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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: EKZ3

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/02/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Patricia Halverson, Unit Supervisor — 06/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
07/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
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
05/29/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5363

June 10, 2014

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

Dear Ms. Matalamaki:

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

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

Effective May 27, 2014 the above facility is certified for:

75 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 10, 2014

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

RE: Project Number S5363023

Dear Ms. Matalamaki:

On May 5, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 17, 2014 that included an investigation of complaint number . This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On June 2, 2014, 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 April 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 27, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 17, 2014, effective May 27, 2014 and therefore remedies outlined in our letter to you dated May 5, 2014, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245363	A. Building B. Wing	6/2/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **05/27/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **05/27/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **05/27/2014**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **05/27/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **05/27/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/27/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/27/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PH	06/10/2014	12835	06/02/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/17/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I
- TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: EKZ3
Facility ID 00848

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245363**
2.STATE VENDOR OR MEDICAID NO.
(L2) **908540800**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/17/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital **05 HHA** **09 ESRD** **13 PTIP** **22 CLIA**
02 SNF/NF/Dual **06 PRTF** **10 NF** **14 CORF**
03 SNF/NF/Distinct **07 X-Ray** **11 ICF/IID** **15 ASC**
04 SNF **08 OPT/SP** **12 RHC** **16 HOSPICE**

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
__1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Ann Hyrkas, HFE NEII 05/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: MPM
Mark Meath, Enforcement Specialist 05/28/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23.LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30.REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32.DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Page 2

CCN: 24-5363

Item 16 Continuation for CMS-1539

At the time of the standard survey completed on April 17, 2014, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed. Post Certification Revisit (PCR) to follow. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING _____ B. WING _____	04/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	OK 5-13-14 PLN	
F 225 SS=D	CENSUS - 65 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225		5/27/14

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

Electronically Signed | 05/13/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING _____ B. WING _____	04/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the administrator and the state agency the financial exploitation for 1 of 7 residents (R125) reviewed for abuse. Findings include: An Admission Record dated 7/16/13, indicated R125's diagnoses included multiple sclerosis and depression. A quarterly Minimum Data Set (MDS) dated 10/17/13, indicated R125 was cognitively intact. A hand-written letter dated 7/12/13, indicated a registered nurse (RN) had become aware of a nursing assistant borrowing a significant amount	F 225	F 225 Investigate/Report, Allegations/Individuals The facility will ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of residents property are reported immediately to the administrator of the facility or other officials in accordance with state law through established procedures. Upon receiving written letter from a night staff nurse on July 15, 2013 the Social worker interviewed resident, called law enforcement and made the initial report to OHFC. At that time resident was alert, oriented, voiced his choices and was able	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING _____ B. WING _____	04/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 of money from R125, and R125 wanted the money repaid. The letter was addressed to licensed social worker (LSW)-A, the administrator and a secretary in the administrator's office. The state agency Investigative Report dated 7/15/13, indicated R125 was alert and oriented and handled most of their own affairs. The Report further indicated R125 was aware of a nursing assistant needing money and offered to loan the money. R125 had been clear the money was not a gift and re-payment was expected. The Report indicated the loan was made about 1 to 2 months previous, but the nursing assistant made no effort to repay R125. On 4/17/14, at 10:20 a.m. the administrator and LSW-A were interviewed. The administrator stated the RN who wrote the letter usually worked the night shift and most likely wrote the letter and left it for LSW-A on the night of Friday, 7/12/13. The administrator stated she usually receives an e-mail message when staff report resident incidents. LSW-A is also notified and conducts the investigation and reporting. The administrator further stated the nursing assistant in question was no longer working for the facility and the police took over the investigation. The administrator confirmed she was not notified about R125's situation until 7/15/13. The administrator verified the RN should have immediately notified not only the administrator but also made a report to the state agency. LSW-A stated she was not notified of R125's incident until 7/15/13. The Vulnerable Adult Abuse Prevention Plan dated as effective 5/21/12, indicated the Social Worker was designated as the person	F 225	to handle his own affairs. When the facility received the written letter about money being loaned to a NA, the staff had already terminated employment. During the investigation the resident voiced that he was hoping to see her again at work and talk to her about paying back the money. The night staff nurse who received the initial report about the borrowed money was counseled about the importance of filing an internal report, leaving a message for the facility administrator, immediately filing the report to OHFC and calling law enforcement. All staff will be inserviced by reviewing our VA Abuse and Prevention Plan by May 27, 2014, with emphasis on reporting timeframe, weekends and after hours. Social worker or designee will monitor all VA reports to ensure that we are in compliance with state regulation and report unusual findings to the QA committee quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING _____ B. WING _____	04/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 responsible for reviewing, investigating, and reporting to the appropriate agency all reportable incidents of maltreatment occurring at the facility. The Plan directed any employee, employer, or person providing services in the facility to make an initial report, immediately, not to exceed 24 hours, to the Minnesota Department of Health via the online reporting system. The Social Worker and Administrator were to be notified immediately. The Plan directed weekend incidents be reported to the Administrator immediately, not to exceed 24 hours. Although R125's financial exploitation incident was not immediately reported to the administrator, all incidents of potential maltreatment over the past year were reviewed, and the administrator was immediately notified for each occurrence. Licensed staff interviews also verified immediate reports were consistently made to the administrator.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement written policies and procedures related to immediate reporting to the administrator and state agency regarding potential financial exploitation for 1 of 1 residents	F 226	F 226 Develop/Implement Abuse/Neglect, etc. Policies The facility has a policy and procedure that prohibits mistreatment, neglect and	5/27/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING _____ B. WING _____	04/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 4 (R125) reviewed for abuse. Findings include: The Vulnerable Adult Abuse Prevention Plan dated as effective 5/21/12, indicated the Social Worker was designated as the person responsible for reviewing, investigating, and reporting to the appropriate agency all reportable incidents of maltreatment occurring at the facility. The Plan directed any employee, employer, or person providing services in the facility to make an initial report, immediately, not to exceed 24 hours, to the Minnesota Department of Health via the online reporting system. The Social Worker and Administrator were to be notified immediately. The Plan directed weekend incidents be reported to the Administrator immediately, not to exceed 24 hours. An Admission Record dated 7/16/13, indicated R125's diagnoses included multiple sclerosis and depression. A quarterly Minimum Data Set (MDS) dated 10/17/13, indicated R125 was cognitively intact. A hand-written letter dated 7/12/13, indicated a registered nurse (RN) had become aware of a nursing assistant borrowing a significant amount of money from R125, and R125 wanted the money repaid. The letter was addressed to licensed social worker (LSW)-A, the administrator and a secretary in the administrator's office. The state agency Investigative Report dated 7/15/13, indicated R125 was alert and oriented and handled most of their own affairs. The Report further indicated R125 was aware of a	F 226	abuse of residents and misappropriation of residents property. Aicota HCC□s VA Abuse and Prevention Plan does address immediate reporting of potential financial exploitation to administrator. Any staff is able to and encouraged to make mandated reports. Contact information is available throughout the facility. All staff were inserviced on the VA Abuse and Prevention policy, focusing on the importance of immediate reporting including weekends and after business hours. Social worker or designee to monitor Aicota HCC□s VA Abuse Prevention Program to ensure staff compliance with policy and reports unusual findings to the QA committee quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING _____ B. WING _____	04/17/2014

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

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F 226	Continued From page 5 nursing assistant needing money and offered to loan the money. R125 had been clear the money was not a gift and re-payment was expected. The Report indicated the loan was made about 1 to 2 months previous, but the nursing assistant made no effort to repay R125. On 4/17/14, at 10:20 a.m. the administrator and LSW-A were interviewed. The administrator stated the RN who wrote the letter usually worked the night shift and most likely wrote the letter and left it for LSW-A on the night of Friday, 7/12/13. The administrator stated she usually receives an e-mail message when staff report resident incidents. LSW-A is also notified and conducts the investigation and reporting. The administrator further stated the nursing assistant in question was no longer working for the facility and the police took over the investigation. The administrator confirmed she was not notified about R125's situation until 7/15/13. The administrator verified the RN should have immediately notified not only the administrator but also made a report to the state agency. LSW-A stated she was not notified of R125's incident until 7/15/13. Although R125's financial exploitation incident was not immediately reported to the administrator, all incidents of potential maltreatment over the past year were reviewed, and the administrator was immediately notified for each occurrence. Licensed staff interviews also verified immediate reports were consistently made to the administrator.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242		5/27/14

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F 242	Continued From page 6 The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure preferences for bathing frequency were honored for 3 of 4 residents (R30, R52, R78) reviewed for choices. Findings include: R30, interviewed on 4/14/14, at 6:41 p.m., stated she asked for 2 baths a week; however, only received one bath weekly. R30's admission information sheet indicated diagnoses that included chronic airway obstruction, chronic pain, osteoarthritis, osteoporosis, congestive heart failure, and cerebrovascular accident (stroke) with hemiplegia (weakness of one side of the body). The quarterly Minimum Data Set (MDS) dated 2/18/14, indicated R30 was cognitively intact and required extensive assistance of two staff with transfers and bathing. R30's care plan dated 6/20/13, indicated preference for a shower, but did not address preference for frequency of bathing. The daily preferences sheet, dated 5/31/13, indicated it was very important to R30 to choose between a tub, bath, shower, or bed bath, but lacked her	F 242	F 242 Self-determination, Right to make choices Any resident at Aicota HCC has the right to choose activities, schedules and health care consistent with his/her interests, assessment, plan of care, interact with members of the community both inside and outside the facility; and make choices about aspects of his/her life in the facility that are significant to the resident. Resident 30 visits with DON or RCC on a daily basis. Bath preference was assessed during the visit on April 28, 2014. Resident chose to have two weekly baths, Sunday and Tuesday at bedtime. The schedule was adjusted. It takes one hour to give resident a bath. On April 30, 2014, resident visited again with DON in her office and resident was upset. She had refused her bath the previous evening and she requested to have a bath only on Sunday evening prior to going to bed. The bath schedule was readjusted to reflect her preference. Resident 78 was interviewed by RCC	

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F 242	Continued From page 7 preference for frequency of bathing. The weekly bathing schedule directed R30 was to receive a bath on Sunday afternoon shift. On 4/16/14, at 1:20 p.m., nursing assistant (NA)-B was interviewed and stated there is a book with bath schedules and night staff writes a list of baths for them each day. NA-B stated when a resident requests additional baths, the RN or DON is informed and they decide when it can be worked into the schedule. On 4/16/14, at 2:10 p.m., registered nurse (RN)-A was interviewed and stated the activity department assesses for bathing preference when a resident is admitted to the facility, however, they do not ask about bathing. RN-A stated bathing frequency was not addressed in quarterly care conference meetings attended by residents and/or family members. On 4/17/14, at 9:55 a.m., activities director (AD)-A was interviewed and verified that she asks how important it is for residents to choose between a bath, shower or bed bath within the first week of admission, but does not ask about preference for frequency of bathing. The facility policy and procedure on nursing process dated 10/10/13, directed nursing staff to determine if a resident prefers a tub or shower as well as the resident's preference for bathing frequency. R78, interviewed on 4/15/14, at 8:48 a.m., stated he would like a bath three times a week. R78 stated that he had gone to a nurse manager's meeting and told them that one shower a week was not enough.	F 242	regarding his bathing preference on April 30, 2014. He indicated that he likes two showers weekly. Resident is very weak r/t severe COPD with continuous oxygen use, he requires extensive assistance with physical mobility, becomes SOB with any activity. Three showers weekly is physically too exhausting for him. The bath schedule was adjusted to reflect his preference. Resident 52 was interviewed by RCC regarding her bathing preference on April 30, 2014. She indicated that she likes to have two baths weekly. Resident is alert and oriented and is able to voice her needs/wishes. Her bath schedule was adjusted to reflect her preference. RCC's will continue to review ADL□s with quarterly care conferences. It is not uncommon at our facility for residents to have two or three showers weekly. RCC's or Staff nurse will assess for bathing preference and frequency on every resident during their admission assessment and document their wishes. This process is ongoing. DON or designee will monitor for compliance by monthly audits of the admission assessments. Results of the audits will be reported to the QA commitee quarterly until compliance is sustained.	

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F 242	Continued From page 8 The significant change MDS dated 2/14/14, indicated it was very important to R78 to choose between a bath or a shower. Preferred bathing frequency was not addressed. The MDS indicated R78 was cognitively intact and required extensive assistance of one staff for transfers and personal hygiene needs. R78's care plan dated 3/14/14, did not address bathing frequency. Interview with NA-F on 4/16/14, at approximately 1:00 p.m. indicated R78 gets a weekly shower because that is what on the bath schedule sheet. Review of the bath schedule indicated R78 got a shower once a week. The director of nursing (DON), interviewed on 4/16/14, at 1:40 p.m., stated residents could have as many showers as they want; however, residents were not specifically asked about preference for bathing frequency. R52, interviewed on 4/14/14, at 7:10 p.m. stated she would like, "At least a couple of baths per week," but only received one bath per week. R52's annual MDS dated 9/17/13, indicated it was very important to her to choose between a tub bath, shower, bed bath or sponge bath. Bathing frequency was not addressed. The quarterly MDS dated 3/18/14 indicated R52 was cognitively intact and required extensive assist of one staff for dressing and physical help in part of bathing activity. The care plan dated 4/9/14, indicated R52 required one staff assistance with bathing but did not address bathing frequency. The weekly bathing schedule directed one bath a	F 242		

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F 242	Continued From page 9 week. On 4/17/14, at 10:25 a.m. nursing assistant (NA)-D stated bathing preferences were discussed at care conferences and requests for multiple baths per week were accommodated. She indicated it was usually the care coordinators who figured out the bath schedules. NA-D stated that, as far as she knew, R52 had never requested additional baths; however, R52 "Was the type who didn't complain." On 4/17/14, at 1:57 p.m. registered nurse (RN)-C stated residents could request multiple baths, but residents were not asked for preference regarding bathing frequency.	F 242		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		5/27/14

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F 279	Continued From page 10 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a plan of care for the use of medications for 2 of 5 residents (R55, R60) reviewed for medications. Additionally, the facility failed to develop a plan of care for nutrition for 1 of 3 residents (R80) reviewed for nutrition. Findings include: During an initial interview on 4/14/14, at 7:06 p.m. R55 stated pain was experienced in the right shoulder and the medicine received helped some what relieve the pain. An Admission Record dated 4/17/14, indicated R55's diagnoses included chronic pain and osteoarthrosis. R55's Physician's Orders dated 4/17/14, directed ES [Extra Strength] Tylenol 2 tabs po [by mouth] TID [three times daily] for shoulder OA [osteoarthrosis] pain and Tylenol ES (500mg) 1 tab po q 4 hours PRN [every 4 hours as needed] for pain. Not closer than 2 hours of scheduled doses. Max 3500 mg po qd [every day] - only 1 prn dose/24 hours. On 4/16/14, at 1:13 p.m. nursing assistant (NA)-A stated R55 sometimes complains of pain the back or arms. NA-A further stated when R55 complains of pain she alerts the nurse. Sometimes R55 will get essential oil of peppermint for the pain or exercises from the physical therapy assistant. On 4/17/14, at 10:00 a.m. licensed practical nurse	F 279	F 279 Develop comprehensive Care Plans The facility will continue to develop a comprehensive Care plan for each resident that includes measurable objectives and time tables to meet a resident medical, nursing and psychosocial needs that are identified in the comprehensive assessment. On April 28, 2014 Resident 55□s care plan was reviewed and updated on potential pain R/T history of hip fracture, shoulder pain and chronic pain R/T osteoarthritis. On May 2, 2014 Resident 60□s care plan was reviewed and updated with specific goals for his diagnosis, use for high risk medications like Coumadin with frequent antibiotic use and diuretics. On April 17. 2014 Resident 80□s care plan was reviewed and updated by adding a nutritional problem and appropriate interventions with added nutritional supplement to maintain current weight. All residents care plans were reviewed and updated to reflect residents needs/problems with attainable goals and time frame.	

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F 279	Continued From page 11 (LPN)-B stated R55 had been receiving the Extra Strength Tylenol 3 times daily, had rarely complained of pain and had rarely used the as needed Tylenol. LPN-B further stated R55 would occasionally receive the essential oils, which were included on the standing orders for pain. On 4/17/14, at approximately 10:15 a.m. registered nurse (RN)-A stated R55's plan of care lacked a problem statement, goals, and interventions to address pain. R60 care plan did not address the use of Coumadin (a medication used to prevent and treat blood clots), Lasix (a diuretic), or Cipro (an antibiotic). R60's physician's orders dated 4/16/14, directed the following: Coumadin 2.5 milligrams (mg) Monday and Friday, and 5 mg the rest of the week for diagnosis of transient ischemic attack (TIA, mini-stroke); Lasix 20 mg twice daily for diagnosis of congestive heart failure (CHF); and Cipro 500 mg every day for 10 days for diagnosis of diabetic toe ulcer. The care plan dated 2/10/14 lacked identification for potential side effects and symptoms related to the use of Coumadin, Lasix and Cipro. On 4/16/14, at 2:15 p.m. RN-A was interviewed and verified the lack of care planning to identifying potential side effects and monitoring of TIAs and the use of Coumadin, CHF and the use of Lasix, and diabetic toe ulcer and the use of Cipro. The facility policy and procedure on care planning dated 11/12/12, directed the care plan to address problems related to diagnoses, have specific	F 279	RCC's will continue to review care plans on a monthly basis and report results to the QA committee quarterly until compliance is sustained.	

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F 279	Continued From page 12 goals that are measurable and reasonable, and must be individualized for the unique needs of the resident. R80's Diagnosis Report dated March 2014, indicated diagnoses that included adult failure to thrive, congestive heart failure, chronic airway obstruction, anxiety, depressive disorder and esophageal reflux. R80's Initial Nutritional Assessment dated 1/16/14, indicatedideal body weight range to be 80-100 pounds (lbs.), the usual body weight to be 85-87 lbs. and her food intake to be 50-75%. Comments included, "Offer supplements d/t [due to] dx [diagnosis]. R80's care plan dated 4/16/14, did not identify goals or interventions to address nutritional needs and risks. Review of the Vital Signs and Weight Record revealed the following: -1/16/14 93 lbs admission weight -1/25/14 83 lbs 10.8% loss 15 days after admission -2/9/14 88 lbs 5.4% loss 30 days after admission -3/15/14 78 lbs 16.1% loss 60 days after admission On 4/17/14, at 2:03 p.m. RN-C confirmed there were no interventions for nutritional risks/needs on R80's care plan. On 4/17/14, at 4:45 p.m. director of nursing (DON) confirmed nutrition interventions were not	F 279		

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F 279	Continued From page 13 a part of R80's care plan. DON stated her expectation was the resident care coordinators would have added these to R80's care plan. The facility policy and procedure on care planning dated 11/12/12, directed the care plan to address problems related to diagnoses, have specific goals that are measurable and reasonable, and must be individualized for the unique needs of the resident.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure coordination of care between facility and hospice aide services for 1 of 1 residents (R12) reviewed for hospice. Findings include: An Admission Record dated 4/17/14, indicated R12's diagnoses included chronic kidney disease (CKD) stage 4 and cerebrovascular disease. The significant change Minimum Data Set (MDS) dated 3/24/14, indicated R12 had both short and long-term memory deficits, delirium with	F 309	F 309 Provider Care/Services for Highest Well Being Each resident will receive and Aicota HCC will provide the necessary care and services to attain or maintain the highest practicable, physical, mental and psychosocial well being according to the comprehensive assessment and plan of care. On 5/7/14, a meeting was held between the Hospice Agency and facility staff to improve care coordination for resident 12.	5/27/14

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F 309	Continued From page 14 continuous inattention and disorganized thinking, and an altered level of consciousness with psychomotor retardation. The MDS further indicated R12 required extensive assistance with personal cares and physical help in part of bathing activity and was receiving hospice services. A Care Area Assessment (CAA) dated 4/17/14, indicated R12 was started on Hospice on 3/11/14, for end stage kidney disease along with a CVA [cerebrovascular accident] on 2/13/14. A Hospice Comprehensive Assessment for Nursing dated 3/11/14, indicated R12 resided in a SNF [skilled nursing facility], required assistance with ADL's [activities of daily living] and would receive HHA [home health aide] services. R12's Care Plan dated 3/27/14, indicated hospice services were started on 3/11/14, for end stage CKD stage 4, and recent CVA with right sided weakness and expressive aphasia. The interventions included hospice support for R12 and family throughout the dying process. A Hospice Services Initial Orders and Plan of Care dated 3/11/14, to 6/8/14, indicated R12 was to receive hospice aide visits 1 time per week for personal care and socialization. A Hospice Services Aide/Homemaker Care Plan dated 3/11/14, indicated R12 was to receive assistance with bathing and personal cares 1 time per week. The undated PM Shift Bath Schedule indicated R12 was to receive a weekly bath from facility staff on Thursday evenings. The Hospice calendar schedule for the month of April, 2014, indicated R12 was to receive HHA visits on 4/18/14, (a Friday) and 4/24/14 (a Thursday).	F 309	A calendar is in front of resident's chart to indicate scheduled weekly hospice visits. Heartland Hospice Nursing Facility Protocols are kept at both nursing stations to utilize for nursing staff to update condition changes or medication orders to Hospice Agency. Facility NA□s provide one bath every Tuesday and Hospice HHA provides another bath every Friday. Hospice staff are invited to the quarterly care conferences of resident 12. Nursing staff was educated on care coordination and the importance of good communication between Hospice care and Facility staff. RCC will monitor for compliance by weekly communication with Hospice Case Manager. Results will be reported to the QA committee quarterly until compliance is sustained.	

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F 309	Continued From page 15 A Hospice Aide Progress Note dated 3/13/14, (a Thursday) indicated R12 had received a tub bath and other personal cares. Another Hospice Aide Progress Note dated 3/29/14, (a Saturday) indicated R12 had already received a shower so none was provided. On 4/16/14, at 1:17 p.m. nursing assistant (NA)-A and NA-E stated R12 was on hospice services and had been assigned a hospice aide for bathing and personal care assistance. Both NA-A and NA-E stated they were unsure what day the hospice aide, visited R12 and would usually just show up. Both NA-A and NA-E further stated the bath received from the hospice aide was an extra weekly bath. Both NA-A and NA-E confirmed R12 had a bath schedule for the facility but no set day for the hospice aide. On 4/17/14, at 1:28 p.m. registered nurse (RN)-A stated hospice aide visits would be considered additional to cares, such as bathing, provided by nursing home staff. RN-A confirmed R12's hospice aide visit was scheduled for Thursdays and further confirmed R12's facility bath day was also on Thursdays. RN-A verified the hospice staff schedule was usually posted in R12's hospice chart. RN-A stated facility staff would sign off on the hospice aide progress notes after each visit to verify cares were provided. RN-A stated R12's medical record lacked documentation of any other hospice aide visits. A copy of the facility's Hospice Coordination of Services policy was requested but not provided.	F 309		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		5/27/14

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F 431	Continued From page 16 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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 interview and document review, the facility failed to develop policy and procedures	F 431	F 431 Drug Records, Label/Store Drugs and Biologicals	

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F 431	Continued From page 17 related to disposal of used Fentanyl (narcotic used for moderate to severe pain) patch's in a manner to prevent potential diversion for 3 or 3 residents (R28, R35, R41) reviewed with prescribed Fentanyl patch's. Findings include: The facility policy and procedure dated 6/17/13, directed disposal of used Fentanyl patches by flushing down the toilet. The policy and procedure did not address the risk of potential diversion of the remaining medication during disposal of used Fentanyl patches. The consultant pharmacist (CP)-A, interviewed on 4/17/14, at 1:00 p.m., verified facility policy directed flushing into the sewer. CP-A verified the policy did not address potential diversion of the narcotic remaining in the patch at the time of disposal. R28's Physician Orders dated 4/3/14, indicated R28's diagnoses included hypertension, edema, and pain. The orders included Fentanyl patch 25 micrograms (mcg) per hour 1 patch topically (to the skin) change every 72 hours. R35's Physician Orders dated 3/5/14, indicated R35's diagnoses included hypertension, edema, and pain. The orders included Fentanyl patch 25 micrograms (mcg) per hour 1 patch topically (to the skin) change every 72 hours. R41's Physician Orders dated 3/5/14, indicated R41's diagnoses included hypertension, seizures, depression, and pain. The orders included Fentanyl patch 25 micrograms (mcg) per hour 1 patch topically (to the skin) change every 72	F 431	The facility will develop a policy and procedure related to disposal of used Fentanyl patches in a manner to prevent potential diversion of the remaining medication during disposal of used Fentanyl patches. The policy for disposal of transdermal patches was reviewed and updated reflecting potential diversion of remaining medication in used Fentanyl patches and requires a licensed staff to observe the disposal/flushing of used Fentanyl patches. The observer/ witness will sign off on MAR as well as the staff removing the patch. Every resident with a Fentanyl patch order was reviewed. Adjustments were made on the MAR for staff observing the flushing to sign off the task. All licensed staff will be educated by reviewing revised policy on disposal of used Fentanyl patches. DON/ designee will monitor for compliance by monthly audits and task observation. Results of audits will be reported to the QA committee quarterly until compliance is sustained.	

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	245363	A. BUILDING _____ B. WING _____	04/17/2014

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

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F 431	Continued From page 18 hours. The director of nurses (DON), interviewed on 4/17/14, at 1:53 p.m., stated licensed staff remove the Fentanyl patch, fold it in half, wrap in Kleenex and then flush into the sewer. The disposal is signed off by the licensed nurse completing the task.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441		5/27/14

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F 441	Continued From page 19 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement contact precautions for 1 of 1 residents (R54) diagnosed with clostridium-difficile (C-Diff) infection. This had the potential to affect all 65 residents in the facility. Findings include: R54 had a diagnosis of C-Diff infection on 4/10/14, and continued to have loose stools as of 4/16/14. Physician's orders dated 4/10/14 included Flagyl 500 mg three times a day for 10 days (medication for the treatment of C-Diff infection). R54 sitting in his room on 4/14/14, from 4:00 p.m. to 7:45 p.m.; and on 4/15/14, from 8:00 a.m. to 12:05 p.m.. There was no sign at the door to cue staff/visitors to acquire further information before entering the room. A toileting commode in R54's room was observed from the hallway and there was a note on the bathroom door to remind R54 not to use the shared bathroom. Staff were observed to enter the room without gloves or gowns.	F 441	F 441 Infection Control, Prevent Spread, Linens The facility will maintain an infection control program to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. Resident 54 was admitted to a semi-private room (no roommate) from our local hospital on March 14, 2014 after being treated for left lower lobe pneumonia, C diff colitis, dehydration and deconditioning. Resident had been at or Assisted Living Facility prior to hospitalization. A private room was not available at our facility. Resident had occasional incontinence of soft stool. Clinical symptoms like watery diarrhea, fever, nausea and/or abdominal pain were not present. His stools were contained. A commode for toileting in his room was provided to prevent sharing a bathroom. Environmental cleaning was done following our policy and procedures for Multi Drug Resistant Organisms. On April	

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	245363	A. BUILDING _____ B. WING _____	04/17/2014

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

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F 441	Continued From page 20 The admission Minimum Data Set (MDS) dated 3/21/14, indicated R54 had moderate cognitive impairment; required two staff for bed mobility and toileting. R54 was frequently incontinent of bowel. On 4/15/14, at 10:10 a.m. licensed practical nurse, (LPN)-B was observed to go into R54's room to administer a multi-dose inhaler. LPN-B did not don gloves or a gown. LPN-B, interviewed on 4/15/14, at 1:05 p.m., stated she did not wear gloves or gown when she administered R54's inhalers or medications. Nursing assistant (NA)-A was observed to provide personal cares for R54 during the morning of 4/15/14. On 4/15/14, at 10:13 a.m. NA-A was interviewed and stated that she washed her hands before she left R54's room. NA-A wore gloves but not a gown when providing care for R54. R54 sometimes had normal stools and sometimes loose stools. At 1:08 p.m., NA-A stated that R54 had no stools on her shift; however, R54 did remove his own incontinent brief and put it in the garbage. Housekeeping staff (H)-A was interviewed on 4/15/14, at 10:05 a.m.. H-A stated R54's room was cleaned just like any other room. H-A wore gloves but not a gown when making or changing the linens. H-A did not put the bedding in plastic bags unless they are wet. H- A stated she knew R54 had C-Diff infection. The director of nurses (DON) was interviewed on 4/15/14, at 10:45 a.m.. The DON stated the facility used MDH and CDC recommendations for infection control precautions for C-Diff. The DON stated gowns were not necessary for R54's care	F 441	15, 2014, the Infecton Control Policy was again reviewed and Contact Precautions were initiated, a sign for visitors was posted on the resident's door and equipment like BP cuff and stethoscope were left in resident's room for his individual use. Resident had a follow up lab test on April 8, 2014 and his stool tested negative for C diff. Facility has hired an Infection Preventionist to consult with prior to admission for residents with communicable disease. All staff to review facility policy on Multi Drug Resistant Organisms, including Contact Precautions and Handwashing. Infection Preventionist will monitor compliance and report findings to QA Committee quarterly until compliance is sustained.	

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	245363	A. BUILDING _____ B. WING _____	04/17/2014

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F 441	Continued From page 21 because the stools were contained. The DON did not know if R54 continued to have loose stools. The DON verified staff were using a multi-use blood pressure cuff that was stored in hallway and available for all residents. On 4/15/14, at 4:00 p.m. a cart with gowns and gloves was observed outside R54's room with a sign directing visitors/staff to see a nurse before entering the room. On 4/17/14, at 10:00 a.m. LPN-C was observed to go into R54's room donning gown or gloves. LPN-C gave R54 medications in a plastic medication cup and then gave R54 an inhaler. After R54 received the inhaler, LPN-C, put the inhaler in her pocket. LPN-C came out of the room and washed her hands in the the dirty utility room before taking keys from her pocket, opened the medication cart, took the inhaler from the pocket and put it back into the medication cart. LPN-C did not clean the inhaler. At 10:15 a.m. LPN-C stated she probably should have worn gloves and a gown. When asked about the blood pressure machine and cuff, LPN-C stated the same machine and cuff were used for all the residents on the unit. The blood pressure machine and cuff were not cleaned between residents. Nursing progress notes dated 4/15/14, and 4/16/14, indicated R54 continued to have loose bowel movements. On 4/15/14, and 4/16/14, the progress notes indicated R54 refused to allow staff assistance with bedtime cares. On 4/17/14, at 11:25 a.m. the DON stated staff need to wear gown and gloves for medication administration for R54.	F 441		

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F 441	Continued From page 22 The Centers for Disease Control and Prevention dated 3/6/12, guidelines and recommendation for C-Diff infections indicated the use contact precautions for residents with known or suspected C-Diff. Because C-Diff infected patients continue to shed organism for a number of days following cessation of diarrhea, some institutions routinely continue isolation for several days. The CDC indicated to implement an environmental cleaning and disinfection strategy: Which included adequate cleaning and disinfection of environmental surfaces and reusable devices. The facility's Infection Control policy dated 10/20/10, addressed C-Diff along with other infectious diseases that were multi-drug resistant. The policy directed contact precautions for residents with symptomatic C. Diff infection. Contact precautions included hand hygiene prior to entering room; gown and gloves when entering the room and for all contact with the resident, resident items, equipment or body fluids; remove gloves and gown and wash hands before leaving the room; and dedicate the use of non-critical resident care equipment to a single resident. The policy did not address cleaning the bedroom floor or surfaces.	F 441		

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

F5363023

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	245363	A. BUILDING **01 - AICOTA NURSING HOME** B. WING _____	**04/16/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Aicota Health Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Aicota Health Care Center, is a 1-story building with no basement. The original building was constructed in 1969 and was determined to be of Type II(111) construction. In 1983 an addition was constructed to the building that was determined to be of Type II(111) construction. In 2007 an assisted living facility was attached, that is properly 2 hour fire rated separated. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 75 beds and had a census of 66 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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