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.

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.

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.

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 8/20/18, through 8/23/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 8/20/18, through 8/23/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An Informal Dispute Resolution was requested and as a result the following tags will be removed from the 2567, F580-Notification of change and F760-Residents are free of significant medication error.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4)	F 585		10/2/18

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

Electronically Signed | 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.

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F 585	Continued From page 1 §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right	F 585		

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F 585	Continued From page 2	F 585		

to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance,

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F 585	Continued From page 3 and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to act upon reported concerns for 1 of 2 residents (R5) reviewed for grievances. Findings include: R5's Face Sheet printed 8/22/18, indicated R5's diagnoses included unspecified dementia without behaviors and scoliosis (curvature of the spine). R5's General Nurse's Observation note dated 8/8/18, indicated R5 had severe cognitive impairment. On 8/20/18, at 4:14 p.m. R5's family member (FM)-A was interviewed, and stated R5 had been using a lap tray on her wheelchair, but the facility removed it, stating it was a restraint. FM-A stated he had spoken to the facility staff about his concern with removing it. FM-A stated R5 used the lap tray for placement of an activity blanket or stuffed animal for R5 to touch. FM-A stated the facility had not addressed his concern to his satisfaction.	F 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 SS/designee will follow up concerns that	

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F 585	Continued From page 4 R5's Occupational Therapy (OT) Treatment Encounter note dated 3/12/18, indicated the lap tray on R5's wheelchair improved R5's posture, and also provided a place for an activity blanket or stuffed animal to assist R5 with sensory activities and tactile stimulation. An OT Discharge Summary note dated 3/22/18, indicated R5's lap tray encouraged erect posture and increased R5's social engagement by providing a place for an activity blanket or stuffed animal to sit. An OT Evaluation and Plan of Treatment dated 5/23/18, indicated R5's family member (FM)-A was displeased with the removal of the full lap tray. R5's OT Evaluation and Plan of Treatment dated 7/18/18, indicated R5's wheelchair was no longer appropriate, and did not address use of the lap tray. On 8/22/18, at 2:08 p.m. occupational therapist (OT)-A was interviewed and stated R5's lap tray was a padded tray, and OT had removed the straps and replaced them with velcro fastener. An additional velcro fastener was placed on R5's wheelchair which allowed the lap tray to be removed quickly. OT-A stated the lap tray improved R5's ability to make eye contact with other people, and R5 was able to have objects placed on the tray to provide tactile stimulation. OT-A stated the lap tray was not used to keep R5 in the wheelchair, but to facilitate positioning and improve posture. OT-A stated R5 was currently using a tilting wheelchair. OT-A stated FM-A continued to request the lap tray be resumed. On 8/22/18, at 2:23 p.m. the director of nursing (DON) was interviewed. The DON stated the lap tray was removed after discussion about it being a restraint. The DON stated the corporate	F 585	are brought forward to ensure the concern has been addressed to the complainant's satisfaction. Will audit all concerns 2x/week for 1 month then 2x/month for 2 months and then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations Completion date: 10/2/18	

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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. 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		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on 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. Findings include: Pressure ulcer stages defined by the National Pressure Ulcer Advisory Panel: Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin	F 641	R24- a modification of the MDS ARD 6/26/18 was corrected to reflect the deep tissue injury (DTI). All residents will be reviewed to ensure that the MDS is coded accurately. 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 record monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations	10/2/18

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F 641	Continued From page 6 color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. R24's Physician's Order Sheet printed 8/23/18, included diagnoses of type two diabetes with diabetic neuropathy, and stage four chronic kidney disease. R24's General Nurse's Observation started on 6/20/18, and completed on 6/26/18, indicated R24 was at low risk for pressure ulcers, and had a deep tissue injury (DTI) on the left heel which was dry and intact. R24's quarterly MDS with an assessment reference date (ARD) of 6/26/18, and a completion date of 7/3/18, indicated R24 had moderately impaired cognition. The MDS identified R24 required extensive assistance from staff with activities of daily living (ADLs). The MDS also indicated R24 was at risk for pressure ulcers, did not have any unhealed pressure ulcers, and had a healed pressure ulcer that was present on the prior assessment. The MDS lacked identification of R24's deep tissue injury. On 8/21/18, at 9:43 a.m. R24 was observed to have a gripper sock on the left foot, and a shoe	F 641	Completion date: 10/2/18	

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F 641	Continued From page 7 on the right foot. R24 stated she had a sore on the back of her foot, they had used scissors to cut on it that morning, but it did not hurt. On 8/23/18, at 10:36 a.m. R24's DTI was observed with licensed practical nurse (LPN)-A. R24's DTI was observed located above the left heel on the Achilles area. The DTI was approximately the size of a quarter and was brown in color with lifted edges. LPN-A stated R24 had the DTI for six months or longer. R24 stated she had the area for a long time, and stated she thought it was from pressure from a shoe. On 8/23/18, at 12:47 p.m. registered nurse (RN)-D (the facility MDS coordinator) verified the DTI was not identified on R24's most current MDS, and stated it was missed. RN-D verified the assessment reference dates included 6/20/18, through 6/26/18, and R24 did have a DTI during the assessment period. RN-D further verified R24's MDS should have been coded as having a DTI. On 8/23/18, at 1:01 p.m. the director of nursing (DON) stated she would expect the MDS would be accurate. The facility's MDS 3.0 Assessment policy dated 4/6/15, directed the purpose was to ensure residents were assessed in order to identify care needs, develop an interdisciplinary care plan, and to ensure the MDS assessment coordinator and the interdisciplinary team followed the required process for submitting, validating, and correcting the MDS.	F 641		
F 761	Label/Store Drugs and Biologicals	F 761		10/2/18

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F 761 SS=D	Continued From page 8 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired eye drops were not in use and were removed from the medication cart in 1 of 2 medication carts observed for medication storage. Findings include: On 8/21/18, at 3:12 p.m. during inspection of the medication cart with licensed practical nurse	F 761	R42□s Cosopt eye drops were removed from the medication cart. All residents have the potential to be affected. All medications were check for viability. All licensed nursing staff and Trained Medication Aides (TMA□s) were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 761	Continued From page 9 (LPN-A), a bottle of Cosopt eye drops belonging to R42 were noted to have an expiration date of 5/18. LPN-A stated the facility protocol was to check the expiration date on the medications prior to administration, and if the medication was expired it was to be ordered. LPN-A stated R42 received the Cosopt drops to both eyes twice a day. LPN-A stated R42 had two additional bottles of the eye drops in the medication cart, and she was unable to tell which bottle of eyedrops were currently being used for R42. R42's Face Sheet printed 8/23/18, identified a diagnosis of dry eye syndrome of unspecified lacrimal gland. R42's Physician Orders dated 7/24/18, directed Cosopt eyedrops, one drop to each eye twice a day. On 8/22/18, at 2:23 p.m. the director of nursing (DON) was interviewed and stated staff was supposed to check the expiration date of medication prior to administering medication. The DON stated if a medication was found to be expired, it was to be removed from the medication cart and destroyed, and a new supply was ordered. The DON also stated there was no way of knowing if R42 received the expired eye drops. The facility Medication Storage Policy dated 7/26/17, directed the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals.	F 761	re-educated on the Medication Storage Policy as it relates to expired medications DON/designee will perform random observational audits 3x/week for 4 weeks and then 2x/month for 2 months then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations Completion date: 10/2/18	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		10/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

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F 812	Continued From page 10 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and use of utensils for handling of food during food service to prevent cross-contamination for 7 of 23 residents (R24, R31, R42, R36, R2, R32, and R4) eating in the Bear's Den dining room. In addition, the facility failed to ensure proper temperatures of soup prior to serving to prevent food-borne illness for 2 of 2 residents (R1, R31) who were served soup. In addition, the facility failed to ensure food service pans were dry and free of food debris when washed, stored, and ready for use to prevent food-borne illness. This had the potential to affect all 43 residents who received food from the kitchen. Findings include: R24's Face Sheet printed 8/23/18, indicated	F 812	Dietary staff involved in meal service were re-educated on proper hand hygiene, proper use of utensils for handling of food during food service, and also on the procedure for heating up food. Dietary staff were also re-educated on the process for washing and drying pans and 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 and use of gloves during meal service. All dietary, nursing, and activity staff were instructed on proper food handling during meal service, and the procedure for heating up food. Dietary staff were also	

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F 812	Continued From page 11 R24's diagnoses included severe chronic kidney disease, dysphagia (swallowing problems), and diabetes. R31's Face Sheet printed 8/23/18, indicated R31's diagnoses included atrial fibrillation and hypertension. R42's Face Sheet printed 8/23/18, indicated R42's diagnoses included diabetes, ulcerative colitis, dementia, and anemia. R36's Face Sheet printed 8/21/18, indicated R36's diagnoses included cerebral infarction (stroke), hypertension, gastro-esophageal reflux, and dysphagia. R2's Face Sheet printed 8/23/18, indicated R2's diagnoses included heart failure, and hypertension. R32's Face Sheet printed 8/23/18, indicated R32's diagnoses included dementia, heart disease, gastroenteritis and colitis. R4's Face Sheet printed 8/23/18, indicated R4's diagnoses included diabetes, hypertension, and atrial fibrillation. R1's Face Sheet printed 8/23/18, indicated R1's diagnoses included adult failure to thrive, abnormal weight loss, and hypertension. On 8/20/18, during the supper meal at 5:09 p.m. dietary aide (DA)-A was observed started serving food from the steam table. DA-A had gloves on her hands. DA-A touched plates, opened cupboards, and opened both the refrigerator and the microwave with her gloved hands while	F 812	re-educated on the process for washing and drying pans and other utensils. T he Assistant Dietary Manager/designee will perform random audits. 3 random observational audits for hand hygiene during meal service will be completed weekly for 4 weeks, then 2 audits/month for 2 months and then monthly thereafter to ensure ongoing compliance. 3 random observational audits will be completed weekly for 4 weeks to ensure pans and other utensils are clean and dry prior to storage will be completed then 2 audits/month for 2 months, then 1 audit monthly thereafter will be completed to ensure ongoing compliance. 3 random audits of food temps will be completed weekly for 4 weeks, then 2 audits/month for 2 months, then monthly thereafter to ensure ongoing compliance. Audit results will be brought to the QAPI committee for review and further recommendations Completion date: 10/2/18	

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F 812	Continued From page 12	F 812		

preparing foods to serve. DA-A took 2 pieces of bread from the bag with her gloved hands, placed them in the toaster, pushed the toaster lever down, then removed her soiled gloves after touching and opening packets of sauces. DA-A donned clean gloves without washing her hands. DA-A pushed the toaster lever down again, and took the toast out of the toaster with the same gloved hands, and placed the toast on a plate for R24. The toast was served to R24. DA-A used the microwave to heat soup in individual bowls. The soup had been taken from a serving dish that sat in ice in a bin on the cart. DA-A stirred the soup, warmed it longer, stirred it again, and served the soup without checking the temperature of the soup. The soup was not steaming at the time. R31 and R1 received and ate the soup. The soup of the day was beef stew, and a creamy soup was served.

On 8/20/18, at 5:28 p.m. DA-A stated the soup comes up cold, and is on the cold cart for up to 3 days. DA-A stated they warm it in the microwave, and verified she did not check the temperature of the soup prior to serving it.

On 8/20/18, at 5:49 p.m. DA-A verified she used her gloved hands to handle the bread, and stated she usually tried to change her gloves throughout meal service, after touching the microwave and refrigerator, but she did not always do it. DA-A verified she used soiled gloves, and did not wash or sanitize her hands between glove changes during the supper meal.

On 8/21/18, at 4:16 p.m. DA-C stated he would check the temperature of soups prior to serving. DA-C stated soups are prepared, and go into the freezer for the week, they are taken out to be

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	245119	A. BUILDING _____ B. WING _____	08/23/2018

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AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 812	Continued From page 13	F 812		

thawed the day before serving, and then used for the soup of the day. The soups are brought up on the cold cart, in ice, and heated by the individual bowl, and left-overs that have not been reheated, are brought down to the cooler.

On 8/23/18, at 11:41 a.m. DA-B was setting up for lunch. DA-B washed her hands and donned gloves. DA-B opened the fridge, took out some soup, put it into a bowl, got another container of soup and put some in a bowl, took out corn dogs in a plastic container, and put two on a plate with gloved hands, poured milk into pudding, removed gloves, and sanitized her hands. DA-B then put soup in the microwave, sanitized her hands, and donned clean gloves.

On 8/23/18, at 11:46, DA-B started serving food using utensils. At 11:47 a.m. DA-B asked a nursing assistant (NA) to take the soup out of the microwave and check the temperature. The temperature was 90 degrees Fahrenheit (F), and the soup was placed back in the microwave, and when checked again, it was 115 degrees F. DA-B stated the soup should be 150-160 degrees. At 11:53 a.m. the soup was boiling. The steaming soup was removed from the microwave, and the temperature of the soup was 177. The soup was served. The NA then put the corn dogs in the microwave for 1 minute and at 11:53 a.m. checked the temperature. The temperature was 115 degrees F. The corn dogs were placed back in the microwave and it was restarted.

On 8/22/18, at 11:54 a.m. DA-B took the bread out of the bag with gloved hands, and made a ham sandwich for R42, which was served to R42. At 11:55 a.m. DA-B removed the corn dogs from the microwave and checked the temperature. It

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	245119	A. BUILDING _____ B. WING _____	08/23/2018

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F 812	Continued From page 14	F 812		

was 176 degrees F.

On 8/22/18, at 11:56 a.m. DA-B took lettuce out of the container with same gloved hands, tore it, and placed the lettuce on a plate for R36. The plate was served to R36. DA-B opened the microwave and checked the temperature of a bowl of soup. At 11:59 a.m., DA-B took bread out of the bag with same gloved hands, put it on a plate and it was served to R31. At 12:01 p.m. DA-B took a piece of bread out with the same gloved hands and it was served to R2. At 12:02 p.m. DA-B took a piece of bread out of the bag with the same gloved hands and it was given to R32's family member seated next to him. R4 was served the corn dogs.

Prior to the meal and during the meal service, nursing assistants had been observed to enter the food service kitchen, open the refrigerator, pour liquids and coffee, and touch various items in the kitchen area.

On 8/22/18, at 12:07 p.m. DA-B verified she forgot to use tongs for the bread, corn dogs and lettuce. DA-B stated she always checked the temperature of the soup after microwaving. DA-B also stated she checked the pans before using, and if wet or had food debris, will have them rewashed.

On 8/20/18, at 2:09 p.m. during a tour with assistant dietary manager (ADM), 3 medium food pans were wet and 2 had residue. 21 medium pans were observed. ADM stated they are used for mashed potatoes, and such foods. 2 of 10 large pans were wet, and 1 of 10 pans had food residue. ADM stated the larger pans were used for such foods as lasagne. 2 of 12 scoops had

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	245119	A. BUILDING _____ B. WING _____	08/23/2018

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F 812	Continued From page 15	F 812		

food residue on them. ADM gave them to the dishwasher to be be re-cleaned. The ADM verified the pans and utensils had been cleaned, and were ready for use. ADM stated the pan are to be air dried prior to storage, dietary staff are to be checking pans prior to use, and return to dishwasher if wet or unclean. ADM stated they cool foods in small pans, but rarely cool left overs. If they cool anything, they cool soups. ADM stated they do not check temperatures of foods while cooling and do not keep cooling temperature logs.

On 8/22/18, at 12:22 p.m. ADM stated they make soup, put it in small pans, put it in the freezer, then switch the soup of the day, every 3 days. The soup goes up on the cold cart, and warm it bowl by bowl. They throw away the soup after it has been thawed for 3 days. ADM stated each bowl of soup should be temped prior to serving. ADM verified dietary staff should wash hands between tasks, between changing gloves, and they should use tongs for bread and other foods. ADM stated staff should change gloves after touching anything else. ADM stated there was a risk of bacteria in food if it was not at the proper temperature, and could cause illness or even death.

The facility policy Hand Washing of Employees undated, directed dietary staff to wash hands after handing soiled utensils, going from dirty to clean dishes, etc. and touching door handles or anything that is not sanitary and could carry contaminates. The policy included a reminder that gloves get just as dirty as hands, and need to be changed between tasks.

The facility policy Preventing Foodborne

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

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F 812	Continued From page 16 Illness-Employee Hygiene and Sanitary Practices undated, directed dietary staff to wash hands during food preparation, as often as necessary to remove soil and contamination, and to prevent cross contamination when changing tasks. The policy indicated food service employees would be trained in the proper use of utensils to prevent foodborne illness, and gloves were to be discarded after completing the task for which they were used. The facility policy Food Handling undated, directed dietary staff to heat leftovers and ready to eat foods to 165 degrees F. Food temperatures would be checked with a thermometer to ensure proper heating. All food service equipment and utensils would be sanitized according to current guidelines. The policy further directed staff to use tongs or other serving utensils to serve breads or other items. All food service equipment should be cleaned, sanitized, dried, and reassembled after each use. The facility policy Dishes and Utensils dated 2/18, directed pots and pans to be scraped and rinsed to remove debris, process through the dish machine, and place all pots and pans on a drying rack to dry. Once dry, they were to be stacked and put away.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		10/2/18

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	245119	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 17	F 842		

agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained

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	245119	A. BUILDING _____ B. WING _____	08/23/2018

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F 842	Continued From page 18 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident or resident representative wishes for advanced directives were accurately documented in all areas of the medical record for 2 of 3 residents (R30, R36) reviewed for advanced directives. Findings include: R30's quarterly Minimum Data Set (MDS) dated 7/24/18, indicated R30 was cognitively intact. R30's Face Sheet printed 8/21/18, indicated R30's diagnoses included multiple sclerosis and Type 2 diabetes. The Face Sheet also indicated R30's advanced directive was "Full Code" or attempt resuscitation/CPR.	F 842	R30's face sheet was updated to accurately reflect the resident's wishes for advance directives as indicated on the POLST and physician order R36's physician orders were updated to accurately reflect the resident's wishes for advance directives as indicated on the POLST and face sheet. All residents were reviewed to ensure the resident's wishes for advance directives were accurately documented in all areas of the medical record. Advanced Directive orders will no longer be put into the electronic physician orders, but will remain in the EMR for viewing as	

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F 842	Continued From page 19 R30's Provider Orders for Life-Sustaining Treatment (POLST) signed by R30 and R30's nurse practitioner on 4/6/18, indicated R30 had selected "Do Not Attempt Resuscitation/DNR" for her resuscitation status in the event R42 had no pulse and was not breathing. R30's Physician Orders dated 8/17/18, indicated R30 was DNR resuscitation status. On 8/21/18, at 3:40 p.m. the director of nursing (DON) verified R30's code status on her POLST, Face Sheet, and Physician Orders did not match. On 8/21/18, at 4:50 p.m. R30 verified she wanted her code status to be "DNR." R36's admission MDS dated 7/18/18, indicated R36 was cognitively intact. R36's Face Sheet printed 8/21/18, indicated R36's diagnoses included cerebral infarction (stroke), and hypertension (high blood pressure). The Face Sheet also indicated R30's advanced directive was "Full Code" or attempt resuscitation/CPR. R36's POLST signed by R36 on 7/5/18, and by the nurse practitioner 7/6/18, indicated R36 had selected "Attempt Resuscitation/CPR" or full code for her code status in the event R36 had no pulse and was not breathing. R36's Physician Orders signed 7/24/18, indicated R36 was a DNR status. On 8/21/18, at 3:41 p.m. the DON verified R36's code status on her POLST, Face Sheet, and Physician Orders did not match.	F 842	well as the signed POLST in the chart. All licensed staff were educated on the process for documenting resident's wishes as it relates to advance directives. DON/designee will complete random chart audits. 2 random chart audits will be completed weekly for 4 weeks and then 2 records/month for 2 months then monthly thereafter to ensure advance directives are accurately documented in all areas of the medical record. Audit results will be brought to the QAPI committee for review and further recommendations. Completion date: 10/2/18	

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	245119	A. BUILDING _____ B. WING _____	08/23/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 20 On 8/21/18, at 4:44 p.m. R36 verified she wanted CPR to be attempted. On 8/21/18, at 3:21 p.m. trained medication assistant (TMA)-A stated he would look at the POLST or the electronic medical record (EMR) for the resident's resuscitation status if a resident was found without a pulse or respirations. On 8/21/18, at 3:26 p.m. licensed practical nurse (LPN)-A stated she would look at the electronic medication administration record (eMAR) or the POLST to determine a resident's resuscitation status. On 8/21/18, at 3:34 p.m. registered nurse (RN)-A stated she would look at the POLST for the resident's resuscitation status. On 8/21/18, at 3:36 p.m. the DON stated nursing could look at the EMR or the POLST for the resident's resuscitation status. On 8/21/18, at 3:41 p.m. the DON verified there could be a risk of resident wishes not being honored. On 8/22/18, at 8:40 a.m. the DON stated the new POLSTs were not being processed as physician/NP orders all the time. The DON stated residents came in with physician orders and then signed a POLST which may be different from the physician orders, and this was not changed in all places in the medical record. The facility policy Advance Care Planning dated 2/18, directed the resident's health care provider to complete and sign the resident's POLST. The	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 21 policy directed the signed POLST would be received as an order for care, and would be noted in the resident's medical record.	F 842		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 9KMY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00002

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245119**

2.STATE VENDOR OR MEDICAID NO.
(L2) **231247600**

3. NAME AND ADDRESS OF FACILITY
(L3) **AITKIN HEALTH SERVICES**
(L4) **301 MINNESOTA AVENUE SOUTH**
(L5) **AITKIN, MN** (L6) **56431**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2006**

6. DATE OF SURVEY **10/22/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Teresa Ament, Unit Supevisor — 10/22/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 10/22/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/09/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/02/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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

DEPARTMENT OF HEALTH

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9KMY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00002

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245119**

2.STATE VENDOR OR MEDICAID NO.
(L2) **231247600**

3. NAME AND ADDRESS OF FACILITY
(L3) **AITKIN HEALTH SERVICES**
(L4) **301 MINNESOTA AVENUE SOUTH**
(L5) **AITKIN, MN** (L6) **56431**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2006**

6. DATE OF SURVEY **08/23/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **44** (L18)
13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathie Siemsen, HFE - NE II 09/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/02/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/09/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - 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;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by 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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 8/20/18, through 8/23/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 8/20/18, through 8/23/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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- (A) An accident involving the resident which	F 580		10/2/18

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

Electronically Signed | 09/14/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	**301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 results in injury and has the potential for requiring physician intervention; (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); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct	F 580		

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	245119	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 580	Continued From page 2 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident representative was informed of a new skin condition for 1 of 3 residents (R42) reviewed for notification of change. Findings include: R42's Face Sheet printed 8/23/18, indicated R42's diagnoses included peripheral vascular disease (a blood circulation problem that decreases blood flow to the extremities), diabetes, amputation of an extremity, and dementia. R42's Face Sheet further indicated R42's identified resident representative was also power of attorney for healthcare. R42's significant change Minimum Data Set (MDS) dated 7/20/18, indicated R42 had a moderate hearing deficit, had a moderately impaired cognitive status, had no venous or arterial (circulatory) areas of concern, was at risk for pressure ulcers and had a current pressure ulcer, open lesions, a surgical wound, and skin tears. R42's care plan dated 3/5/18, indicated R42 was at potential for significant changes in medical condition, and was at risk for skin breakdown. On 8/20/18, at 6:45 p.m. R42 was observed to have a white dressing and wrap on the left shin above the ankle, with the skin reddened and shiny above the dressing.	F 580	R42□s representative was advised of the chronic reoccurring blister to her leg r/t edema. All residents with change in condition will be reviewed to ensure representative is notified appropriately according to regulation and policy. All licensed nursing staff will be educated on the regulation and policy r/t notification of changes. Policy and procedures r/t notification of changes was reviewed and revised. DON/designee will complete random chart audits to ensure the resident/representative was updated on change in condition as directed by policy. 3 random chart audits will be completed per week for 4 weeks and then 2x/month for 2 months then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations Completion date: 10/2/18	

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F 580	Continued From page 3 On 8/20/18, at 7:15 p.m. R42's representative was interviewed and stated R42 had a big, red sore on her left leg. R42's representative stated she had not been notified of the sore on R42's leg. R42's representative repeated this concern during the conversation, and stated she was concerned that the facility did not notify her of the change, and she expected them to notify her of changes. R42's medical record lacked documentation that R42's representative had been notified of R42's change in skin condition. On 8/23/18, at 3:41 p.m. licensed practical nurse (LPN)-A stated she thought she had told R42's representative of the sore on R42's leg. LPN-A stated R42's representative was aware of the sore on R42's leg. On 8/23/18, at 3:44 p.m. the director of nursing (DON) stated she would expect the facility would notify resident representatives of changes in condition. The facility policy Notification of Change dated 10/17, directed nursing to immediately inform the resident, consult with the physician and notify the resident representative when there was a significant change for the resident, such as when a new form of treatment was initiated. The policy further directed even when a resident was mentally competent, the designated resident representative would be notified of significant changes in the resident health status.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4)	F 585		10/2/18

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F 585	Continued From page 4 §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for	F 585		

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F 585	Continued From page 5 completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be	F 585		

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F 585	Continued From page 6 taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to act upon reported concerns for 1 of 2 residents (R5) reviewed for grievances. Findings include: R5's Face Sheet printed 8/22/18, indicated R5's diagnoses included unspecified dementia without behaviors and scoliosis (curvature of the spine). R5's General Nurse's Observation note dated 8/8/18, indicated R5 had severe cognitive impairment. On 8/20/18, at 4:14 p.m. R5's family member (FM)-A was interviewed, and stated R5 had been using a lap tray on her wheelchair, but the facility removed it, stating it was a restraint. FM-A stated he had spoken to the facility staff about his concern with removing it. FM-A stated R5 used the lap tray for placement of an activity blanket or stuffed animal for R5 to touch. FM-A stated the facility had not addressed his concern to his	F 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	

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F 585	Continued From page 7 satisfaction. R5's Occupational Therapy (OT) Treatment Encounter note dated 3/12/18, indicated the lap tray on R5's wheelchair improved R5's posture, and also provided a place for an activity blanket or stuffed animal to assist R5 with sensory activities and tactile stimulation. An OT Discharge Summary note dated 3/22/18, indicated R5's lap tray encouraged erect posture and increased R5's social engagement by providing a place for an activity blanket or stuffed animal to sit. An OT Evaluation and Plan of Treatment dated 5/23/18, indicated R5's family member (FM)-A was displeased with the removal of the full lap tray. R5's OT Evaluation and Plan of Treatment dated 7/18/18, indicated R5's wheelchair was no longer appropriate, and did not address use of the lap tray. On 8/22/18, at 2:08 p.m. occupational therapist (OT)-A was interviewed and stated R5's lap tray was a padded tray, and OT had removed the straps and replaced them with velcro fastener. An additional velcro fastener was placed on R5's wheelchair which allowed the lap tray to be removed quickly. OT-A stated the lap tray improved R5's ability to make eye contact with other people, and R5 was able to have objects placed on the tray to provide tactile stimulation. OT-A stated the lap tray was not used to keep R5 in the wheelchair, but to facilitate positioning and improve posture. OT-A stated R5 was currently using a tilting wheelchair. OT-A stated FM-A continued to request the lap tray be resumed. On 8/22/18, at 2:23 p.m. the director of nursing (DON) was interviewed. The DON stated the lap tray was removed after discussion about it being	F 585	SS/designee will follow up concerns that are brought forward to ensure the concern has been addressed to the complainant's satisfaction. Will audit all concerns 2x/week for 1 month then 2x/month for 2 months and then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations Completion date: 10/2/18	

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F 585	Continued From page 8 a restraint. The DON stated the corporate 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. 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		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on 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. Findings include: Pressure ulcer stages defined by the National Pressure Ulcer Advisory Panel: Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister.	F 641	R24- a modification of the MDS ARD 6/26/18 was corrected to reflect the deep tissue injury (DTI). All residents will be reviewed to ensure that the MDS is coded accurately. 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 record monthly thereafter. Audit results will be brought to the QAPI committee for	10/2/18

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F 641	Continued From page 9 Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. R24's Physician's Order Sheet printed 8/23/18, included diagnoses of type two diabetes with diabetic neuropathy, and stage four chronic kidney disease. R24's General Nurse's Observation started on 6/20/18, and completed on 6/26/18, indicated R24 was at low risk for pressure ulcers, and had a deep tissue injury (DTI) on the left heel which was dry and intact. R24's quarterly MDS with an assessment reference date (ARD) of 6/26/18, and a completion date of 7/3/18, indicated R24 had moderately impaired cognition. The MDS identified R24 required extensive assistance from staff with activities of daily living (ADLs). The MDS also indicated R24 was at risk for pressure ulcers, did not have any unhealed pressure ulcers, and had a healed pressure ulcer that was present on the prior assessment. The MDS lacked identification of R24's deep tissue injury. On 8/21/18, at 9:43 a.m. R24 was observed to	F 641	review and further recommendations Completion date: 10/2/18	

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F 641	Continued From page 10	F 641		

have a gripper sock on the left foot, and a shoe on the right foot. R24 stated she had a sore on the back of her foot, they had used scissors to cut on it that morning, but it did not hurt.

On 8/23/18, at 10:36 a.m. R24's DTI was observed with licensed practical nurse (LPN)-A. R24's DTI was observed located above the left heel on the Achilles area. The DTI was approximately the size of a quarter and was brown in color with lifted edges. LPN-A stated R24 had the DTI for six months or longer. R24 stated she had the area for a long time, and stated she thought it was from pressure from a shoe.

On 8/23/18, at 12:47 p.m. registered nurse (RN)-D (the facility MDS coordinator) verified the DTI was not identified on R24's most current MDS, and stated it was missed. RN-D verified the assessment reference dates included 6/20/18, through 6/26/18, and R24 did have a DTI during the assessment period. RN-D further verified R24's MDS should have been coded as having a DTI.

On 8/23/18, at 1:01 p.m. the director of nursing (DON) stated she would expect the MDS would be accurate.

The facility's MDS 3.0 Assessment policy dated 4/6/15, directed the purpose was to ensure residents were assessed in order to identify care needs, develop an interdisciplinary care plan, and to ensure the MDS assessment coordinator and the interdisciplinary team followed the required process for submitting, validating, and correcting the MDS.

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F 760	Continued From page 11	F 760		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate dosing of insulin with an insulin pen that was not primed for 1 of 2 residents (R14) observed for insulin administration. Findings include: R14's Face Sheet printed 8/23/18, indicated R14's diagnoses included type 2 diabetes mellitius. R14's Physician Orders dated 7/10/18, directed orders for Lantus Insulin Pen 30 units subcutaneously 1 times a day, Novolog Insulin by Flexpen 7 units at 11:30 a.m., 8 units at 4:30 p.m., and 9 units at 7:30 a.m. In addition, R14 had an order for Novolog Flexpen Insulin sliding scale based on her blood glucose levels. On 8/20/18, at 4:56 p.m. registered nurse (RN-C) was observed preparing Novalog insulin Flexpen for an insulin injection for R14. RN-C placed the needle on the Flexpen, dialed the Flexpen dose dial to 8 units without priming the needle with 2 units of insulin. RN-D proceeded to R14's room. RN-C injected the 8 units of insulin into R14's abdomen. After leaving R14's room, RN-C was asked about priming the needle prior to setting the ordered dose of insulin. RN-C stated she did not prime the needle, and it should have been	F 760	R14- staff caring for R14 were re-educated on priming an insulin pen prior to administration All residents that utilize insulin pens have the potential to be affected by a deficient practice in this area. All licensed nursing staff were re-educated on the procedure for priming an insulin pen. The insulin pen policy was reviewed and revised. DON/designee will perform random observational audits 3x/week for 4 weeks and then 2x/month for 2 months then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations Completion date: 10/2/18	10/2/18

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F 760	Continued From page 12 primed with 2 units of insulin before setting it for 8 units. On 8/22/18, at 2:23 PM the director of nursing (DON) was interviewed and stated the nurse should primed the needle every time a dose was given, to ensure accurate administration of insulin. The DON stated staff had received training on insulin administration. The DON further stated the manufacturer's instructions also indicated the needle should be primed with each dose of insulin given. The facility policy Insulin Pens dated 3/23/18, directed prime the insulin pens by setting the dose dial at 2 units, and press the push button all the way in.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		10/2/18

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F 761	Continued From page 13 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired eye drops were not in use and were removed from the medication cart in 1 of 2 medication carts observed for medication storage. Findings include: On 8/21/18, at 3:12 p.m. during inspection of the medication cart with licensed practical nurse (LPN-A), a bottle of Cosopt eye drops belonging to R42 were noted to have an expiration date of 5/18. LPN-A stated the facility protocol was to check the expiration date on the medications prior to administration, and if the medication was expired it was to be ordered. LPN-A stated R42 received the Cosopt drops to both eyes twice a day. LPN-A stated R42 had two additional bottles of the eye drops in the medication cart, and she was unable to tell which bottle of eyedrops were currently being used for R42. R42's Face Sheet printed 8/23/18, identified a diagnosis of dry eye syndrome of unspecified lacrimal gland. R42's Physician Orders dated 7/24/18, directed Cosopt eyedrops, one drop to each eye twice a day. On 8/22/18, at 2:23 p.m. the director of nursing (DON) was interviewed and stated staff was	F 761	R42□s Cosopt eye drops were removed from the medication cart. All residents have the potential to be affected. All medications were check for viability. All licensed nursing staff and Trained Medication Aides (TMA□s) were re-educated on the Medication Storage Policy as it relates to expired medications DON/designee will perform random observational audits 3x/week for 4 weeks and then 2x/month for 2 months then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendations Completion date: 10/2/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 761	Continued From page 14 supposed to check the expiration date of medication prior to administering medication. The DON stated if a medication was found to be expired, it was to be removed from the medication cart and destroyed, and a new supply was ordered. The DON also stated there was no way of knowing if R42 received the expired eye drops. The facility Medication Storage Policy dated 7/26/17, directed the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 812	Dietary staff involved in meal service	10/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

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AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 812	Continued From page 15 review, the facility failed to ensure proper hand hygiene and use of utensils for handling of food during food service to prevent cross-contamination for 7 of 23 residents (R24, R31, R42, R36, R2, R32, and R4) eating in the Bear's Den dining room. In addition, the facility failed to ensure proper temperatures of soup prior to serving to prevent food-borne illness for 2 of 2 residents (R1, R31) who were served soup. In addition, the facility failed to ensure food service pans were dry and free of food debris when washed, stored, and ready for use to prevent food-borne illness. This had the potential to affect all 43 residents who received food from the kitchen. Findings include: R24's Face Sheet printed 8/23/18, indicated R24's diagnoses included severe chronic kidney disease, dysphagia (swallowing problems), and diabetes. R31's Face Sheet printed 8/23/18, indicated R31's diagnoses included atrial fibrillation and hypertension. R42's Face Sheet printed 8/23/18, indicated R42's diagnoses included diabetes, ulcerative colitis, dementia, and anemia. R36's Face Sheet printed 8/21/18, indicated R36's diagnoses included cerebral infarction (stroke), hypertension, gastro-esophageal reflux, and dysphagia. R2's Face Sheet printed 8/23/18, indicated R2's diagnoses included heart failure, and hypertension.	F 812	were re-educated on proper hand hygiene, proper use of utensils for handling of food during food service, and also on the procedure for heating up food. Dietary staff were also re-educated on the process for washing and drying pans and 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 and use of gloves during meal service. All dietary, nursing, and activity staff were instructed on proper food handling during meal service, and the procedure for heating up food. Dietary staff were also re-educated on the process for washing and drying pans and other utensils. T he Assistant Dietary Manager/designee will perform random audits. 3 random observational audits for hand hygiene during meal service will be completed weekly for 4 weeks, then 2 audits/month for 2 months and then monthly thereafter to ensure ongoing compliance. 3 random observational audits will be completed weekly for 4 weeks to ensure pans and other utensils are clean and dry prior to storage will be completed then 2 audits/month for 2 months, then 1 audit monthly thereafter will be completed to ensure ongoing compliance. 3 random audits of food temps will be completed weekly for 4 weeks, then 2 audits/month for 2 months, then monthly thereafter to	

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	245119	A. BUILDING _____ B. WING _____	08/23/2018

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AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 812	Continued From page 16 R32's Face Sheet printed 8/23/18, indicated R32's diagnoses included dementia, heart disease, gastroenteritis and colitis. R4's Face Sheet printed 8/23/18, indicated R4's diagnoses included diabetes, hypertension, and atrial fibrillation. R1's Face Sheet printed 8/23/18, indicated R1's diagnoses included adult failure to thrive, abnormal weight loss, and hypertension. On 8/20/18, during the supper meal at 5:09 p.m. dietary aide (DA)-A was observed started serving food from the steam table. DA-A had gloves on her hands. DA-A touched plates, opened cupboards, and opened both the refrigerator and the microwave with her gloved hands while preparing foods to serve. DA-A took 2 pieces of bread from the bag with her gloved hands, placed them in the toaster, pushed the toaster lever down, then removed her soiled gloves after touching and opening packets of sauces. DA-A donned clean gloves without washing her hands. DA-A pushed the toaster lever down again, and took the toast out of the toaster with the same gloved hands, and placed the toast on a plate for R24. The toast was served to R24. DA-A used the microwave to heat soup in individual bowls. The soup had been taken from a serving dish that sat in ice in a bin on the cart. DA-A stirred the soup, warmed it longer, stirred it again, and served the soup without checking the temperature of the soup. The soup was not steaming at the time. R31 and R1 received and ate the soup. The soup of the day was beef stew, and a creamy soup was served.	F 812	ensure ongoing compliance. Audit results will be brought to the QAPI committee for review and further recommendations Completion date: 10/2/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

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AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 812	Continued From page 17	F 812		

On 8/20/18, at 5:28 p.m. DA-A stated the soup comes up cold, and is on the cold cart for up to 3 days. DA-A stated they warm it in the microwave, and verified she did not check the temperature of the soup prior to serving it.

On 8/20/18, at 5:49 p.m. DA-A verified she used her gloved hands to handle the bread, and stated she usually tried to change her gloves throughout meal service, after touching the microwave and refrigerator, but she did not always do it. DA-A verified she used soiled gloves, and did not wash or sanitize her hands between glove changes during the supper meal.

On 8/21/18, at 4:16 p.m. DA-C stated he would check the temperature of soups prior to serving. DA-C stated soups are prepared, and go into the freezer for the week, they are taken out to be thawed the day before serving, and then used for the soup of the day. The soups are brought up on the cold cart, in ice, and heated by the individual bowl, and left-overs that have not been reheated, are brought down to the cooler.

On 8/23/18, at 11:41 a.m. DA-B was setting up for lunch. DA-B washed her hands and donned gloves. DA-B opened the fridge, took out some soup, put it into a bowl, got another container of soup and put some in a bowl, took out corn dogs in a plastic container, and put two on a plate with gloved hands, poured milk into pudding, removed gloves, and sanitized her hands. DA-B then put soup in the microwave, sanitized her hands, and donned clean gloves.

On 8/23/18, at 11:46, DA-B started serving food using utensils. At 11:47 a.m. DA-B asked a nursing assistant (NA) to take the soup out of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 812	Continued From page 18	F 812		

microwave and check the temperature. The temperature was 90 degrees Fahrenheit (F), and the soup was placed back in the microwave, and when checked again, it was 115 degrees F. DA-B stated the soup should be 150-160 degrees. At 11:53 a.m. the soup was boiling. The steaming soup was removed from the microwave, and the temperature of the soup was 177. The soup was served. The NA then put the corn dogs in the microwave for 1 minute and at 11:53 a.m. checked the temperature. The temperature was 115 degrees F. The corn dogs were placed back in the microwave and it was restarted.

On 8/22/18, at 11:54 a.m. DA-B took the bread out of the bag with gloved hands, and made a ham sandwich for R42, which was served to R42. At 11:55 a.m. DA-B removed the corn dogs from the microwave and checked the temperature. It was 176 degrees F.

On 8/22/18, at 11:56 a.m. DA-B took lettuce out of the container with same gloved hands, tore it, and placed the lettuce on a plate for R36. The plate was served to R36. DA-B opened the microwave and checked the temperature of a bowl of soup. At 11:59 a.m., DA-B took bread out of the bag with same gloved hands, put it on a plate and it was served to R31. At 12:01 p.m. DA-B took a piece of bread out with the same gloved hands and it was served to R2. At 12:02 p.m. DA-B took a piece of bread out of the bag with the same gloved hands and it was given to R32's family member seated next to him. R4 was served the corn dogs.

Prior to the meal and during the meal service, nursing assistants had been observed to enter the food service kitchen, open the refrigerator,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 812	Continued From page 19	F 812		

pour liquids and coffee, and touch various items in the kitchen area.

On 8/22/18, at 12:07 p.m. DA-B verified she forgot to use tongs for the bread, corn dogs and lettuce. DA-B stated she always checked the temperature of the soup after microwaving. DA-B also stated she checked the pans before using, and if wet or had food debris, will have them rewashed.

On 8/20/18, at 2:09 p.m. during a tour with assistant dietary manager (ADM), 3 medium food pans were wet and 2 had residue. 21 medium pans were observed. ADM stated they are used for mashed potatoes, and such foods. 2 of 10 large pans were wet, and 1 of 10 pans had food residue. ADM stated the larger pans were used for such foods as lasagne. 2 of 12 scoops had food residue on them. ADM gave them to the dishwasher to be be re-cleaned. The ADM verified the pans and utensils had been cleaned, and were ready for use. ADM stated the pan are to be air dried prior to storage, dietary staff are to be checking pans prior to use, and return to dishwasher if wet or unclean. ADM stated they cool foods in small pans, but rarely cool left overs. If they cool anything, they cool soups. ADM stated they do not check temperatures of foods while cooling and do not keep cooling temperature logs.

On 8/22/18, at 12:22 p.m. ADM stated they make soup, put it in small pans, put it in the freezer, then switch the soup of the day, every 3 days. The soup goes up on the cold cart, and warm it bowl by bowl. They throw away the soup after it has been thawed for 3 days. ADM stated each bowl of soup should be temped prior to serving.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 812	Continued From page 20	F 812		

ADM verified dietary staff should wash hands between tasks, between changing gloves, and they should use tongs for bread and other foods. ADM stated staff should change gloves after touching anything else. ADM stated there was a risk of bacteria in food if it was not at the proper temperature, and could cause illness or even death.

The facility policy Hand Washing of Employees undated, directed dietary staff to wash hands after handing soiled utensils, going from dirty to clean dishes, etc. and touching door handles or anything that is not sanitary and could carry contaminates. The policy included a reminder that gloves get just as dirty as hands, and need to be changed between tasks.

The facility policy Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices undated, directed dietary staff to wash hands during food preparation, as often as necessary to remove soil and contamination, and to prevent cross contamination when changing tasks. The policy indicated food service employees would be trained in the proper use of utensils to prevent foodborne illness, and gloves were to be discarded after completing the task for which they were used.

The facility policy Food Handling undated, directed dietary staff to heat leftovers and ready to eat foods to 165 degrees F. Food temperatures would be checked with a thermometer to ensure proper heating. All food service equipment and utensils would be sanitized according to current guidelines. The policy further directed staff to use tongs or other serving utensils to serve breads or other items.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 21 All food service equipment should be cleaned, sanitized, dried, and reassembled after each use. The facility policy Dishes and Utensils dated 2/18, directed pots and pans to be scraped and rinsed to remove debris, process through the dish machine, and place all pots and pans on a drying rack to dry. Once dry, they were to be stacked and put away.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		10/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 22 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842		

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	245119	A. BUILDING _____ B. WING _____	08/23/2018

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F 842	Continued From page 23 Based on interview and document review, the facility failed to ensure the resident or resident representative wishes for advanced directives were accurately documented in all areas of the medical record for 2 of 3 residents (R30, R36) reviewed for advanced directives. Findings include: R30's quarterly Minimum Data Set (MDS) dated 7/24/18, indicated R30 was cognitively intact. R30's Face Sheet printed 8/21/18, indicated R30's diagnoses included multiple sclerosis and Type 2 diabetes. The Face Sheet also indicated R30's advanced directive was "Full Code" or attempt resuscitation/CPR. R30's Provider Orders for Life-Sustaining Treatment (POLST) signed by R30 and R30's nurse practitioner on 4/6/18, indicated R30 had selected "Do Not Attempt Resuscitation/DNR" for her resuscitation status in the event R42 had no pulse and was not breathing. R30's Physician Orders dated 8/17/18, indicated R30 was DNR resuscitation status. On 8/21/18, at 3:40 p.m. the director of nursing (DON) verified R30's code status on her POLST, Face Sheet, and Physician Orders did not match. On 8/21/18, at 4:50 p.m. R30 verified she wanted her code status to be "DNR." R36's admission MDS dated 7/18/18, indicated R36 was cognitively intact. R36's Face Sheet printed 8/21/18, indicated	F 842	R30's face sheet was updated to accurately reflect the resident's wishes for advance directives as indicated on the POLST and physician order R36's physician orders were updated to accurately reflect the resident's wishes for advance directives as indicated on the POLST and face sheet. All residents were reviewed to ensure the resident's wishes for advance directives were accurately documented in all areas of the medical record. Advanced Directive orders will no longer be put into the electronic physician orders, but will remain in the EMR for viewing as well as the signed POLST in the chart. All licensed staff were educated on the process for documenting resident's wishes as it relates to advance directives. DON/designee will complete random chart audits. 2 random chart audits will be completed weekly for 4 weeks and then 2 records/month for 2 months then monthly thereafter to ensure advance directives are accurately documented in all areas of the medical record. Audit results will be brought to the QAPI committee for review and further recommendations. Completion date: 10/2/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 24	F 842		

R36's diagnoses included cerebral infarction (stroke), and hypertension (high blood pressure). The Face Sheet also indicated R30's advanced directive was "Full Code" or attempt resuscitation/CPR.

R36's POLST signed by R36 on 7/5/18, and by the nurse practitioner 7/6/18, indicated R36 had selected "Attempt Resuscitation/CPR" or full code for her code status in the event R36 had no pulse and was not breathing.

R36's Physician Orders signed 7/24/18, indicated R36 was a DNR status.

On 8/21/18, at 3:41 p.m. the DON verified R36's code status on her POLST, Face Sheet, and Physician Orders did not match.

On 8/21/18, at 4:44 p.m. R36 verified she wanted CPR to be attempted.

On 8/21/18, at 3:21 p.m. trained medication assistant (TMA)-A stated he would look at the POLST or the electronic medical record (EMR) for the resident's resuscitation status if a resident was found without a pulse or respirations.

On 8/21/18, at 3:26 p.m. licensed practical nurse (LPN)-A stated she would look at the electronic medication administration record (eMAR) or the POLST to determine a resident's resuscitation status.

On 8/21/18, at 3:34 p.m. registered nurse (RN)-A stated she would look at the POLST for the resident's resuscitation status.

On 8/21/18, at 3:36 p.m. the DON stated nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/23/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 25 could look at the EMR or the POLST for the resident's resuscitation status. On 8/21/18, at 3:41 p.m. the DON verified there could be a risk of resident wishes not being honored. On 8/22/18, at 8:40 a.m. the DON stated the new POLSTs were not being processed as physician/NP orders all the time. The DON stated residents came in with physician orders and then signed a POLST which may be different from the physician orders, and this was not changed in all places in the medical record. The facility policy Advance Care Planning dated 2/18, directed the resident's health care provider to complete and sign the resident's POLST. The policy directed the signed POLST would be received as an order for care, and would be noted in the resident's medical record.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/21/2018**

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AITKIN HEALTH SERVICES	**301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Aitkin Health Services was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Surveyed as one building: Aitkin Health Services is a one story building with a full basement. The original building was constructed in 1955 with additions in 1962, and a dining room main entry was added in 2002. Both the existing building and the addition are type II(111) construction. In 2009-2010 an addition was added that was a one story addition with a full basement that was determined to be of Type II(111) Constructions. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 44 beds and had a census of 43 at the time of the survey. At this time, the conditions of 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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