to be air dried prior be checking pans p dishwasher if wet o cool foods in small overs. If they cool a ADM stated they do foods while cooling temperature logs. On 8/22/18, at 12:2 soup, put it in small then switch the sour The soup goes up o bowl by bowl. They has been thawed fo bowl of soup should ADM verified dietar between tasks, betw they should use ton ADM stated staff sh touching anything e risk of bacteria in for temperature, and co death. The facility policy H undated, directed d after handing soiled clean dishes, etc. a anything that is not contaminates. The gloves get just as d changed between t	 m. ADM gave them to the ere-cleaned. The ADM dutensils had been cleaned, use. ADM stated the pan are to storage, dietary staff are to prior to use, and return to runclean. ADM stated they pans, but rarely cool soups. anything, they cool soups. and check temperatures of and do not keep cooling 2 p.m. ADM stated they make pans, put it in the freezer, p of the day, every 3 days. On the cold cart, and warm it of throw away the soup after it or 3 days. ADM stated each d be temped prior to serving. Y staff should wash hands ween changing gloves, and the proper bould cause illness or even and Washing of Employees ietary staff to wash hands a utensils, going from dirty to nd touching door handles or sanitary and could carry policy included a reminder that irty as hands, and need to be 	F	812 S			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245119	B. WING		08/2	23/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	EALTH SERVICES			301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812 F 842 SS=D	undated, directed d during food prepara remove soil and cor- cross contamination policy indicated foo- trained in the prope foodborne illness, a discarded after cor- were used. The facility policy Fe directed dietary stat to eat foods to 165 temperatures would thermometer to ensiservice equipment a sanitized according policy further directed serving utensils to s All food service equipment a sanitized, dried, and The facility policy D directed pots and p to remove debris, p machine, and place rack to dry. Once c and put away. Resident Records - CFR(s): 483.20(f)(5) S483.20(f)(5) Resid (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable	ygiene and Sanitary Practices ietary staff to wash hands tion, as often as necessary to ntamination, and to prevent in when changing tasks. The diservice employees would be r use of utensils to prevent ind gloves were to be inpleting the task for which they bod Handling undated, if to heat leftovers and ready degrees F. Food I be checked with a ure proper heating. All food and utensils would be to current guidelines. The ed staff to use tongs or other iserve breads or other items. ipment should be cleaned, direassembled after each use. ishes and Utensils dated 2/18, and to be scraped and rinsed rocess through the dish all pots and pans on a drying iry, they were to be stacked Identifiable Information .), 483.70(i)(1)-(5) ent-identifiable information. release information that is to the public. release information that is	F 8	12		10/2/18

Facility ID: 00002

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					FORM	APPROVED
		S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		245119	B. WING	i	 08/;	23/2018
NAME OF I	PROVIDER OR SUPPLIER					
	AITKIN HEALTH SERVICES					
(X4) ID PREFIX TAG	AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245119 B. WING 08/23/2018 E OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431 AITKIN, MN 56431 ID ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (x5) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE COMPLETED ID REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE COMPLETED					
F 842	agrees not to use o except to the extent to do so. §483.70(i) Medical §483.70(i)(1) In acc professional standa must maintain med that are- (i) Complete; (ii) Accurately docu (iii) Readily accessi (iv) Systematically of §483.70(i)(2) The fa all information conta regardless of the for records, except whe (i) To the individual, representative whe (ii) Required by Law (iii) Required by Law (iii) For treatment, p operations, as pern with 45 CFR 164.50 (iv) For public healt neglect, or domesti activities, judicial ar law enforcement pu purposes, research medical examiners, a serious threat to h by and in compliant §483.70(i)(3) The fa record information a unauthorized use.	r disclose the information t the facility itself is permitted records. cordance with accepted ards and practices, the facility ical records on each resident mented; ble; and organized acility must keep confidential ained in the resident's records, or or storage method of the en release is- or their resident re permitted by applicable law; v; payment, or health care nitted by and in compliance D6; h activities, reporting of abuse,	Fξ	342		

		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(3) DATE	SURVEY PLETED
		245119	B. WING	÷		08/2	3/2018
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	IEALTH SERVICES				801 MINNESOTA AVENUE SOUTH NITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	for- (i) The period of tim (ii) Five years from there is no requirem (iii) For a minor, 3 y legal age under Sta §483.70(i)(5) The m (i) Sufficient information (ii) A record of the re- (iii) The comprehen- provided; (iv) The results of a and resident review determinations cond (v) Physician's, nurs- professional's progr (vi) Laboratory, radi- services reports as This REQUIREMEN- by: Based on interview facility failed to ensu- representative wish- were accurately door- medical record for 2 reviewed for advance Findings include: R30's quarterly Min 7/24/18, indicated F R30's Face Sheet p R30's diagnoses incompared Type 2 diabetes. The	e required by State law; or the date of discharge when nent in State law; or ears after a resident reaches te law. nedical record must contain- ation to identify the resident; esident's assessments; sive plan of care and services ny preadmission screening evaluations and ducted by the State; se's, and other licensed ress notes; and ology and other diagnostic required under §483.50. NT is not met as evidenced and document review, the ure the resident or resident es for advanced directives cumented in all areas of the 2 of 3 residents (R30, R36) ced directives.	F	842	R30's face sheet was updated to accurately reflect the resident's wishe advance directives as indicated on th POLST and physician order R36's physician orders were updated accurately reflect the resident's wishe advance directives as indicated on th POLST and face sheet. All residents were reviewed to ensure resident's wishes for advance directive were accurately documented in all and of the medical record. Advanced Directive orders will no lon be put into the electronic physician or but will remain in the EMR for viewing	e the ves reas	

Facility ID: 00002

If continuation sheet Page 19 of 22

		AND HUMAN SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	E SURVEY PLETED
		245119	B. WING	;		08/2	23/2018
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	HEALTH SERVICES				01 MINNESOTA AVENUE SOUTH NTKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	R30's Provider Ord Treatment (POLST nurse practitioner of selected "Do Not At her resuscitation st pulse and was not b R30's Physician Or R30 was DNR resu On 8/21/18, at 3:40 (DON) verified R30 Face Sheet, and Pl On 8/21/18, at 4:50 her code status to b R36's admission M R36's admission M R36's Face Sheet p R36's face Sheet p R36's diagnoses in (stroke), and hyper The Face Sheet als directive was "Full of resuscitation/CPR. R36's POLST signed the nurse practition selected "Attempt F for her code status and was not breath R36's Physician Or R36's Physician Or R36's A a DNR sta On 8/21/18, at 3:41	ers for Life-Sustaining) signed by R30 and R30's on 4/6/18, indicated R30 had ttempt Resuscitation/DNR" for atus in the event R42 had no breathing. ders dated 8/17/18, indicated iscitation status. p.m. the director of nursing l's code status on her POLST, hysician Orders did not match. p.m. R30 verified she wanted be "DNR." DS dated 7/18/18, indicated cluded cerebral infarction tension (high blood pressure). so indicated R30's advanced Code" or attempt ed by R36 on 7/5/18, and by er 7/6/18, indicated R36 had Resuscitation/CPR" or full code in the event R36 had no pulse ing. ders signed 7/24/18, indicated atus. p.m. the DON verified R36's POLST, Face Sheet, and	F	842	well as the signed POLST in the ch All licensed staff were educated on process for documenting resident's wishes as it relates to advance dire DON/designee will complete randou audits. 2 random chart audits will b completed weekly for 4 weeks and records/month for 2 months then m thereafter to ensure advance direct are accurately documented in all ar the medical record. Audit results wi brought to the QAPI committee for and further recommendations. Completion date: 10/2/18	the ctives. m chart be then 2 nonthly tives reas of II be	

If continuation sheet Page 20 of 22

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI	E SURVEY PLETED
		245119	B. WING	i		08/:	23/2018
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	IEALTH SERVICES				301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	Continued From pa	ge 20	F٤	342			
	On 8/21/18, at 4:44 CPR to be attempted	p.m. R36 verified she wanted					
	On 8/21/18, at 3:21 assistant (TMA)-As POLST or the elect for the resident's re was found without a On 8/21/18, at 3:26 (LPN)-A stated she medication adminis POLST to determin status. On 8/21/18, at 3:34 stated she would lo resident's resuscita On 8/21/18, at 3:36 could look at the EN resident's resuscita On 8/21/18, at 3:41	 p.m. trained medication stated he would look at the ronic medical record (EMR) suscitation status if a resident a pulse or respirations. p.m. licensed practical nurse would look at the electronic tration record (eMAR) or the e a resident's resuscitation p.m. registered nurse (RN)-A ok at the POLST for the tion status. p.m. the DON stated nursing MR or the POLST for the tion status. p.m. the DON verified there 		S			
	honored. On 8/22/18, at 8:40 POLSTs were not b physician/NP orders residents came in v signed a POLST wh physician orders, an places in the medic The facility policy Av 2/18, directed the re	s all the time. The DON stated with physician orders and then hich may be different from the and this was not changed in all					

If continuation sheet Page 21 of 22

	EPARTMENT OF HEALTH AND HUMAN SERVICES FORMEDICARE & MEDICAID SERVICES OMBING							
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE	E SURVEY PLETED		
		245119	B. WING		08/:	23/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
	HEALTH SERVICES			301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 842		signed POLST would be er for care, and would be noted	F 8					

Facility ID: 00002

PRINTED: 11/27/2018

DEPARTMENT OF HEALTH	AND HUMAN	SERVICES			CENTERS FOR M	IEDICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: 9KMY
					TE SURVEY AGENCY	Facility ID: 00002
1. MEDICARE/MEDICAID PROVIDER (L1) 245119 2.STATE VENDOR OR MEDICAID NO. (L2) 231247600	NO.	 NAME AND AL (L3) AITKIN HE (L4) 301 MINNES (L5) AITKIN, MN 	ALTH SERVIO SOTA AVENU	CES	(L6) 56431	4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
 EFFECTIVE DATE CHANGE OF OW (L9) 07/01/2006 	/NERSHIP	 PROVIDER/SU 01 Hospital 	PPLIER CATEGO	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
	2/2018 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	06/30
11LTC PERIOD OF CERTIFICATION From (a): To (b):		Complian		S:	And/Or Approved Waivers Of T 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN	The Following Requirements: 6. Scope of Services Limit 7. Medical Director IF) 8. Patient Room Size
12.Total Facility Beds	44 (L18)				5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	44 (L17)		mpliance with Prog and/or Applied Wa		* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDOW	/N				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
44 (L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMAR	RKS (IF APPLICABL	E SHOW LTC CANCI	ELLATION DATE	E):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Teresa Ament, Unit Sup	pevisor		10/22/2018	(L19)	Joanne Simon, Enfo	rcement Specialist 10/22/2018
P	ART II - TO BE	COMPLETED	BY HCFA R	EGIONAI	L OFFICE OR SINGLE ST	TATE AGENCY
 DETERMINATION OF ELIGIBILIT <u>X</u> 1. Facility is Eligible to Pa <u>2</u>. Facility is not Eligible 	articipate		MPLIANCE WITH GHTS ACT:	CIVIL		ancial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
	(L21)					
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 03/09/1967	BEGINNING	DATE	ENDING DA	ΓΕ	01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursen 03-Risk of Involuntary Terminatio	5
25. LTC EXTENSION DATE:	27. ALTERNATI				04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind Sus	of Admissions: pension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	DETERMINATION	OF APPROVAL D	DATE		
	(L32)	10/02/2018		(L33)	DETERMINATION APPI	ROVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 22, 2018

CMS Certification Number (CCN): 245119

Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, MN 56431

Dear Administrator:

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 October 2, 2018 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 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.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 22, 2018

Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, MN 56431

RE: Project Number S5119026

Dear Administrator:

On September 6, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on August 23, 2018. 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 October 22, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 23, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 2, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard and therefore remedies outlined in our letter to you dated September 6, 2018, 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.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

	DICARE/MEDICAI RT I - TO BE COMP									D: 9KM Facility ID:	
MEDICARE/MEDICAID PROVIDER NO. (L1) 245119 2.STATE VENDOR OR MEDICAID NO. (L2) 231247600	3. NAME AND AD (L3) AITKIN HE. (L4) 301 MINNES (L5) AITKIN, MN	DRESS OF FACII ALTH SERVIC SOTA AVENUI	LITY C ES		(L6) 5			4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertificat 3. Termination 4. CHOW 5. Validation 6. Complaint			L8) certification OW
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 07/01/2006 6. DATE OF SURVEY 08/23/2018 (L34 8. ACCREDITATION STATUS:		PPLIER CATEGO 05 HHA 06 PRTF 07 X-Ray	RY 09 ESRD 10 NF 11 ICF/IID	<u>02</u> 13 PTIP 14 CORF 15 ASC	(L7)	22 CLIA	_	8. Ful	Site Visit I Survey After (EAR ENDIN		(L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF	08 OPT/SP	12 RHC	16 HOSPI	ICE				06/30		
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 S 44 (L37) (L38) 16. STATE SURVEY AGENCY REMARKS (IF APPLIC	Compliance 	Requirements ce Based On: Acceptable POC mpliance with Prog and/or Applied Wa IID (L43)	ivers:	2 3 4 5 * Code: 15. FACIE	. Techn . 24 Ho . 7-Day . Life S B LITY MI	ical Person ur RN RN (Rura afety Code	nnel al SNF) e	6. 7. 8.	equirements: Scope of Ser Medical Dir Patient Roon Beds/Room (L15)	vices Limit ector	
17. SURVEYOR SIGNATURE	Date :			18. STAT	E SURV	'EY AGEN	NCY AF	PROVAL		Date:	
Kathie Siemsen, HFE - NE II	(09/19/2018	(L19)	Joann	<u>e Sin</u>	<u>non, E</u>	Infor	cemen	<u>t Specia</u>	<u>list</u> 10	0/02/2018 _{(L}
PART II - TO	BE COMPLETED	BY HCFA RI	EGIONAL	OFFICE	E OR S	SINGLE	E STA	TE AGE	NCY		
 DETERMINATION OF ELIGIBILITY _X1. Facility is Eligible to Participate 2. Facility is not Eligible (L2) 	RIG	IPLIANCE WITH GHTS ACT:	CIVIL	21.	2. Ov		Control I		(HCFA-2572) losure Stmt (H)
22. ORIGINAL DATE 23. LTC AGR	EEMENT 24	4. LTC AGREEN	IENT	26. TER	MINATI	ON ACTI	ON:			(L30)	
OF PARTICIPATION BEGINN 03/09/1967	IING DATE	ENDING DAT	Έ	<u>VOLUNT</u> 01-Merger,			_00_		<u>INVOLUN</u> 05-Fail to N	<u>TARY</u> leet Health	/Safety
(L24) (L41)		(L25)		02-Dissatis				t	06-Fail to M	leet Agreer	nent
A. Suspe	IATIVE SANCTIONS ension of Admissions: d Suspension Date:	(L44)		03-Risk of 04-Other R		-			OTHER 07-Provide 00-Active	Status Cha	inge
	-	(L45)									
28. TERMINATION DATE:	29. INTERMEDIARY/0			30. REMA	DVC						

(L31)

(L33)

DETERMINATION APPROVAL

03001

32. DETERMINATION OF APPROVAL DATE

(L28)

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 6, 2018

Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, MN 56431

RE: Project Number S5119026

Dear Administrator:

On August 23, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that 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.

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

<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>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 an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor Duluth Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Duluth Technology Village 11 East Superior Street, Suite 290 Duluth, Minnesota 55802-2007 Email: teresa.ament@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 October 2, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 2, 2018 the following remedy will be imposed:

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

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:

- Discretionary 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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

Aitkin Health Services September 6, 2018 Page 4

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 23, 2018 (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

Aitkin Health Services September 6, 2018 Page 5

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 February 23, 2019 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division Aitkin Health Services September 6, 2018 Page 6

> 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

> Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245119	B. WING		08/	/23/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 301 MINNESOTA AVENUE SOUTH AITKIN, MN 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 CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0(00		
F 000	Emergency Prepare conducted 8/20/18, recertification surve	iance with CMS Appendix Z edness Requirements, was through 8/23/18, during a ey. The facility is in compliance C Emergency Preparedness	F 0	00		
	was completed at y Department of Hea was in compliance	h 8/23/18, a standard survey our facility by the Minnesota Ith to determine if your facility with the requirements of 42 part B, and Requirements for icilities.				
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve f compliance upon the otance. Because you are rour signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.				
F 580 SS=D	on-site revisit of you validate that substa regulations has bee your verification. Notify of Changes (acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with Injury/Decline/Room, etc.) 14)(i)-(iv)(15)	F 5	80		10/2/18
	§483.10(g)(14) Not (i) A facility must im consult with the res consistent with his of representative(s) w (A) An accident inve	olving the resident which				
	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 09/14/2018
Election	ically Signed					03/14/2010

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.

PRINTED: 09/24/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING	í		08/2	23/2018
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	HEALTH SERVICES				301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	results in injury and physician intervention (B) A significant char mental, or psychoso deterioration in hear status in either life-to- clinical complication (C) A need to alter that a need to discontinue treatment due to add commence a new for (D) A decision to transition resident from the far §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent information is available and pro- physician. (iii) The facility must resident and the rest when there is- (A) A change in root as specified in §483 (B) A change in rest State law or regulatt (e)(10) of this section (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a com- that is a composite §483.5) must disclo- its physical configur	I has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lith, mental, or psychosocial threatening conditions or ns); treatment significantly (that is, ue an existing form of dverse consequences, or to orm of treatment); or ansfer or discharge the acility as specified in otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the at also promptly notify the sident representative, if any, and or roommate assignment 3.10(e)(6); or ident rights under Federal or tions as specified in paragraph on. at record and periodically a (mailing and email) and	F 5	580			

Facility ID: 00002

If continuation sheet Page 2 of 26

		& MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		E SURVEY PLETED
		245119	B. WING			23/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
AITKIN H	IEALTH SERVICES			301 MINNESOTA AVENUE SOUTH 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 580	Continued From pa	age 2	F 58	0		
	room changes betw under §483.15(c)(9 This REQUIREME by:	cify the policies that apply to veen its different locations)). NT is not met as evidenced v and document review, the		P42⊡a representative was	advised of the	
	facility failed to ens was informed of a r	ure the resident representative new skin condition for 1 of 3 viewed for notification of		R42⊡s representative was chronic reoccurring blister to edema. All residents with change in) her leg r/t	
	Findings include:	arintad 9/22/19 indiactad		be reviewed to ensure repre notified appropriately accord regulation and policy.	sentative is	
	R42's diagnoses in disease (a blood ci decreases blood flo diabetes, amputation dementia. R42's F	printed 8/23/18, indicated cluded peripheral vascular rculation problem that ow to the extremities), on of an extremity, and ace Sheet further indicated ident representative was also		All licensed nursing staff will on the regulation and policy of changes. Policy and proc notification of changes was revised.	r/t notification edures r/t	
	power of attorney for R42's significant ch (MDS) dated 7/20/7 moderate hearing of impaired cognitive arterial (circulatory) for pressure ulcers			DON/designee will complete audits to ensure the resident/representative was change in condition as direc 3 random chart audits will be per week for 4 weeks and th for 2 months then monthly th Audit results will be brought committee for review and fu recommendations	updated on ted by policy. e completed ien 2x/month nereafter. to the QAPI	
	at potential for sign	ted 3/5/18, indicated R42 was ificant changes in medical at risk for skin breakdown.		Completion date: 10/2/18		
	have a white dress	5 p.m. R42 was observed to ing and wrap on the left shin ith the skin reddened and essing.				

If continuation sheet Page 3 of 26

		AND HUMAN SERVICES				FORM	09/24/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION		E SURVEY PLETED
		245119	B. WING			08/2	23/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AITKIN H	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 580	Continued From pa	ge 3	F 5	80			
	was interviewed and sore on her left leg. she had not been n leg. R42's represend during the conversa concerned that the change, and she ex- changes. R42's medical reco R42's representative change in skin cond On 8/23/18, at 3:41 (LPN)-A stated she representative of th stated R42's representative sore on R42's leg. On 8/23/18, at 3:44 (DON) stated she winotify resident representative of the stated she winotify resident representative of the stated she winotify resident representative she winotify representative s	 p.m. R42's representative d stated R42 had a big, red R42's representative stated otified of the sore on R42's tative repeated this concernation, and stated she was facility did not notify her of the cpected them to notify her of rd lacked documentation that re had been notified of R42's dition. p.m. licensed practical nurse thought she had told R42's e sore on R42's leg. LPN-A sentative was aware of the p.m. the director of nursing yould expect the facility would esentatives of changes in 					
F 585 SS=D	10/17, directed nurs resident, consult wi resident representa significant change f a new form of treats further directed ever mentally competent representative woul changes in the resid Grievances		F 5	85			10/2/18

If continuation sheet Page 4 of 26

		AND HUMAN SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING			08/2	23/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	EALTH SERVICES				01 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	Continued From pa	ige 4	F £	585			
	grievances to the fa that hears grievance reprisal and without reprisal. Such griev respect to care and furnished as well as furnished, the beha residents, and othe facility stay. §483.10(j)(2) The re facility must make p resolve grievances accordance with thi §483.10(j)(3) The fa on how to file a grie to the resident. §483.10(j)(4) The fa grievance policy to of all grievances reg contained in this pa provider must give a to the resident. The include: (i) Notifying residen postings in promine facility of the right to (meaning spoken) of grievance offican be filed, that is, address (mailing an	esident has the right to voice acility or other agency or entity ses without discrimination or t fear of discrimination or vances include those with I treatment which has been s that which has not been avior of staff and of other or concerns regarding their LTC esident has the right to and the prompt efforts by the facility to the resident may have, in					

		AND HUMAN SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING	i		08/2	23/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH SERVICES			-	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	completing the revie to obtain a written of grievance; and the independent entities be filed, that is, the Quality Improvement Agency and State L program or protecti (ii) Identifying a Grie responsible for over receiving and tracking conclusions; leading by the facility; main information associate example, the identify grievances submitted written grievance do coordinating with st necessary in light of (iii) As necessary, the prevent further poter right while the allege investigated; (iv) Consistent with reporting all alleged abuse, including inj and/or misappropria anyone furnishing s provider, to the adm as required by State (v) Ensuring that all include the date the summary of the per regarding the reside as to whether the g	ew of the grievance; the right decision regarding his or her contact information of s with whom grievances may pertinent State agency, nt Organization, State Survey ong-Term Care Ombudsman on and advocacy system; evance Official who is rseeing the grievance process, ing grievances through to their g any necessary investigations taining the confidentiality of all ated with grievances, for ty of the resident for those ed anonymously, issuing ecisions to the resident; and rate and federal agencies as f specific allegations; aking immediate action to ential violations of any resident ed violation is being §483.12(c)(1), immediately d violations involving neglect, uries of unknown source, ation of resident property, by services on behalf of the ninistrator of the provider; and	F 5	585	5		

If continuation sheet Page 6 of 26

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 09/24/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DAT	E SURVEY IPLETED
		245119	B. WING		08/	23/2018
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	ST	IREET ADDRESS, CITY, STATE, ZIP CODE	
AITKIN H	EALTH SERVICES				01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	taken by the facility and the date the wr (vi) Taking appropri accordance with Sta of the residents' rigi or if an outside entit the State Survey Ag Organization, or loc confirms a violation rights within its area (vii) Maintaining evi result of all grievand 3 years from the iss decision. This REQUIREMEN by: Based on observat review, the facility fa concerns for 1 of 2 grievances. Findings include: R5's Face Sheet pr diagnoses included behaviors and scoli R5's General Nurse 8/8/18, indicated R5 impairment. On 8/20/18, at 4:14 (FM)-A was intervie using a lap tray on I removed it, stating i he had spoken to th concern with remov the lap tray for place	ge 6 as a result of the grievance, itten decision was issued; ate corrective action in ate law if the alleged violation nts is confirmed by the facility ty having jurisdiction, such as gency, Quality Improvement al law enforcement agency for any of these residents' a of responsibility; and dence demonstrating the ces for a period of no less than suance of the grievance NT is not met as evidenced ion, interview, and document ailed to act upon reported residents (R5) reviewed for inted 8/22/18, indicated R5's unspecified dementia without osis (curvature of the spine). I's Observation note dated 5 had severe cognitive p.m. R5's family member wed, and stated R5 had been her wheelchair, but the facility t was a restraint. FM-A stated he facility staff about his ing it. FM-A stated R5 used ement of an activity blanket or i5 to touch. FM-A stated the essed his concern to his	F 5	585	R5- met with representative to follow up on the concern related removal of lap tray. Offered personal padded lap desk as an alternative or tray table to accommodate. Resident representative satisfied with alternative. A letter was sent out to all resident's and/or representatives that included the grievance policy as a way to make resident's/representatives aware of how to voice concerns as well as how to file a grievance. Staff responsible for reviewing the admission packet on admission will document that the grievance policy was reviewed. All staff were re-educated on the grievance policy and how to document a concern	

Facility ID: 00002

		AND HUMAN SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT OF DEFICI AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245119	B. WING			08/2	23/2018
NAME OF PROVIDER (OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN HEALTH S	ERVICES				01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431		
PREFIX (EAC	H DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
R5's Oc Encount tray on I and also or stuffe activities Summa tray enc R5's so an activi Evaluati indicate displeas R5's OT 7/18/18, appropr tray. On 8/22 (OT)-A v was a p straps a addition wheelch removed improve other pe placed c OT-A st in the wi improve using a continue	cupational ter note dat R5's wheeled o provided a ad animal to s and tactile ry note date ouraged er cial engage ity blanket of on and Pla d R5's familie ad R5's familie ad with the Evaluation indicated I iate, and di /18, at 2:08 was intervie added tray, nd replace ad velcro fa air which a d quickly. C d R5's abili cople, and F on the tray fa ted the lap heelchair, to posture. C d to reque /18, at 2:23 was intervie	Therapy (OT) Treatment ed 3/12/18, indicated the lap chair improved R5's posture, a place for an activity blanket a sasist R5 with sensory e stimulation. An OT Discharge ed 3/22/18, indicated R5's lap ect posture and increased ment by providing a place for or stuffed animal to sit. An OT n of Treatment dated 5/23/18, ly member (FM)-A was e removal of the full lap tray. and Plan of Treatment dated R5's wheelchair was no longer d not address use of the lap 8 p.m. occupational therapist ewed and stated R5's lap tray and OT had removed the d them with velcro fastener. An stener was placed on R5's llowed the lap tray to be 0T-A stated the lap tray ty to make eye contact with R5 was able to have objects to provide tactile stimulation. tray was not used to keep R5 but to facilitate positioning and 0T-A stated R5 was currently lchair. OT-A stated FM-A st the lap tray be resumed. B p.m. the director of nursing wed. The DON stated the lap after discussion about it being	F 5	585	SS/designee will follow up concerns are brought forward to ensure the of has been addressed to the complait satisfaction. Will audit all concerns 2x/week for 1 month then 2x/month months and then monthly thereafte results will be brought to the QAPI committee for review and further recommendations Completion date: 10/2/18	concern inant's n for 2	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245119	B. WING			08/2	23/2018
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH SERVICES				1 MINNESOTA AVENUE SOUTH TKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585 F 641 SS=D	a restraint. The DO compliance officer to restraint, and needed stated R5's lap tray activities. The facility Grievand directed a grievand care or treatment, the individuals receiving regarding a residen voiced by an individ investigate and residen voiced by an individ investigate and residen voiced by an individ investigate and residen Accuracy of Assess CFR(s): 483.20(g) §483.20(g) Accurace The assessment more resident's status. This REQUIREMEN by: Based on observator review, the facility fa Minimum Data Setor tissue injury for 1 of for pressure ulcers. Findings include: Pressure ulcer stag Pressure Ulcer Adv Deep Tissue Presson non-blanchable deed discoloration Intact or non-intactor purple discoloration	N stated the corporate thought the lap tray was a ed to be removed. The DON was used for positioning and ce policy dated 1/9/17, e included those regarding he behavior of staff or other g services, and other concerns t stay. If a grievance was lual, the facility would promptly olve the grievance. sments cy of Assessments. ust accurately reflect the NT is not met as evidenced tion, interview, and document ailed to accurately code the (MDS) to identify a deep f 3 residents (R24) reviewed	F 6	585	R24- a modification of the MDS AR 6/26/18 was corrected to reflect the tissue injury (DTI). All residents will be reviewed to ens that the MDS is coded accurately. Staff involved in coding the MDS we re-educated on ensuring the coding MDS is accurate and reflects the assessment. DON/designee will complete randor audits of the MDS. A total of 2 reco be audited weekly for 4 weeks and record monthly thereafter. Audit res will be brought to the QAPI committ	2D deep sure of the ords will then 1 sults	

Facility ID: 00002

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245119	B. WING _			08/:	23/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH 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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From pa	ige 9	F 64	41			
		ure change often precede skin coloration may appear			review and further recommendation	IS	
	differently in darkly results from intense and shear forces at The wound may ev	pigmented skin. This injury e and/or prolonged pressure t the bone-muscle interface. rolve rapidly to reveal the sue injury, or may resolve			Completion date: 10/2/18		
	without tissue loss. subcutaneous tissu muscle or other und this indicates a full						
	DTPI to describe va						
	included diagnoses	Order Sheet printed 8/23/18, of type two diabetes with y, and stage four chronic					
	6/20/18, and compl R24 was at low risk	se's Observation started on leted on 6/26/18, indicated (for pressure ulcers, and had ((DTI) on the left heel which					
	reference date (AR completion date of moderately impaire identified R24 requi staff with activities of MDS also indicated ulcers, did not have ulcers, and had a h present on the prior	PS with an assessment (D) of 6/26/18, and a 7/3/18, indicated R24 had ed cognition. The MDS ired extensive assistance from of daily living (ADLs). The d R24 was at risk for pressure e any unhealed pressure healed pressure ulcer that was r assessment. The MDS n of R24's deep tissue injury.					
	On 8/21/18, at 9:43	a.m. R24 was observed to					

Facility ID: 00002

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		AND HUMAN SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING			08/2	23/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	HEALTH SERVICES				01 MINNESOTA AVENUE SOUTH NTKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	have a gripper sock on the right foot. R2 the back of her foot on it that morning, b On 8/23/18, at 10:3 observed with licent R24's DTI was obse heel on the Achilles approximately the s brown in color with R24 had the DTI for stated she had the stated she had the stated she thought shoe. On 8/23/18, at 12:4 (RN)-D (the facility DTI was not identifin MDS, and stated it assessment referent through 6/26/18, and the assessment pel R24's MDS should DTI. On 8/23/18, at 1:01 (DON) stated she we be accurate. The facility's MDS 3 4/6/15, directed the residents were asses needs, develop an it to ensure the MDS the interdisciplinary	c on the left foot, and a shoe 24 stated she had a sore on t, they had used scissors to cut	F6	641			

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1		<u>MB NO.</u>	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245119	B. WING		08/2	23/2018
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	IEALTH SERVICES			301 MINNESOTA AVENUE SOUTH 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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 760	Continued From pa	ige 11	F 760)		
	Residents are Free CFR(s): 483.45(f)(2	of Significant Med Errors 2)	F 760			10/2/18
	medication errors. This REQUIREMEN by: Based on observat review, the facility f dosing of insulin wi primed for 1 of 2 re insulin administration Findings include: R14's Face Sheet p	tents are free of any significant NT is not met as evidenced tion, interview, and document ailed to ensure appropriate th an insulin pen that was not sidents (R14) observed for		R14- staff caring for R14 were re-educated on priming an insulin p prior to administration All residents that utilize insulin pens the potential to be affected by a del practice in this area. All licensed nursing staff were re-educated on the procedure for p	s have ficient	
	orders for Lantus Ir subcutaneously 1 ti Flexpen 7 units at 7 p.m., and 9 units at had an order for No scale based on her On 8/20/18, at 4:56 was observed prep for an insulin injecti needle on the Flexy dial to 8 units witho units of insulin. RN RN-C injected the 8 abdomen. After lea asked about primin the ordered dose o	ders dated 7/10/18, directed hsulin Pen 30 units imes a day, Novolog Insulin by 11:30 a.m., 8 units at 4:30 t 7:30 a.m. In addition, R14 byolog Flexpen Insulin sliding blood glucose levels. 6 p.m. registered nurse (RN-C) aring Novalog insulin Flexpen ion for R14. RN-C placed the ben, dialed the Flexpen dose but priming the needle with 2 -D proceeded to R14's room. 8 units of insulin into R14's ving R14's room, RN-C was ig the needle prior to setting f insulin. RN-C stated she did le, and it should have been		an insulin pen. The insulin pen pol reviewed and revised. DON/designee will perform random observational audits 3x/week for 4 and then 2x/month for 2 months the monthly thereafter. Audit results w brought to the QAPI committee for and further recommendations Completion date: 10/2/18	n weeks en ill be	

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		AND HUMAN SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING			08/2	23/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH NTKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760 F 761 SS=D	units. On 8/22/18, at 2:23 (DON) was interview should primed the r given, to ensure acc insulin. The DON st training on insulin a further stated the medle dose of insulin given The facility policy In directed prime the in dose dial at 2 units, the way in. Label/Store Drugs a CFR(s): 483.45(g)(f §483.45(g) Labeling Drugs and biological labeled in accordan professional princip	of insulin before setting it for 8 PM the director of nursing wed and stated the nurse needle every time a dose was curate administration of tated staff had received administration. The DON nanufacturer's instructions also e should be primed with each n. nsulin Pens dated 3/23/18, nsulin pens by setting the , and press the push button all and Biologicals h)(1)(2) g of Drugs and Biologicals als used in the facility must be nee with currently accepted oles, and include the	F 7		DEFICIENCY)		10/2/18
	applicable.	e expiration date when					
	§483.45(h) Storage	of Drugs and Biologicals					
	Federal laws, the fa	cordance with State and acility must store all drugs and d compartments under proper ls, and permit only authorized access to the keys.					
		facility must provide separately y affixed compartments for					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING			08/2	23/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	EALTH SERVICES				01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	storage of controlle the Comprehensive Control Act of 1976 abuse, except when package drug distril quantity stored is m be readily detected. This REQUIREMEN by: Based on observat review, the facility fa drops were not in us the medication cart observed for medic Findings include: On 8/21/18, at 3:12 medication cart with (LPN-A), a bottle of to R42 were noted to 5/18. LPN-A stated check the expiration prior to administratii expired it was to be received the Cosop day. LPN-A stated F of the eye drops in was unable to tell w currently being used R42's Face Sheet p diagnosis of dry eye lacrimal gland. R42 7/24/18, directed Co each eye twice a da On 8/22/18, at 2:23	d drugs listed in Schedule II of e Drug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can NT is not met as evidenced ion, interview, and document ailed to ensure expired eye se and were removed from in 1 of 2 medication carts ation storage. p.m. during inspection of the n licensed practical nurse Cosopt eye drops belonging to have an expiration date of the facility protocol was to n date on the medications on, and if the medication was ordered. LPN-A stated R42 t drops to both eyes twice a R42 had two additional bottles the medication cart, and she shich bottle of eyedrops were d for R42.	F 7	761	R42 s Cosopt eye drops were ren from the medication cart. All residents have the potential to b affected. All medications were check for viab All licensed nursing staff and Traine Medication Aides (TMA s) were re-educated on the Medication Stor Policy as it relates to expired medic DON/designee will perform random observational audits 3x/week for 4 and then 2x/month for 2 months the monthly thereafter. Audit results wi brought to the QAPI committee for and further recommendations Completion date: 10/2/18	e bility. ed rage cations weeks en ill be	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING			08/2	23/2018
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	EALTH SERVICES				01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761 F 812 SS=F	medication prior to a DON stated if a mere expired, it was to be medication cart and was ordered. The D way of knowing if R drops. The facility Medicat 7/26/17, directed the discontinued, outdat biologicals. Food Procurement, CFR(s): 483.60(i)(1) §483.60(i) Food saf The facility must - §483.60(i)(1) - Proc approved or conside state or local author (i) This may include from local producer and local laws or re (ii) This provision do facilities from using gardens, subject to safe growing and foo (iii) This provision d from consuming foo §483.60(i)(2) - Store serve food in accord standards for food s This REQUIREMEN by:	the expiration date of administering medication. The dication was found to be a removed from the destroyed, and a new supply ON also stated there was no 42 received the expired eye ion Storage Policy dated e facility shall not use ted, or deteriorated drugs or Store/Prepare/Serve-Sanitary)(2) fety requirements. ure food from sources ered satisfactory by federal, rities. food items obtained directly s, subject to applicable State gulations. Des not prohibit or prevent produce grown in facility compliance with applicable od-handling practices. oes not procured by the facility. e, prepare, distribute and dance with professional service safety. NT is not met as evidenced	F 7	312			10/2/18
	Based on observat	ion, interview, and document			Dietary staff involved in meal servio	ce	

Facility ID: 00002

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		& MEDICAID SERVICES				<u>MB NO.</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245119	B. WING_			08/23/2018	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	EALTH SERVICES				01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 812	Continued From pa	ge 15	F 8	12			
		ailed to ensure proper hand			were re-educated on proper hand		
	hygiene and use of	utensils for handling of food			hygiene, proper use of utensils for		
	during food service				handling of food during food servic		
		n for 7 of 23 residents (R24,			also on the procedure for heating u		
		, R32, and R4) eating in the oom. In addition, the facility			Dietary staff were also re-educated process for washing and drying pa		
		per temperatures of soup prior			other utensils.	ns anu	
		t food-borne illness for 2 of 2					
ו ג ו	0 1) who were served soup. In			All residents have the potential to b	be	
		failed to ensure food service			affected by a deficient practice in the	his	
		free of food debris when			area.		
		d ready for use to prevent This had the potential to affect			All dietary, nursing, and activity sta	ffworo	
		p received food from the			re-educated on proper hand hygier		
	kitchen.				use of gloves during meal service.		
					dietary, nursing, and activity staff w	vere	
	Findings include:				instructed on proper food handling		
					meal service, and the procedure for		
		orinted 8/23/18, indicated cluded severe chronic kidney			heating up food. Dietary staff wer re-educated on the process for wa		
		(swallowing problems), and			and drying pans and other utensils		
	diabetes.	(endiernig prezienie), and			T		
					he Assistant Dietary Manager/desi	gnee	
		printed 8/23/18, indicated			will perform random audits. 3 rand		
	-	cluded atrial fibrillation and			observational audits for hand hygie		
	hypertension.				during meal service will be comple weekly for 4 weeks, then 2 audits/r		
	R42's Face Sheet r	printed 8/23/18, indicated			for 2 months and then monthly the		
		cluded diabetes, ulcerative			to ensure ongoing compliance. 3		
	colitis, dementia, ar				observational audits will be comple		
					weekly for 4 weeks to ensure pans		
		printed 8/21/18, indicated			other utensils are clean and dry pri	or to	
		cluded cerebral infarction ion, gastro-esophageal reflux,			storage will be completed then 2 audits/month for 2 months, then 1	audit	
	and dysphagia.	on, gastro-esophayear renux,			monthly thereafter will be complete		
					ensure ongoing compliance. 3 ran		
	R2's Face Sheet pr	inted 8/23/18, indicated R2's			audits of food temps will be comple	eted	
	diagnoses included	heart failure, and			weekly for 4 weeks, then 2 audits/r		
	hypertension.				for 2 months, then monthly thereaf	tor to	

Facility ID: 00002

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		AND HUMAN SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING			08/2	23/2018
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH ITKIN, MN 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	Continued From pa	ige 16	F 8	12			
		printed 8/23/18, indicated cluded dementia, heart eritis and colitis.			ensure ongoing compliance. Audit results will be brought to the QAPI committee for review and further recommendations		
		inted 8/23/18, indicated R4's I diabetes, hypertension, and			Completion date: 10/2/18		
	diagnoses included	inted 8/23/18, indicated R1's l adult failure to thrive, ss, and hypertension.					
	dietary aide (DA)-A food from the steam her hands. DA-A to cupboards, and ope the microwave with preparing foods to s bread from the bag them in the toaster, down, then remove touching and openin donned clean glove DA-A pushed the to took the toast out of gloved hands, and p R24. The toast was the microwave to he The soup had been sat in ice in a bin or soup, warmed it lon served the soup wit temperature of the s	soup. The soup was not e. R31 and R1 received and soup of the day was beef stew,					

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		AND HUMAN SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245119	B. WING			08/	23/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
AITKIN H	EALTH SERVICES				301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 812	On 8/20/18, at 5:28 comes up cold, and days. DA-A stated t and verified she did the soup prior to se On 8/20/18, at 5:49 her gloved hands to she usually tried to meal service, after refrigerator, but she verified she used so or sanitize her hand during the supper n On 8/21/18, at 4:16 check the temperat DA-C stated soups freezer for the week thawed the day beft the soup of the day on the cold cart, in individual bowl, and reheated, are broug On 8/23/18, at 11:4 lunch. DA-B washe gloves. DA-B open soup, put it into a b soup and put some in a plastic containe gloved hands, pour gloves, and sanitize soup in the microwa donned clean glove	 p.m. DA-A stated the soup d. is on the cold cart for up to 3 hey warm it in the microwave, a not check the temperature of aving it. p.m. DA-A verified she used p.m. DA-C stated stated change her gloves throughout touching the microwave and e did not always do it. DA-A oiled gloves, and did not wash ds between glove changes neal. p.m. DA-C stated he would cure of soups prior to serving. are prepared, and go into the k, they are taken out to be ore serving, and then used for The soups are brought up ice, and heated by the d left-overs that have not been ght down to the cooler. 1 a.m. DA-B was setting up for ed her hands and donned ied the fridge, took out some owl, got another container of in a bowl, took out corn dogs er, and put two on a plate with ed milk into pudding, removed ed her hands. DA-B then put 	F٤	312			

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I					FORM	09/24/2018 APPROVED 0938-0391
	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245119	B. WING			08/2	23/2018
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN HEALTH SERVICES			-	01 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
 the soup was placed b when checked again, it DA-B stated the soup s degrees. At 11:53 a.m steaming soup was rer and the temperature of soup was served. The in the microwave for 1 checked the temperatu 115 degrees F. The co in the microwave and it On 8/22/18, at 11:54 a. out of the bag with glow ham sandwich for R42 At 11:55 a.m. DA-B rer the microwave and che was 176 degrees F. On 8/22/18, at 11:56 a. of the container with sa and placed the lettuce plate was served to R3 microwave and checked bowl of soup. At 11:59 of the bag with same g plate and it was served DA-B took a piece of b gloved hands and it wa p.m. DA-B took a piece of with the same gloved f R32's family member s served the corn dogs. Prior to the meal and d nursing assistants had 	the temperature. The egrees Fahrenheit (F), and back in the microwave, and it was 115 degrees F. should be 150-160 n. the soup was boiling. The moved from the microwave, of the soup was 177. The e NA then put the corn dogs minute and at 11:53 a.m. ure. The temperature was orn dogs were placed back it was restarted. a.m. DA-B took the bread ved hands, and made a 2, which was served to R42. moved the corn dogs from ecked the temperature. It a.m. DA-B took lettuce out ame gloved hands, tore it, on a plate for R36. The 36. DA-B opened the ed the temperature of a 9 a.m., DA-B took bread out gloved hands, put it on a d to R31. At 12:01 p.m. oread out with the same as served to R2. At 12:02 e of bread out of the bag hands and it was given to seated next to him. R4 was	F 8	312			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING			08/2	23/2018
NAME OF PRO	VIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN HEA	LTH SERVICES				01 MINNESOTA AVENUE SOUTH NITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
PC in Ou fou lef tel als ar re Ou as pa fou lau re fou fou lau re fou fou dis ve ar to be dis cov AL fou fou fou lau fou fou fou fou fou fou fou fou fou fo	the kitchen area. In 8/22/18, at 12:0 rgot to use tongs in tuce. DA-B state mperature of the sister so stated she che ind if wet or had for washed. In 8/20/18, at 2:09 sistant dietary may ans were wet and ans were observed r mashed potatoe rge pans were we sidue. ADM state r such foods as la od residue on the shwasher to be be rified the pans an ind were ready for be air dried prior e checking pans p shwasher if wet or pol foods in small p vers. If they cool a DM stated they do ods while cooling mperature logs. In 8/22/18, at 12:22 pup, put it in small en switch the soup ne soup goes up co powl by bowl. They	ge 19 fee, and touch various items 7 p.m. DA-B verified she for the bread, corn dogs and d she always checked the soup after microwaving. DA-B cked the pans before using, od debris, will have them p.m. during a tour with anager (ADM), 3 medium food 2 had residue. 21 medium d. ADM stated they are used s, and such foods. 2 of 10 t, and 1 of 10 pans had food ed the larger pans were used sagne. 2 of 12 scoops had m. ADM gave them to the e re-cleaned. The ADM d utensils had been cleaned, use. ADM stated the pan are to storage, dietary staff are to rior to use, and return to r unclean. ADM stated they pans, but rarely cool left anything, they cool soups. on the cold cart, and warm it throw away the soup after it r 3 days. ADM stated each	F	312			

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		AND HUMAN SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245119	B. WING			08/2	23/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	EALTH SERVICES				01 MINNESOTA AVENUE SOUTH NITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	ADM verified dietar between tasks, betw they should use ton ADM stated staff sh touching anything er risk of bacteria in for temperature, and co death. The facility policy H undated, directed d after handing soiled clean dishes, etc. a anything that is not contaminates. The gloves get just as d changed between the The facility policy P Illness-Employee H undated, directed d during food prepara remove soil and con cross contamination policy indicated foo- trained in the prope foodborne illness, a discarded after com- were used. The facility policy F directed dietary stat to eat foods to 165 temperatures would thermometer to ensist service equipment a sanitized according policy further directed	y staff should wash hands ween changing gloves, and logs for bread and other foods. hould change gloves after else. ADM stated there was a bod if it was not at the proper ould cause illness or even and Washing of Employees lietary staff to wash hands d utensils, going from dirty to and touching door handles or sanitary and could carry policy included a reminder that lirty as hands, and need to be asks. reventing Foodborne lygiene and Sanitary Practices lietary staff to wash hands ation, as often as necessary to ntamination, and to prevent in when changing tasks. The d service employees would be er use of utensils to prevent and gloves were to be inpleting the task for which they ood Handling undated, ff to heat leftovers and ready degrees F. Food	F٤	312			

Facility ID: 00002

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245119	B. WING	-		08/:	23/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	EALTH SERVICES				301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	sanitized, dried, and The facility policy D directed pots and pa to remove debris, p machine, and place rack to dry. Once d and put away. Resident Records - CFR(s): 483.20(f)(5) §483.20(f)(5) Resid (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a c agrees not to use of except to the extent to do so. §483.70(i) Medical n §483.70(i)(1) In acc professional standa must maintain medi that are- (i) Complete; (ii) Accurately docun (iii) Readily accessid (iv) Systematically c	ipment should be cleaned, d reassembled after each use. ishes and Utensils dated 2/18, ans to be scraped and rinsed rocess through the dish all pots and pans on a drying dry, they were to be stacked Identifiable Information b), 483.70(i)(1)-(5) ent-identifiable information. crelease information that is to the public. release information that is to an agent only in contract under which the agent r disclose the information t the facility itself is permitted records. cordance with accepted and practices, the facility ical records on each resident mented; ble; and organized acility must keep confidential ained in the resident's records, rm or storage method of the en release is-	F		2		10/2/18
	regardless of the fo records, except whe (i) To the individual,	rm or storage method of the en release is-					

		AND HUMAN SERVICES				FORM	09/24/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245119	B. WING			08/:	23/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AITKIN H	EALTH SERVICES				01 MINNESOTA AVENUE SOUTH NITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	 (ii) Required by Law (iii) For treatment, poperations, as pern with 45 CFR 164.50 (iv) For public healt neglect, or domesti activities, judicial ar law enforcement pupuposes, research medical examiners, a serious threat to he by and in compliance §483.70(i)(3) The farecord information a unauthorized use. §483.70(i)(4) Medic for- (i) The period of time (ii) Five years from there is no requiren (iii) For a minor, 3 y legal age under Statistical age and resident review determinations con (v) Physician's, nursprofessional's progressional's progressio	v; payment, or health care nitted by and in compliance D6; h activities, reporting of abuse, c violence, health oversight nd administrative proceedings, urposes, organ donation purposes, or to coroners, funeral directors, and to avert nealth or safety as permitted ce with 45 CFR 164.512. acility must safeguard medical against loss, destruction, or cal records must be retained ne required by State law; or the date of discharge when nent in State law; or rears after a resident reaches ite law. nedical record must contain- ation to identify the resident; esident's assessments; usive plan of care and services any preadmission screening v evaluations and ducted by the State; se's, and other licensed	Fε	342			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	LETED		
		245119	B. WING		08/2	3/2018		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
AITKIN H	EALTH SERVICES			301 MINNESOTA AVENUE SOUTH 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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE		
F 842	Continued From pa	age 23	F 84	2				
	facility failed to ens representative wish were accurately do medical record for reviewed for advan Findings include: R30's quarterly Min 7/24/18, indicated F	nimum Data Set (MDS) dated R30 was cognitively intact.		 R30's face sheet was upon accurately reflect the resident advance directives as indited POLST and physician orders were accurately reflect the resident advance directives as indited POLST and face sheet. All residents were reviewere resident's wishes for advance directives as indited advance directives as a sheet. 	lent's wishes for cated on the er ere updated to lent's wishes for cated on the ed to ensure the nce directives			
	R30's diagnoses in Type 2 diabetes. TI R30's advanced din attempt resuscitation R30's Provider Ord	printed 8/21/18, indicated icluded multiple sclerosis and he Face Sheet also indicated rective was "Full Code" or on/CPR. lers for Life-Sustaining		were accurately document of the medical record. Advanced Directive orders be put into the electronic p but will remain in the EMR well as the signed POLST	s will no longer bhysician orders, t for viewing as			
	selected "Do Not A	on 4/6/18, indicated R30 had ttempt Resuscitation/DNR" for tatus in the event R42 had no breathing.		All licensed staff were edu process for documenting r wishes as it relates to adv	resident's ance directives.			
	R30 was DNR resu			DON/designee will complete audits. 2 random chart au completed weekly for 4 we records/month for 2 month	idits will be eeks and then 2 ns then monthly			
	(DON) verified R30 Face Sheet, and P) p.m. the director of nursing)'s code status on her POLST, hysician Orders did not match.		thereafter to ensure advar are accurately documente the medical record. Audit brought to the QAPI comm	d in all areas of results will be nittee for review			
	her code status to l) p.m. R30 verified she wanted be "DNR." IDS dated 7/18/18, indicated		and further recommendati Completion date: 10/2/18				

Facility ID: 00002

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		AND HUMAN SERVICES				FORM	09/24/2018 APPROVED			
CENTERS FOR MEDICARE & MEDICAID SERVICESSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT A. BUILDIN		MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED					
		245119	B. WING_			08/:	23/2018			
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	SI	TREET ADDRESS, CITY, STATE, ZIP CODE	-				
	IEALTH SERVICES		301 MINNESOTA AVENUE SOUTH AITKIN, MN 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 842	R36's diagnoses ind (stroke), and hyperf The Face Sheet als directive was "Full O resuscitation/CPR. R36's POLST signet the nurse practition selected "Attempt F for her code status and was not breath R36's Physician Orr R36 was a DNR sta On 8/21/18, at 3:41 code status on her Physician Orders di On 8/21/18, at 4:44 CPR to be attempte On 8/21/18, at 4:44 CPR to be attempte On 8/21/18, at 3:21 assistant (TMA)-A s POLST or the elect for the resident's re was found without a On 8/21/18, at 3:26 (LPN)-A stated she medication adminis POLST to determin status. On 8/21/18, at 3:34 stated she would lo resident's resuscita	cluded cerebral infarction tension (high blood pressure). so indicated R30's advanced Code" or attempt ed by R36 on 7/5/18, and by er 7/6/18, indicated R36 had Resuscitation/CPR" or full code in the event R36 had no pulse ing. ders signed 7/24/18, indicated atus. p.m. the DON verified R36's POLST, Face Sheet, and id not match. p.m. trained medication stated he would look at the ronic medical record (EMR) esuscitation status if a resident a pulse or respirations. p.m. licensed practical nurse would look at the electronic stration record (eMAR) or the ne a resident's resuscitation of p.m. registered nurse (RN)-A bok at the POLST for the	F 84	42						

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/24/2018 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
245119		B. WING			08/23/2018				
NAME OF I	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE				
	HEALTH SERVICES		301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 842	could look at the EN resident's resuscita On 8/21/18, at 3:41 could be a risk of re honored. On 8/22/18, at 8:40 POLSTs were not b physician/NP orders residents came in v signed a POLST wi physician orders, ai places in the medic The facility policy A 2/18, directed the re to complete and sig policy directed the s	MR or the POLST for the ation status. I p.m. the DON verified there esident wishes not being 0 a.m. the DON stated the new being processed as is all the time. The DON stated with physician orders and then hich may be different from the nd this was not changed in all cal record. dvance Care Planning dated esident's health care provider gn the resident's POLST. The signed POLST would be er for care, and would be noted	F 8	42					

Facility ID: 00002

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					F5119027	FORM	08/28/2018 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 '	LE CONSTRUCTION 01 - MAIN BUILDING 01	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		245119		B. WING	WING 08/21		/2018
	PROVIDER OR SUPPLIER HEALTH SERVICES		301 MIN		tate, zip code AVENUE SOUTH 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCII F BE PRECEDED BY FULL INTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 00	0 INITIAL COMMEN	TS		K 000			-
	Minnesota Departn Marshal Division. A Aitkin Health Servic with the requirement Medicare/Medicaid 483.70(a), Life Safe edition of National	Survey was conduct nent of Public Safety At the time of this sur- ces was found in con- nts for participation in at 42 CFR, Subpart ety from Fire, and the Fire Protection Assoc 01, Life Safety Code g Health Care.	, Fire vey, npliance 1 e 2012 ciation				
	a full basement. The constructed in 1955 dining room main e the existing building II(111) construction was added that wa	ces is a one story bu be original building w 5 with additions in 19 entry was added in 20 g and the addition ar 1. In 2009-2010 an a s a one story additio was determined to b	as 162, and a 202. Both e type ddition n with a				
	facility has a comp smoke detection in open to the corrido	y sprinkler protected. lete fire alarm syster the corridors and sp r, that is monitored f artment notification.	n with baces				
		censed capacity of 4 of 43 at the time of tl					
	At this time, the co 483.70(a) is MET.	nditions of 42 CFR, 3	Subpart				
LABORAT	ORY DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRES	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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APP CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLI IDENTIFICATION NU			R/CLIA (X2) MULTIPLE CONSTRU IBER: A. BUILDING 01 - MAIN I		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
245119			B. WING			08/21/2018		
	PROVIDER OR SUPPLIER				STATE, ZIP CODE	•		
	HEALTH SERVICES			NNESOTA , MN 5643	AVENUE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL I INTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	

If continuation sheet Page 2 of 2

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