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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ESGH

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 **12/07/2021** (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 :
Susan Frericks, Unit Supervisor 01/07/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/07/2022 (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
01/05/2022 (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 7, 2022

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 November 23, 2021 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/or 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
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
January 7, 2022

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

RE: CCN: 245119
Cycle Start Date: October 15, 2021

Dear Administrator:

On November 8, 2021, we notified you a remedy was imposed. On December 7, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 23, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 23, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 8, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 23, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 23, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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: ESGH

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(L4) **301 MINNESOTA AVENUE SOUTH**
(L5) **AITKIN, MN** (L6) **56431**

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3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
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(L9) **07/01/2006**

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2 AOA 3 Other

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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

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From (a) :
To (b) :

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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)

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Colleen Johnson HFE - NE II 12/10/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/31/2021 (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)

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25. LTC EXTENSION DATE: (L27)

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B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
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05-Fail to Meet Health/Safety
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28. TERMINATION DATE: (L28)

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03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically Submitted
November 8, 2021

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

RE: CCN: 245119
Cycle Start Date: October 15, 2021

Dear Administrator:

On October 15, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On October 15, 2021, the situation of immediate jeopardy to potential health and safety cited at F 880 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 23, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 23, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 23, 2021, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 15, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 April 15, 2022 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with

which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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 _____	10/15/2021

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 000	INITIAL COMMENTS On 10/11/21, through 10/15/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F880 when the facility failed to ensure isolation precautions for symptomatic residents, failed to implement quarantine procedures for residents after a high-risk exposure and failed to ensure proper PPE use. The IJ began on 10/2/21, when the facility failed to implement transmission based precautions for a resident with COVID-19 symptoms. The immediacy was removed on 10/15/21, at 4:45 p.m.. The following complaints were found to be UNSUBSTANTIATED: H5119022C (MN74034), H5119023C (MN73951), and H5119024C (MN68322). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and	F 550		11/20/21

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

Electronically Signed | 11/17/2021

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 _____	10/15/2021

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 550	Continued From page 1 access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 550	AHS will ensure a dignified dining	

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 _____	10/15/2021

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 550	Continued From page 2 review, the facility failed to ensure a dignified dining experience was provided to 1 of 8 residents (R10) observed to not receive their meal in a timely manner. Findings include: R10's Face Sheet printed 10/14/21, indicated R10's diagnoses included essential tremor (a nervous system disorder that causes rhythmic shaking), anxiety disorder, adult failure to thrive, and low back pain. R10's quarterly Minimum Data Set (MDS) dated 8/10/21, indicated R10 was moderately cognitively intact and required extensive assistance of one with eating meals. R10's care plan dated 6/1/17, identified R10 had a potential for alteration in nutrition. One of the approaches listed was to assist with "feeding". On 10/12/21, at 9:28 a.m. R10 was observed seated at her table waiting for assistance with her meal while her tablemate ate. On 10/13/21, at 7:59 a.m. a continuous observation of R10 was started, R10 was seated in the Bear Den dining room at a table alone, she had beverages in two-handled cups with straws. R10 did not have a breakfast meal. On 10/13/21, at 8:10 a.m. staff were bringing breakfast meals out of the dining room on a cart. Five residents were seated in the dining room. They had all been served their breakfast. On 10/13/21, at 8:18 a.m. staff brought a breakfast out to a resident seated in the	F 550	experience is provided to their residents. R10 will be asked her preferences with dining to ensure that a dignified dining experience is provided. Her care plan and care sheet will be reviewed/revised with any changes. All residents that require assistance with eating have the potential to an undignified experience in the Dining Room by not receiving assistance in a timely manner. All staff were educated on 11/16/21 on 'dignity with dining R/T receiving timely assistance with eating'. Random audits of the Dining Room will be completed 4X/week X 1 week, 2X/week X1 week and weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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F 550	Continued From page 3	F 550		

courtyard. R10 remained seated at her table with the beverages, no breakfast meal.

On 10/13/21, at 8:26 a.m. staff was seated next to a resident in the courtyard. They were assisting him with eating his breakfast. R10 remained seated alone at her table with no breakfast meal.

On 10/13/21, at 8:34 a.m. R10 remained seated at her table, no breakfast, other residents had come and gone, R10 was looking around the room.

On 10/13/21, at 8:36 a.m. three staff were heard discussing if R10 had been "fed".

On 10/13/21, at 8:41 a.m. nursing assistant (NA)-C brought food to R10's table, put a cover up on her and walked away. Registered nurse (RN)-C was seated talking with R10.

On 10/13/21, at 8:50 a.m. R10 received her first bite of breakfast.

On 10/13/21, at 9:36 a.m. NA-B stated typically staff will bring R10 to the dining room and she will help R10 with eating. NA-B stated staff do not come and find her to tell her when R10 has been brought to the dining room and is ready to breakfast. NA-B stated her routine was to pass morning waters to residents and then go to the dining room and help R10 with eating in the morning. NA-B verified it was not dignified to make a resident wait in the dining room from 7:59 a.m. to 8:50 a.m. waiting for their meal.

On 10/13/21, at 9:58 a.m. the director of nursing (DON) verified it was not dignified to bring someone to the dining room and make them wait

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F 550	Continued From page 4 for almost an hour for their food while others are eating. The DON stated it would be her expectation for staff to bring a resident to the dining room and assist them with their meal right away. On 10/13/21, at 10:19 a.m. R10 stated it bothered her to sit and wait for meals. R10 stated, "it happens every day". R10 added she doesn't like to sit so long in the dining room. The facility policy Dignity Policy with revision date of 9/2017, indicated residents would be treated with dignity and respect at all times. "Treated with dignity" means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. The policy did not specifically address dignity in dining.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		11/20/21

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F 609	Continued From page 5 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 ensure allegations of abuse were reported immediately (within two hours) to the administrator and the State Agency (SA) for 1 of 2 (R35) reviewed for abuse. Findings include: R35's Face Sheet printed 10/14/21, indicated R35's diagnoses included chronic pain syndrome, hypertension, osteoarthritis, low back pain, depressive episodes, anxiety disorder, rheumatoid arthritis (chronic progressive disease causing inflammation in the joints and resulting in painful deformity and immobility), and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should). R35's admission Minimum Data Set (MDS) dated 9/2/21, indicated R35 was cognitively intact and required extensive assistance with her activities of daily living (ADLs). R35's care plan dated 9/15/21, indicated R35 was refusing cares, medications and/or treatments related to racial prejudice. Approaches for R35	F 609	AHS will ensure alleged violations involving abuse are reported immediately to the administrator and the State agency. R35's alleged violation was reported to OHFC on 10/15/21. All residents have the potential to be involved in an alleged abuse situation. The allegation of potential verbal abuse noted on survey was reported immediately to the State and when the investigation revealed another potential allegation, it was also reported to the State. The Abuse policies were reviewed and the reporting process was revised. All staff were educated on the updated Abuse policies and reporting process on 10/28/21. Any potential abuse situation is reviewed by the Administrator and DON and audited to ensure each step of the process is	

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F 609	Continued From page 6 were updated on 10/13/21, to include two person assist as needed, one staff as a witness. R35's progress note dated 8/28/21, at 5:37 p.m. indicated the licensed practical nurse (LPN)-A was called to the room, the resident told her the two staff were "hurting her and were not being very nice to her". R35's progress note dated 9/3/21, at 2:45 p.m. indicated R35's family member (FM)-E spoke with the social service designee (SS)-A "that nurse (rent a nurse, the Columbian one) is mean to her and wants to see nurse fired. Said that nurse spacifically [sic] targets her sister. Said that nurse laughs, teases her and yells at her for having to use the bathroom." The note went on, "we did look into it and was found to be unfounded." On 10/13/21, at 10:44 a.m. the director of nursing (DON) verified allegations of abuse (emotional and/or physical) need to be reported within two hours to the SA. The DON further stated she would expect staff to report the allegation of abuse unless it could be thoroughly investigated before the two hours were up. On 10/13/21, at 2:28 p.m. SS-A stated she was not made aware of the allegation of physical and emotional abuse until Monday following the allegation. SS-A provided a written summary of the event. The written summary dated 8/30/21 indicated R10 was unhappy with a staff of a different race nursing assistant (NA)-C, another staff NA-A was also present. The report indicated the incident was reported to LPN-A. On 8/30/21, SS-A spoke with R10, LPN-A, NA-A, and NA-C and determined "no truths were founded that night". LPN-A did not report the allegation on the	F 609	being followed. Audits of alleged violations will be completed 3X/week X2 weeks, 2X/week X 2 weeks, and weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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F 609	Continued From page 7 day it occurred and SS-A did not report the allegation when she learned of it the following Monday. SS-A verified the allegation should have been reported within the two hour timeframe per their policy. On 10/14/21, at 4:29 p.m. the DON verified staff should have called the oncall nurse if they were unsure if an allegation of abuse needed to be reported and not waited until the following Monday to report the allegation. The DON verified she would expect staff to follow the facility policy on reporting. The facility policy titled Skilled Nursing Facility Maltreatment Reporting Guidelines reviewed/amended 4/1/19, directed staff to report alleged maltreatment immediately, but not later than two hours after the allegation is made if the incident involves abuse. The facility policy titled Maltreatment Prohibition Policy reviewed/amended 2/19/18, defined physical and emotional abuse as: If a Vulnerable Adult (VA) complains of staff treating them 'roughly', this may be investigated as potential abuse. If a VA complains that staff was 'rude' to them, this may be investigated as potential abuse.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		11/23/21

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F 656	Continued From page 8 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete a comprehensive care plan for 2 of 3 residents (R9	F 656	AHS will ensure residents have a comprehensive care plan.	

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F 656	Continued From page 9 and R33) reviewed for care planning to incude hospice services for R9 and smoking for R33. Findings include: Hospice and End of Life R9's Face Sheet printed 10/14/21, indicated R9's diagnoses included dementia, stage three chronic kidney disease, anxiety and major depressive disorder, and cerebral infarction (stroke). R9's significant change Minimum Data Set (MDS) dated 8/10/21, indicated R9 had a life expectancy less than six months and received hospice services. R9's Physician Order Sheet dated 10/14/21, indicated R9 had orders for a hospice referral ordered on 8/9/21. R9's care plan printed by the facility on 10/14/21, lacked identification of hospice services, goals and intervention for R9. R9's NAR Assignment Sheet revised 10/1/21, indicated R9 received hospice care from St. Croix hospice. On 10/15/21, at 2:20 p.m. registered nurse (RN)-D stated each resident who was on hospice should have a hospice care plan in the hospice binder which was kept at the nurses station. RN-D verifed R9 did not have a hospice care plan in R9's hard chart or in the St. Croix hospice binder. . On 10/15/21, at 5:12 p.m. the director of nursing (DON) stated R9 did not have a hospice care	F 656	An individualized Hospice care plan was developed for resident R9. A care plan regarding smoking was developed for resident R33. NAR assignment sheet was reviewed/revised for R33□s smoking. The care plan process for Hospice and smoking was reviewed along with how a comprehensive care plan should be developed with the appropriate nursing staff on 11/16/21. All residents could have the potential to be affected by this. They will have their care plans audited by the DON/designee for appropriate person-centered approaches, goals, and interventions. DON or designee will do care plan audits 3x/week x 2 weeks, 2x/week x 2 weeks, 1x/week x 2 weeks and then monthly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations	

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F 656	Continued From page 10	F 656		

plan from St. Croix hospice in the R9's paper chart, or in St. Croix's hospice binder. The DON further verifed R9's care plan printed on 10/14/21, did not include Hospice services. The DON stated it was important to have a hospice care plan to know what services hospice was providing for the resident.

The Hospice-Nursing Facility Service Agreement undated, indicated the facility obtained a service agreement with St. Croix Hospice effective 6/20/19. The service agreement directed the facility would ensure the facility's care plan for each hospice patient reflected both the most recent hospice plan of care and description of the facility services furnished by the facility.

The facility policy Care Planning undated, indicated care plans should include identified resident needs, problems/concerns with measurable goals. The policy further indicated care plans included the care and services that must be provided to meet those goals, frequency of services and date expected goals were to be achieved. The policy directed care plans to be updated on an ongoing basis and as needed, based on changes to accommodate the residents needs that occur between care conferences.

Accidents

R33's Face Sheet printed 10/14/21, indicated R33's diagnoses included chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe), nicotine dependence, and mild cognitive impairment.

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R33's quarterly Minimum Data Set (MDS) dated 8/24/21, indicated R9 had mild impaired cognition, was independent with activities of daily living (ADLs) and identified R33 as a smoker.

R33's care plan printed 10/20/21, failed to identify R33's risks, needs, concerns, goals, and interventions for smoking.

R33's NAR Assignment Sheet revised 10/1/21, lacked identification R33 was a smoker and further lacked direction and interventions for R33's smoking.

R33's Smoking Assessment was completed on 3/23/21, and indicated R33 had slight impaired cognition, dexterity was impaired but functional, had no vision concerns, history of smoking practice isolated incidents, safety awareness for decision making and problem solving-moderately independent. The assessment indicated R33 had the ability to identify proper extinguishing receptacles, and could light, hold and extinguish smoking materials.

On 10/11/21, at 6:22 p.m. R33 stated she was a smoker and since the facility was "smoke free", R33 had to smoke off the premises and would go down the street on the side walk to smoke.

On 10/14/21, at 7:48 a.m. R33 and housekeeper (HSK)-B were observed walking into the facility together from outside. R33 stated she just came in from smoking outside.

On 10/14/21, at 5:28 p.m. R33 was observed exiting the facility by herself.

On 10/12/21, at 3:32 p.m. LPN-B stated she was

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unaware if R33 had any smoking restrictions or safety interventions in place, and verified R33's care plan did not identify R33 as a smoker. LPN-B stated R33 usually went outside a couple times a day to smoke and R33 needed to smoke off the property and R33 went around the building on the sidewalk.

On 10/13/21, at 7:28 a.m. NA-E stated R33 went outside to smoke by herself and would smoke on the side walk next to the road. NA-E verifed the NAR Assignment Sheet dated 10/1/21, did not identify R33 as a smoker or list any smoking interventions.

On 10/14/21, at 8:27 a.m. HSK-B stated R33 was her "smoking buddie". HSK-B stated the facility was "smoke free" and HSK-B and R33 went off the facility premises to smoke which was around the side of the building on the public sidewalk.

On 10/15/21, at 9:42 a.m. trained medication aide (TMA)-A-stated she was unsure where residents were allowed to smoke outside. TMA-A verifed the NAR Assignment Sheet lacked information and directions about R33's smoking.

On 10/15/21, at 9:56 a.m. NA-F stated R33 was independent and was able to go outside on her own and smoke but not on the property. NA-F stated she was unsure where R33 was permitted to smoke outside. NA-F verified smoking was not addressed for R9 on the NAR Assignment sheet dated 10/1/21.

On 10/15/21, at 2:14 p.m. RN-D stated she did not feel comfortable answering where R33 could smoke because RN-D did not complete R33's smoking assessment and would refer to R33's

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F 656	Continued From page 13 plan of care for direction. RN-D stated she would expect staff to refer to the residents care plan and the NAR Assignment sheet to know what a residents needs were. R33 verifed R33's care plan and NAR Assignment Sheet lacked identification of R33's smoking risks, needs, concerns, goals and interventions. On 10/15/21, at 5:06 p.m. the director of nursing (DON) stated R33's care plan should include smoking to ensure R33 was safe when smoking and so staff would know where R33 could smoke, where R33's cigarettes and lighter were stored and if there were any safety interventions that needed to be in place. The facility policy Resident Smoking dated 10/23/17, indicated smoking was forbidden anywhere on facility property grounds, and the designated smoking area would be a distance away from buildings to avoid smoke drifting through open doors and windows or people who entered the building. The policy further indicated resident's "smoking" would be care planned.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		11/20/21

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F 657	Continued From page 14 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a care conference was conducted for 1 of 2 (R35) residents reviewed for care planning. Findings include: R35's Face Sheet printed 10/14/21, indicated R35's diagnoses included chronic pain syndrome, hypertension, osteoarthritis, low back pain, depressive episodes, anxiety disorder, rheumatoid arthritis (chronic progressive disease causing inflammation in the joints and resulting in painful deformity and immobility), and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should). R35's admission Minimum Data Set (MDS) dated 9/2/21, indicated R35 was cognitively intact and required extensive assistance with her activities of daily living (ADLs).	F 657	The facility will ensure care conferences are held in a timely manner in order to develop the resident's care plan. The appropriate nursing and social service staff were-educated on the care conference process on 11/16/21. Random audits of Care conference completion will be conducted by the DON/designee 3 X week X 2, then weekly X 2 and monthly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations	

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R35's care plan with a start date of 9/15/21, did not address R35's or her family member's involvement with care planning and approaches to care.

On 10/11/21, at 3:05 p.m. R10 stated she had never had a care conference since she arrived at the facility on 8/26/21.

On 8/13/21, at 9:18 a.m. Social Service designee (SS)-A progress noted indicated she called R10's family member (FM)-E to set up a meeting. The note indicated FM-E did not answer and did not call back.

On 9/3/21, at 2:45 p.m. in progress note by SS-A, the note indicated FM-E would be coming to the facility on Wednesday to fill out paperwork and meet with staff.

On 10/12/21, at 2:58 p.m. SS-A stated the process for the initial care conference was as follows: the care conference should occur at five days, then every 30 days. SS-A stated the MDS nurse was the person who would coordinate setting up the care conferences. SS-A stated care conferences could be held in person or by phone. SS-A was not able to find any evidence of an initial care conference for R10.
SS-A provided a document dated 9/9/21, and signed by activities aide (AA)-A. The document indicated AA-A spoke with FM-E on 9/9/21, and FM-E stated she would not able to attend the scheduled care conference on 9/14/21, as she had forgotten she had an appointment. The note indicated FM-E did not want to reschedule. SS-A was not able to provide any documentation of a care conference held on 9/14/21, with or without

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F 657	Continued From page 16 R35. On 10/13/21, at 10:44 a.m. the director of nursing (DON) verified an initial care conference had not been conducted on day five nor had the facility conducted any care conferences for R35. The DON verified a care conference should be held even if the resident or family member did not want to participate, the interdisciplinary team should still have met without the resident. The facility provided a blank undated document titled Care Conference Attendance Sheet Aitkin Health Services. The document had a spot for the resident's name, date and time of care conference, attendees, and whether the resident/resident representative reviewed current care plan and provided a copy. The facility was not able to provide a completed document for R35. The facility document titled Care Conferences reviewed/revised 1/1/17, directed care conferences would be scheduled by the MDS/Resident Assessment Instrument (RAI) Coordinator based upon the RAI process and in accordance with state and federal guidelines. In addition a copy of the baseline care plan would be given to the resident/representative at the initial care conference. The RAI dated 10/2019, indicated the following: Care Planning-Establishing a course of action with input from the resident (resident's family and/or guardian or other legally authorized representative), resident's physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise;	F 657		

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F 657	Continued From page 17 crafting the "how" of resident care. In addition the RAI indicated the following; The care plan completion date (item V0200C2) must be either later than or the same date as the CAA completion date (item V0200B2), but no later than 7 calendar days after the CAA completion date. The MDS completion date (item Z0500B) must be earlier than or the same date as the care plan completion date. In no event should either date be later than the established time frames as described in Section 2.6.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate skin care to promote wound healing for 1 of 1 resident (R3) reviewed for pressure ulcers. Findings include: Pressure Ulcer stages defined by the National	F 686	AHS will ensure residents receive care, consistent with professional standards pf practice, to prevent pressure ulcers and receive treatment and services to promote healing, and prevent new ulcers from developing. All residents that are at risk for skin ulcers	11/20/21

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F 686	Continued From page 18 Pressure Ulcer Advisory Panel (NPUAP): A Stage 2 Pressure Injury is a partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. R3's quarterly Minimum Data Set (MDS) dated 7/31/21, identified R3 had a severe cognitive impairment and had diagnoses that included hemiplegia. R3 required assistance with transfers and mobility. The MDS also identified R3 was at risk for pressure ulcer/injury, however, did not identify if R3 had any current skin conditions. R3's Summary for Quarterly MDS with Assessment Reference Date (ARD) of 10/5/21, identified R3's Braden Risk Assessment score was 14 on 10/8/21, which identified R3 was at moderate risk for skin breakdown. R3 did have a callused area on the left bottom of her left foot by the heel. However, the callused area did open due to R3 dragging her foot on the floor while in her wheelchair on 9/23/21. Interventions of a foot pedal and a foot protector were implemented. The Summary indicated wound care was in place for the opened area and monitoring would be continued by a nurse once weekly. R3's care plan dated 9/24/21, identified R3 was at risk for friction injury due to dragging her left foot and directed staff to apply a boot protector along with a raised wheelchair foot pedal. R3 required assistance with transfers and directed staff to provide assist of two with a sit to stand mechanical lift. The care plan additionally identified R3 was at risk for impaired skin integrity related to her impaired mobility. The goal was for R3 to be free of pressure ulcers and R3 was followed with podiatry for foot care, had pressure	F 686	have the potential to be affected. R3's wound was reassessed and a Root Cause Analysis was completed on 11/17/21. Nursing staff that are involved in the assessment process were reeducated on the facility skin protocol on 11/16/21. All residents with a current skin issue will be reassessed to ensure appropriate interventions have been implemented. Random audits of any new skin issues will be conducted 2xwkx4, and weekly thereafter . Audit results will be brought to the QAPI Committee for review and further recommendations.	

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reducing cushion on wheelchair, was turned, and repositioned every six hours when lying and every 6 hours when sitting. Additionally, weekly monitoring of R3's skin was conducted by nursing with charting by exception.

R3's Braden Scale for Predicting Pressure Sore Risk dated 10/8/21, identified R3 was at moderate risk for pressure sores.

R3's Physician's orders dated 9/28/21, included wound care instructions for R3's left foot open area: cleanse left foot; apply foam dressing to wound; change every Tuesday and Friday and as needed. However, the order did not provide instructions for what product should be used to cleanse R3's wound.

Although all wound documentation for R3 was requested, the facility only provided documentation after 9/28/21. In addition, R3's wound opened on 9/23/21, but were no measurements or staging evident until 10/3/21.

R3's Skin Condition/Wound Progression note dated 9/29/21, identified R3 had an "abrasion" to the bottom of her left foot. The note indicated the wound had no apparent odor, drainage consistency was thin with a minimal amount; color was clear yellow. R3 had a bath and a dressing change was needed. R3's wound was described as having a beefy read base and epithelium present at the wound edges. However, the Skin Condition/Wound Progression note lacked staging and measurement of the wound.

R3's Skin Condition/Wound Progression note dated 10/1/21, identified the dressing was changed to R3's left foot wound due to the

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dressing was 75% saturated. The skin surrounding the wound was pink and was without signs/symptoms of infection. However, the Skin Condition/Wound Progression note lacked staging and measurement of the wound.

R3's Skin Condition/Wound Progression note dated 10/2/21, identified R3's left foot wound had no apparent odor and was without drainage. the area was much improved since last assessment; affected and surrounding tissues were blanchable and wound size decreased and was without sign/symptoms of infection. The wound base was visible, surrounding tissue was edematous (swollen with an excessive accumulation of fluid), margins were irregular with site improvement noted. However, the Skin Condition/Wound Progression note lacked staging and measurement of the wound to determine improvement or worsening of the wound.

R3's Skin Condition/Wound Progression note dated 10/3/21, identified R3's left foot wound had improved since last assessment; affected and surrounding tissue was normal; wound size had decreased without signs/symptoms of infection noted. The wound base was visible with the surrounding tissue edematous. The area measured 2 centimeter (cm) by 1 cm. This was the first documented measurement of R3's wound.

R3's Skin Condition/Wound Progression note dated 10/5/21, identified R3's left foot wound skin was blanchable, no apparent odor, and drainage consistency was thin; minimal drainage was present and that was bright red in color. The note additionally identified R3's wound was not covered by a padded bandage and had opened

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again and was bleeding. The wound was cleansed, a padded bandage was applied and wrapped to secure bandage along with the tub-grip (a tubular elastic bandage designed to provide tissue support and compression). However, the Skin Condition/Wound Progression note lacked staging and measurement of the wound.

R3's Skin Condition/Wound Progression note dated 10/7/21, identified R3's left foot wound as an "abrasion"; the area was cleansed, a new dressing was applied, and no signs/symptoms of infection were noted. However, the Skin Condition/Wound Progression note lacked staging and measurement of the wound.

R3's Skin Condition/Wound Progression note dated 10/8/21, identified R3's left foot wound dressing was 30% saturated. The drainage was tan colored with some blood and the overall status of the wound had improved, The skin to foot surrounding areas continued to be dry and flaky. Coconut oil was applied. However, the Skin Condition/Wound Progression note lacked staging and measurement of the wound to determine improvement or worsening of the wound.

R3's Skin Condition/Wound Progression note dated 10/11/21, identified R3's left foot wound was bleeding and still at a "stage II" injury with no signs of healing. R3 had no complaints of pain while performing the dressing change. No measurements of the area were documented.

R3's Skin Condition/Wound Progression note dated 10/12/21, identified R3's left foot wound dressing was removed and was 25% saturated

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with yellowish/bloody drainage and there was no odor. The wound was cleansed and a new dressing applied as ordered. However, the Skin Condition/Wound Progression note lacked staging and measurement of the wound.

During an interview on 10/12/21, at 3:06 p.m. licensed practical nurse (LPN)-A stated R3 had a wound to the outer aspect of her left foot. The wound was "definitely a pressure wound" and R3 wore a padded dressing that was changed on Tuesdays and Fridays.

During an interview on 10/13/21, at 2:26 p.m. registered nurse/MDS coordinator (RN-MDS) stated she was a former unit manager and wound care coordinator for the facility but had taken another role approximately two weeks ago. Because of this, it was unclear who was the wound care coordinator. The RN-MDS stated R3 did not reside on her unit and she was unaware of R3's left foot wound. RN-MDS stated she had frequently not been notified of wounds by the other unit manager and wounds on R3's unit were monitored by the nursing staff for approximately four months prior to her role change. Upon review of R3's wound documentation, RN-MDS stated R3 had an "abrasion" to her left outer foot that began on 9/23/21. Then on 9/27/21, the dressing order was changed to a padded dressing to relieve pressure. Additionally, the RN-MDS noted only one measurement had been documented for R3's left foot wound on 9/23/21, of 3.8 cm by 3.8 cm. RN-MDS stated all wounds should be measured at least weekly and documented for continuity of healing. Further, RN-MDS stated she had registered for wound care training, but had never been able to complete the training and was unaware of any wound care training available for

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the nursing staff.

During an interview on 10/13/21, at 2:42 p.m. registered nurse (RN)-D stated some of the nursing staff had been conducting wound assessments, but also was unaware of any wound care training that was available for staff. RN-D stated she was aware of R3's left foot wound and it was determined it was caused by R3 dragging her foot to propel her wheelchair. Interventions of a padded dressing, a wheelchair foot pedal and a sheepskin cover were implemented approximately two to three weeks ago. However, RN-D stated she was unsure if R3's left foot wound had ever been measured, but the facility had recently contracted with an outside group to evaluate wounds monthly. However, RN-D was not aware if the wound care group had evaluated R3's left foot wound. RN-D stated wound measurements should be conducted by nursing staff at least weekly during dressing changes for all wounds.

During an observation of R3's left foot wound dressing change on 10/15/21, at 9:51 a.m. registered nurse (RN)-B stated he had not worked for the previous week, so he really was not sure what R3's wound looked like. RN-B applied clean gloves after hand hygiene and then proceeded to remove R3's dressing. R3's tubi-grip was removed, then a gauze wrap was removed. RN-B stated he did not know why the gauze wrapping was covering the foam padding, but the foam padding did have a scant amount of red and tan drainage.

- At 9:53 a.m. RN-B continued his assessment of the wound and stated the surrounding tissue was blanchable and R3 denied pain with touch. Two

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small openings were observed with the surrounding tissue white in color approximately 1/4 inch from wound edges. RN-B stated the white colored tissue was due to moisture-associated skin damage related to the drainage on the foam padding and then stated, "I would have expected it to be a little bit better than this."

- At 9:57 a.m. RN-B lowered R3's left leg and placed onto left wheelchair foot pedal. However, RN-B placed no barrier between R3's foot and the foot pedal and R3's open wound rested against the foot pedal. The foot pedal was observed to be soiled with food debris and/or other unknown materials. RN-B left the room to gather dressing supplies for R3.

- At 10:00 a.m. RN-B returned to the room with supplies and proceeded to measure R3's wound. RN-B stated he was going to measure the two open areas as one because they were so close together. The wound measured 1.8 cm by 1.5 cm. RN-B stated the area was flush and he "guessed" it was "clearly stage one". RN-B stated the wound occurred because R3's left foot turned outward, and she dragged her foot across the floor to propel her wheelchair forward. Initially, the wound was determined to be an "abrasion", however, RN-B stated he was unable to classify wounds because that was the wound care coordinator's responsibility. Additionally, RN-B stated he was unable to classify any wound "as pressure" at the facility. "Not at all." However, RN-B stated the facility did not have a wound care coordinator currently, but then restated that the facility "must have a wound nurse". RN-B stated the facility did have a contracted company come into the facility monthly to assess wounds,

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but RN-B did not believe R3 had ever been assessed by that group.

- At 10:06 a.m. RN-B cut up a heal foam padded dressing to fit area and cleansed R3's left foot wound with an alcohol pad. R3 made no comments or exhibited any signs/symptoms of pain. A foam padded dressing was applied to the wound and RN-B wrapped with gauze to cover the foam dressing. R3's tubi-grip was then applied.

- 10:11 a.m. RN-B stated he always cleaned R3's left foot wound with either an alcohol pad or wound prep, whatever was available. Additionally, RN-B stated he did not put any type of barrier under R3's foot to protect the wound or the surrounding environment because the facility did not have anything like that. Further, RN-B stated wound measurements were the responsibility of the wound care coordinator, but he was able to measure a wound when it initially occurred.

During an interview on 10/15/21, at 2:01 p.m. the director of nursing (DON) stated when staff noticed a skin issue, they reported it to the nursing manager for that unit. Then, the nurse who was on duty at that time would assess and measure the wound. The information would be entered into a wound note and a root cause analysis would be conducted. Then, depending on the wound type, the facility had a contracted wound specialist group to evaluate wounds monthly. This group would do more of the open wounds or pressure ulcers. Small wounds such as a skin tear would be handled by the nursing staff. Additionally, dietary and the resident's physician would be notified of any wound for further input or possible treatment options.

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F 686	Continued From page 26 Further, when an order stated, "cleanse the wound", it would be cleansed with normal saline unless specifically ordered by the physician. However, the DON would not expect a nurse to cleanse an open wound with an alcohol pad and nursing was additionally expected to protect the wound and the surrounding environment during dressing changes. Ultimately, staff were expected to measure wounds at least weekly as that was part of the wound description: size, location, and drainage. . The facility policy Skin Ulcer Protocol updated 7/1/20, indicated resident would not develop pressure sores or other skin ulcers unless it was clinically unavoidable, and appropriate care and services would be provided to prevent, treat, and monitor progress of all healing ulcer(s). The policy directed staff to daily document if the dressing was or was not present, the condition of the surrounding tissue, presence of any possible complications such as increasing size or infection, and the presence of pain and if controlled. Wound Round documentation (weekly at minimum) was to include the following: type of wound, location and staging, size with measurements in centimeters, presence of pain, wound bed condition, description of wound edges and surrounding tissue, interventions with current treatment and response to treatment, and tracking of wound status. The policy additionally provided a wound care protocol that instructed staff to cleanse all wounds with normal saline or wound cleanser.	F 686		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors.	F 759		11/20/21

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F 759	Continued From page 27 The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 7.69% with two errors out of 26 opportunities for error involving 2 of 8 (R2, R15) residents who were observed during the medication pass. Findings include: R15's Face Sheet printed 10/14/21, at 9:43 a.m. indicated R15 had diagnoses which included chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing), congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), type two diabetes mellitus, and depression. R15's quarterly Minimum Data Set (MDS) dated 7/20/21, indicated R15 was cognitively intact and required extensive assistance of one with activities of daily living (ADLs). R15's Physician Order Sheet dated 9/21/21, at 12:00 a.m. included the following orders: -Humalog Kwikpen U-100 (fast acting insulin pen) 100 units per milliliter (ml) administer eight units subcutaneous two times per day 7:30 a.m. and 4:30 p.m. for type two diabetes mellitus with hyperglycemia. -Victoza pen (anti-diabetic medication) 0.6 milligrams (mg) per 0.1 ml, inject 1.2 mgs	F 759	Med error rate greater than 5% All residents utilizing Insulin pens could be affected. All nursing staff were reeducated on priming the insulin pens prior to administering the insulin on 11/16/21. Random audits of Medication passes for insulin will be conducted 3Xwk x2, then 2xwkx2, and weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations	

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subcutaneous one time per day at 5:00 p.m. for type two diabetes mellitus with hyperglycemia.
-Toujeo Solostar (long acting insulin pen) 300 units per ml. Inject 13 units subcutaneous one time per day at 5:00 p.m. for type two diabetes mellitus with hyperglycemia.
-Humalog Kwikpen U-100 100 units per ml. As directed three times per day with meals for type two diabetes mellitus with hyperglycemia. Give insulin per sliding scale; greater than or equal to 201 give two units, greater than 251 give four units, greater than 351 give eight units, greater than 401 notify provider for instructions.
-Humalog Kwikpen U-100 (insulin pen) 100 units per ml. Administer seven units subcutaneous one time per day at 11:00 a.m. for type two diabetes mellitus with hyperglycemia.

On 10/13/21, at 7:52 a.m. registered nurse (RN)-C was at the medication cart in the Town Square. R15 approached RN-C asking for her medications. RN-C performed a blood glucose test. The blood sugar reading was 118. RN-C then removed R15's insulin pen, cleaned the top of the pen with an alcohol wipe, put the insulin needle on the pen and dialed up eight units of Humalog insulin. RN-C asked R15 where she wanted her insulin injection and gave the insulin per the resident's preference.

On 10/13/21, at approximately 8:05 a.m. RN-C verified she did not prime the insulin needle with two units of insulin. RN-C stated she had learned two methods; to always prime the insulin needle with two units of insulin or only to prime the insulin needle the first time the insulin pen was opened.

On 10/13/21, at 8:07 a.m. RN-C stated she

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checked with another nurse and stated she was supposed to prime the insulin needle with two units of insulin prior to dialing up the resident's insulin dose.

R2's Face Sheet printed 10/15/21, at 2:48 p.m. indicated R2's diagnoses included longstanding persistent atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), congestive heart failure, type two diabetes mellitus, and morbid obesity.

R2's quarterly MDS dated 9/28/21, indicated R2 was cognitively intact and required supervision with ADLs.

R2's Physician Order Sheet dated 10/15/21, at 12:00 a.m. included the following orders:
-Lantus Solostar (long-acting insulin pen) 100 units per ml. Administer 54 units subcutaneous one time per day at bedtime or type two diabetes mellitus with diabetic neuropathy.
-Humalog Kwikpen U-100, 100 units per ml. Administer 15 units subcutaneous one time per day for type two diabetes with diabetic neuropathy.
-Humalog Kwikpen U-100, 100 units per ml. Administer 10 units one time per day at 11:30 a.m. for type two diabetes mellitus with diabetic polyneuropathy.
-Humalog Kwikpen U-100, 100 units per ml. Administer 12 units one time per day at 4:30 p.m. for type two diabetes mellitus with diabetic polyneuropathy.

On 10/13/21, at 11:40 a.m. licensed practical nurse (LPN)-B was preparing medications for R2. LPN-B cleaned the top of R2's Humalog insulin pen with an alcohol wipe, put on an insulin needle

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F 759	Continued From page 30 and then dialed up 10 units of insulin. LPN-B stated the following, "it has a self-priming needle, so I can't prime the needle". LPN-B brought the insulin pen to R2 and gave the insulin to R2. On 10/13/21, between 11:00 a.m. and 12:00 p.m. LPN-A verified the needles for the insulin pens were not "self-priming" and the needles needed to be primed with two units of insulin prior to dialing up an insulin dose. On 10/14/21, at 8:03 a.m. clinical manager (CM)-A verified the needles for the insulin pens needed to be primed with two units of insulin prior to dialing up insulin. On 10/14/21, at 4:32 p.m. the director of nursing (DON) verified she would expect staff to prime the insulin pen prior to dialing up the insulin dose. The facility policy titled Insulin Pens reviewed/revised 9/14/18, directed staff to perform the following: 2. Performing air shot (checking the flow) before injection a. Dial dose select to 2 units. Hold pen with needle pointing up. b. Press the push-button all the way in. The dose selector returns to 0. You should see drops of insulin at the end of the needle, if not repeat the steps.	F 759		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		11/20/21

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designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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F 880	Continued From page 32 least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the Centers for Disease Controls (CDC) guidance for individualized transmission-based precautions including appropriate personal protective equipment (PPE) and isolation precautions to prevent the spread of COVID-19 for 1 of 1 resident (R3) who displayed symptoms of COVID-19. This practice resulted in an immediate jeopardy (IJ) situation which had the high likelihood to cause serious illness and/or death In addition, the facility failed to ensure proper hand hygiene was performed during dining for 2	F 880	Precautions/PPE/Isolation AHS will ensure that all residents that are exhibiting signs/symptoms of COVID □ 19 are quarantined and individualized transmission precautions with the appropriate PPE are put into place. All residents have the potential to be affected by not following policies, using individualized transmission based precautions, proper PPE and quarantine precautions. Education was provided to all staff	

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F 880	Continued From page 33 of 5 (R9, R34) residents reviewed for dining; failed to ensure shared equipment was cleaned and disinfected for 2 of 3 (R9, R39) residents reviewed for shared equipment use; and failed to ensure soiled laundry was carried in a manner to prevent potential contamination for 2 of 2 residents (R9 and R21) reviewed for infection control . Finally, the facility failed to ensure proper eye protection was used to prevent the spread of COVID-19 for 1 of 1 resident (R33) who was reviewed for transmission based precautions. The IJ began on 10/2/21, when it was determined the facility failed to implement quarantine procedures for R3 after exhibiting potential COVID-19 symptoms and failed to ensure proper personal protective equipment (PPE) use. The administrator, director of nursing (DON) and nurse consultant were notified of the IJ at 5:30 p.m. on 10/14/21. The IJ was removed at 5:45 p.m. on 10/15/21, but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not IJ. Findings include: The CDC guidance People with Certain Medical Conditions dated 10/14/21, identified older adults were more likely to get seriously ill from COVID-19. More than 81% of COVID-19 deaths have occurred in people over the age of 65, and the number of COVID-19 deaths among people over 65 is 80 times higher than the number of deaths among people aged 18-29. Further, the risk of severe COVID-19 increases as teh number of underlying medical conditions increases in a person. Severe illness means a	F 880	regarding transmission based and droplet precautions and on the proper PPE to use. Education was provided to nursing staff on suspected or confirmed COVID-19, COVID prevention, screening and identification and COVID-19 testing. Education started on 10/14/21. DON or designee will do audits on residents that have sign/symptoms of COVID-19 to ensure that proper precautions, and PPE are in use. Every shift 4X/week x 1 week, 2X/wee x1 week and then weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations. Hand Hygiene AHS will ensure that proper hand hygiene is done in between assisting residents in the dining room. All residents that need assistance in the dining room have potential to be affected by this. Education on hand hygiene while assisting residents in the dining room will be given to all staff on 11/16/21. Random audits of hand hygiene will be conducted 4x/week x1 week, then 2x/week x 1 week, and weekly thereafter.	

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F 880	Continued From page 34 person with COVID-19: may require hospitalization, need intensive care, require a ventilator to help them breathe, or die. The CDC guidance Interim Infection Prevention and Control Recommendation to Prevent SARS-CoV-2 Spread in Nursing Homes dated 9/10/21, directed residents symptomatic residents, regardless of vaccination status, should be restricted to their rooms and cared for by healthcare personnel (HCP) using a N95 or equivalent or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face) gloves, and a gown pending evaluation for SARS-CoV-2 infection. R3's quarterly Minimum Data Set (MDS) dated 7/31/21, identified R3 had severe cognitive impairment and diagnoses that included hemiplegia, epilepsy, and bipolar disorder. R3's care plan revised 9/24/21, identified R3 was at risk for shortness of breath related to history of pneumonia as exhibited by decreased oxygen saturations. Staff were directed to monitor for changes in respiratory function and to update R3's physician or nurse practitioner. Additionally, staff were directed to provide oxygen as ordered by the physician in order to remain above 88%. R3's nursing progress notes included the following: - On 10/2/21, at 12:19 a.m. the nurse was called to R3's room by the nursing assistant. R3 was diaphoretic (sweating heavily) and R3's breathing was noted to be a little labored. When R3 was asked how she was feeling she replied "fine". R3's temperature was 100.3 degrees Fahrenheit	F 880	Audit results will be brought to the QAPI Committee for review and further recommendations. Shared Equipment Cleaning AHS will ensure that shared equipment will be cleansed and disinfected in between residents. All residents that require equipment for transfers have the potential to be affected by this. Education on cleaning and disinfecting shared equipment will be done on 11/16/21. Random audits of cleaning and disinfecting shared equipment will be completed 4x/week x1 week, 2X weekly X 1 week and weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations. Eye Protection AHS will ensure that the proper eye protection is used by staff to prevent the spread of COVID-19. All staff has the potential to be affected by not utilizing the proper eye protection.	

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F 880	Continued From page 35 (F) with oxygen saturations 76-80% on room air. Oxygen was applied at two liters per nasal cannula and R3's oxygen saturations rapidly rose to 90% while the head of R3's bed was elevated. - On 10/2/21, at 4:08 a.m. R3 was administered Tylenol (a fever reducing medication) for a temperature of 100.3. R3's temperature decreased to 98.3 following use of Tylenol. R3 stated she felt fine and kept removing her oxygen tubing. R3 had remained at 87-98% on room air throughout the night which was normal for R3. However, R3 had come into contact with a medical provider who had tested positive for COVID-19. A rapid COVID-19 test was collected on R3 on 10/2/21, and was negative. - On 10/3/21, at 4:14 a.m. the progress note indicated R3 was really tired at about 7:30 p.m. the evening prior. R3 stated "tired and wanted to go to bed". R3's vital signs were documented as all within normal limits and R3 had remained afebrile through the night. R3's oxygen saturations remained 89-92% on room air. R3 had no complaints of shortness of breath and slept well all night. Although R3 progress notes indicated she had symptoms of COVID-19 including fever, labored breathing and low oxygen levels, the documentation lacked indication whether R3 had a confirmatory COVID-19 test and lacked indication of whether R3 was placed into transmission-based precautions. On 10/11/21, at 5:25 p.m. R3 was observed sitting at a table in the dining room with one other resident while waiting for her supper meal. R3 was not wearing a mask and no social distancing	F 880	Education was provided to all staff on 10/14/21 on the proper eye protection to use. The policy for COVID prevention, screening and identification was reviewed/revised to ensure that it listed the proper eye protection to utilize. The DON or designee will do ransom audits 4X/week X 1 week, 2X/week x 1 week and weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations. Soiled Linen Handling AHS will ensure that soiled linens are handled properly. All residents have the potential to be affected by this. Education will be given to all nursing staff on how to properly handle soiled linen on 11/16/21. DON or designee will do random audits 3x/week x 2 weeks, 2X/week x 2 weeks, and weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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was observed while traveling to and from the dining room nor while R3 sat at the table. The other resident at R3's table was not masked, nor were the other residents in the dining room.

On 10/11/21, at 6:49 p.m. R3 was seated in her wheelchair in her room with her room door open. There was no signage for transmission-based precautions on her door nor a cart containing personal protective equipment (PPE) for staff usage.

During an observation on 10/12/21, at 2:06 p.m. nursing assistant (NA)-C and NA-D entered R3's room to provide direct care for R3. NA-C and NA-D wore surgical mask and goggles, but did not don gloves or gown. After R3 was assisted to her wheelchair, staff wheeled R3 to the dining room. R3 was not offered or encouraged to wear a mask.

During an interview on 10/13/21, at 2:11 p.m. licensed practical nurse (LPN)-A stated she was unaware R3 had exhibited COVID-19 symptoms on 10/2/21, because that was her normal week off. LPN-A stated if a resident had a fever and wasn't feeling well, the first thing the nurse should do was a head-to-toe assessment, and interview the nursing assistants to ask them about the resident's symptoms. LPN-A then stated the nurse would talk to the unit manager to determine if a rapid COVID-19 test was warranted, and a rapid test would be collected. LPN-A stated afterwards, a tracking form would be filled out for the director of nursing (DON). LPN-A further stated a symptomatic resident would be placed in transmission-based precautions (TBP) even if the rapid test was negative. The resident would need to continue to be in TBP for 14 days or, if he/she

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tested positive, for 10 days. LPN-A also verified since the rapid test was negative, a confirmatory PCR test should have been collected. LPN-A stated R3 should have been in transmission-based precautions until 10/12/21, but verified R3 had not been put on precautions after symptoms were first observed 10/2/21, nor was R3 in precautions when observed on 10/12/21.

On 10/13/21, at 2:15 p.m. R3's COVID-19 test results were requested from the DON and R3's Rapid Test Report Form dated 10/2/21 indicated the test was negative. R3's confirmatory PCR results were requested but no results were received.

During an interview with the DON and the nurse consultant on 10/13/21, at 3:19 p.m. the DON indicated R3's last COVID-19 test was collected more than three months ago. R3's test collected on 10/2/21, was a rapid antigen test and was negative. Because of this, the DON stated she would need to review the facility policy regarding confirmatory testing to determine whether R3 should have had a PCR collected.

- At 3:21 p.m. on 10/13/21, the DON stated they did suspect COVID-19 on 10/2/21, and collected a COVID-19 test which was negative. According to facility policy, after that, measures would be put into place and that included possible quarantine however, since R3 was fully vaccinated, no quarantine was needed, and the were to monitor the resident. The DON verified R3 had spiked a temperature, but it went down and R3 had no other symptoms. At that time the nurse consultant stated, "It really was not much of a temperature." The DON stated there were no notes in the paper

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chart, in the electronic medical record or the communication binder that documented R3 was evaluated by the doctor or that the doctor determined R3 did not need a confirmatory test nor TBP. The DON confirmed R3 was not placed into TBP over the weekend. At that time, the DON stated she expected nursing staff to call and speak with an on-call doctor during weekend hours for next steps when a resident was symptomatic but had a negative rapid antigen COVID-19 test.

During an interview on 10/14/21, at 8:13 a.m. the DON stated R3 had been exposed to a nurse practitioner (NP)-A who was at the facility on 9/28/21, who later tested positive for COVID-19. The DON said NP-A had sent her a text on 9/30/21, stating she had tested positive. The DON stated NP-A had her pull the billing statements to determine which residents had been exposed. The DON said on 10/1/21, all residents who were exposed to NP-A who were unvaccinated were given PCR tests for COVID-19. However, R3 was not in that sample due to being fully vaccinated. According to the DON, an antigen test was collected on R3 10/2/21, and she expected staff to contact the resident's medical provider for next steps such as determination of whether to collect a PCR, or for isolation. The DON stated there was not documentation to show these next steps happened. The DON indicated the facility policy directed for discontinuation of isolation precautions if a resident had signs/symptoms of COVID-19, they would need to be 72 hours without a fever without medication, and 24 hours of resolution of other symptoms.

During a phone interview on 10/14/21, at 11:10

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a.m. NP-A stated she contacted the facility via text on 9/30/21, to inform them of her positive COVID-19 test. She verified she had worked in the facility on 9/28/21, and 9/29/21 and became symptomatic the evening of 9/29/21. NP-A said because 10/2/21, was a weekend, the facility should have contacted the on-call provider for a PCR test for R3. Additionally, a note should have been placed in the provider book for the provider to review during rounds on the following Monday (10/4/21). NP-A said, at a minimum, R3 should have been placed into isolation when she became symptomatic until the provider was at the facility on Monday.

The facility policy Suspected (or Confirmed) Coronavirus (COVID-19) Outbreak reviewed/revised 9/17/21, indicated Coronavirus symptoms included (but were not limited to) cough, shortness of breath or difficulty breathing, fever, chills, muscle pain (new), sore throat, and new loss of taste or smell. Residents with suspected or confirmed COVID-19 disease, immediate infection control measures would be put into place, including possible quarantine. The resident's provider would be contacted for management of care.

The IJ which began on 10/14/21, was removed on 10/15/21, at 5:45 p.m. when it could be verified through observation, interview and document review the facility:
- Reviewed its COVID-19 protocols for isolating symptomatic residents
- On 10/14/21, education began for all staff on the topic of "Transmission Based Precautions" and "droplet precautions". Staff were required to review each policy prior to the start of their shift and signed confirming their understanding of the

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policy.
- On 10/14/21, education began for all nursing staff on the topics of "suspected or confirmed COVID-19 outbreak", "COVID-19 prevention, screening, an identification" and "COVID-19 testing". Staff were required to review each policy prior to the start of their shift and signed confirming their understanding of the policy.
- A bright arrow message was sent to the staff to inform them of the required education as well as one on one conversations with various staff throughout the building.
- In addition a bright yellow message, one on one communication, and an email was sent to staff to inform them that "side shields" would no longer be an acceptable form of eye protection
- All other staff that did not routinely work at the care cent would be educated by the DON or designee prior to their return to work via telephone and given the appropriate policies in their employee folder for confirmation signature.
- Audits on proper isolation precautions and appropriate PPE use would be conducted to ensure the policies noted above were abided by.
- Risk assessments were conducted on 10/14/21 for those that were potentially exposed to R3. No high risk exposures were identified. R3 had not been symptomatic since 10/2/21 and was back to baseline. Therefore quarantine was no longer deemed to be necessary at that time.

HAND HYGIENE IN DINING ROOM

R9's Face Sheet printed 10/14/21, indicated R9's diagnoses included dementia, stage three chronic kidney disease, anxiety, major depressive disorder, and cerebral infarction (stroke).

R9's significant change MDS dated 8/10/21,

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indicated R9 required extensive assistance with activities of daily living (ADL)s , and limited assistance with eating.

R9's care plan dated 2/13/19, indicated R9 required assistance with dressing, grooming, personal hygiene, required the EZ stand with the assist of staff for transferring, and directed staff to encourage self feeding.

R9's NAR Assignment sheet revised 10/1/21, indicated R9 was non-ambulatory, sometimes required total assistance with eating, required assistance with grooming, dressing and R9 transferred with the assist of one and an EZ stand.

R34's Face Sheet printed 10/14/21, indicated R34's diagnosis included Alzheimer's disease.

R34's NAR Assignment sheet revised 10/1/21, indicated R34 required set up and supervision with eating.

R34's quarterly MDS dated 8/31/21, indicated R34 required supervision for eating.

On 10/13/21, at 8:36 a.m. activity aide (AA)-B got up from assisting R9 to eat breakfast and without performing hand hygiene, AA-B went over to R34 and picked up R34's spoon and started to assist R34 with breakfast.

On 10/13/21, at 9:50 a.m. AA-B stated she should have performed hand hygiene or used hand sanitizer in between assisting R9 and R34 with breakfast

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DISINFECTING EQUIPMENT
R39's Face Sheet printed 10/22/21, indicated R39 had the following diagnoses periprosth fracture around internal prosthetic hip joint (a broken bone that occurs around the implants of a total hip replacement), cellulitis of the right lower limb, and malignant neoplasm of the right breast and uterus.

R39's five day MDS dated 9/23/21, indicated R39 had a moderate cognitive impairment, and required extensive assistance of two staff with transfers.

On 10/13/21, at 7:14 a.m. after an observation of staff assisting R39 transfer from R39's bed to R39's wheelchair with the use of the EZ stand. Nursing assistant (NA)-E brought the EZ stand into R39's room without disinfecting the EZ stand to assist R39 transfer to the bathroom. NA-E stated she should have disinfected the EZ stand before she brought the EZ stand into R39's room.

SOILED LINENS

R9's Face Sheet printed 10/14/21, indicated R9's diagnoses included dementia, stage three chronic kidney disease, anxiety, major depressive disorder, and cerebral infarction (stroke).

R9's care plan dated 2/13/19, indicated R9 required assistance with dressing, grooming, personal hygiene, required the EZ stand with the assist of staff for transferring, and directed staff to encourage self feeding.

R21's Face Sheet printed 10/14/21, indicated R21

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diagnoses included Alzheimer's, and dementia.

R21's care plan dated 7/10/18, indicated R21 required assistance with dressing, grooming, eating, and extensive assist with transfers..

On 10/13/21, at 7:13 a.m. NA-E was observed exiting R9's room carrying unbagged soiled linens, not wearing gloves and carrying the soiled linens through the resident room hallway into the soiled utility room.

On 10/13/21, at 8:43 a.m. NA-G was observed exiting R21's room with unbagged soiled linens walking through the resident room hallway to the soiled utility room. NA-G stated soiled linens did not have to be bagged when bringing to the soiled utility room unless the linens were visibly soiled.

LACK OF APPROPRIATE EYE PROTECTION
R33's Face Sheet printed 10/14/21, indicated R33's diagnoses included chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe), nicotine dependence, and mild cognitive impairment.

R33's quarterly MDS dated 8/24/21, indicated R33 had mild impaired cognition, and was independent with activities of daily living (ADLs).

On 10/13/21, at 7:30 a.m. housekeeper (H)-A was observed wearing a pair of prescription glasses with wing shields on the sides of the glasses and was told her eye wear was acceptable eye protection and the eye wing shields were provided by the facility.

On 10/14/21, at 8:21 a.m. H-B was observed

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exiting R33's room who was on droplet precaution, wearing a pair of prescription glasses with wing shields on the side of the arms of the glasses. H-B stated the wing shields on the side of her prescription glasses were provided by the facility and were approved eye wear. H-B stated she did not put on another form of eye protection when entering R33's room who was on droplet precautions.

On 10/14/21, at 12:18 p.m. the DON stated the policy for handling linens directed staff to place soiled linens into a plastic bag and bring directly to the soiled utility room. The DON further stated if there was no plastic bag available in the residents room, staff should be wearing gloves and carry the soiled linens away from their uniform and brought directly to the soiled utility room. The DON further sated the importance of bagging soiled linens was to prevent the risk of contaminating the uniform or the environment while caring the linens through the resident hallways. The DON further stated staff should be washing their hands in between assisting residents with eating. The DON stated the EZ stand should be disinfected after use and before the equipment was brought into another's residents room to prevent the spread of infection. The DON also ensured that staff were educated that "side shields" for prescription glasses were no longer allowed as an acceptable form of eye protection. The facility policy was updated on 10/14/21, to specifically address "side shields".

The facility policy Cleaning/Disinfecting Resident Care Equipment dated 6/5/21, indicated reusable resident care equipment would be decontaminated between residents. The policy further indicated durable medical equipment

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F 880	Continued From page 45 (DME) would be cleaned and disinfected before reuse by another resident. The facility policy Linen Handling dated 1/8/18, directed all soiled linen must be placed into a predetermined plastic bad and /or directly into a covered soiled linen cart. The facility policy Hand Hygiene dated 5/8/17, directed hand hygiene was to be performed before and after contact with environmental surfaces or equipment in the immediate vicinity of the resident, after removing gloves, prior to preparing or handling foods. The policy further directed the use of hand sanitizers before and after assisting a resident when not in contact with bodily fluids, before and after contact with environmental surfaces or equipment in the immediate vicinity of the resident.	F 880		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;	F 886		11/20/21

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F 886	Continued From page 46 (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in	F 886		

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F 886	Continued From page 47 emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a confirmatory, RT-PCR (real-time reverse transcription polymerase chain reaction test) was obtained for 1 of 1 resident (R3) after a presumptive negative rapid antigen (screening) and who was displaying signs and symptoms of COVID-19. Findings include: The Centers for Disease Control and Prevention (CDC) guidance SARS CoV-2 Antigen Testing in Long Term Care Facilities dated 1/7/21, identified symptomatic people who test antigen negative should have a confirmatory test performed. Confirmatory test should be performed with nucleic acid amplifications tests (NAAT) such as reverse transcriptase polymerase chain reaction (RT-PCR). As the sensitivity of antigen tests is generally lower than RT-PCR, negative POC antigen tests should be considered presumptive. Testing of symptomatic residents or healthcare personel (HCP). -If an antigen test is presumptive negative, perform NAAT immediately (e.g., within 2 days). -Symptomatic residents should be kept on transmission-based precautions until NAAT results return. -If a confirmatory NAAT is performed within 2 days, people should be assumed to be infectious until the confirmatory test results are completed. For instance, in general, if a symptomatic resident	F 886	AHS will ensure that all negative rapid antigen tests are confirmed with a RT-PCR test, per CDC guidelines. All residents have the potential to be affected by not following up with a confirmatory RT-PCR test. All nursing staff will be educated on COVID-19 prevention, screening and identification, suspected and confirmed and COVID-19 testing on 11/16/21. DON or designee will do audits to ensure all negative antigen test when signs/symptoms of COVID-19 are present, are followed up with a RT-PCR test. Also any high risk exposure will be followed up with a RT-PCR test. Audits will be done 3x/week for 2 weeks, 2x/week for 2 weeks and then weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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tests presumptive negative by antigen test and a NAAT is performed, the resident should remain in Transmission-Based Precautions until the NAAT result is available.

According to the CDC's COVID Data Tracker, Aitkin county transmission rate for the week of 9/28/21, was high (greater than 10%).

R3's quarterly Minimum Data Set (MDS) dated 7/31/21, identified R3 had a severe cognitive impairment and diagnoses that included hemiplegia, epilepsy, and bipolar disorder.

R3's immunization record identified R3 was immunized for COVID-19 on 1/3/21, and 1/31/21. R3 was fully vaccinated.

R3's care plan reviewed 10/12/21, identified R3 was at risk for shortness of breath related to history of pneumonia as exhibited by decreased oxygen saturations. Staff were directed to monitor for changes in respiratory function and to update R3's physician or nurse practitioner. Additionally, staff were directed to provide oxygen as ordered by the physician in order to remain above 88%.

R3's nursing progress notes included the following:
- On 10/2/21, at 12:19 a.m. the nurse was called to R3's room by the nursing assistant. R3 was diaphoretic (sweating heavily) and R3's breathing was noted to be a little labored. When R3 was asked how she was feeling she replied "fine". R3's temperature was 100.3 degrees Fahrenheit (F) with oxygen saturations 76-89% on room air. Oxygen was applied at two liters per nasal cannula and R3's oxygen saturations rapidly rose to 90% with the head of R3's bed elevated.

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- On 10/2/21, at 4:08 a.m. R3 was administered Tylenol (a fever reducing medication) for a temperature of 100.3 degrees F. R3's temperature decreased to 98.3 degrees F. R3 stated she felt fine and kept removing her oxygen tubing. R3 had remained at 87 -89% on room air throughout the night which was normal for R3. However, R3 had come into contact with a medical provider who had tested positive for COVID. A rapid COVID test was collected and was negative. However, no confirmatory COVID-19 test was not mentioned.
- On 10/3/21, at 4:14 a.m. R3 stated she had been "tired and wanted to go to bed". R3's vital signs were documented as all within normal limits and R3 had remained afebrile through the night. R3's oxygen saturations remained 89-92% on room air, R3 had no complaints of shortness of breath and slept well all night. However, the note does not indicate if R3 had a confirmatory COVID-19 test.

During an interview on 10/13/21, at 2:11 p.m. licensed practical nurse (LPN)-A stated if a resident had a fever and wasn't feeling well, the first thing nursing would do was a head-to-toe assessment and talk to the nursing assistants. What had they noticed? Was the resident coughing? Did the resident have foul urine? Then, nursing staff would talk to the unit manage to determine if a rapid COVID-19 test was warranted and a rapid test would be collected. Afterwards, a tracking form would be filled out for the director of nursing.

On 10/13/21, at 2:15 p.m. R3's COVID-19 test results were requested from the DON and R3's Rapid Test Report Form dated 10/2/21, was provided the facility.

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On 10/13/21, at 2:15 p.m. R3's R3's confirmatory PCR results were requested but not received.

During an interview with the DON and the nurse consultant on 10/13/21, at 3:19 p.m. the DON stated R3's last COVID-19 RT-PCR test was collected on 5/6/21. R3's test that was collected on 10/2/21, was a rapid antigen test and was negative. Because of this, the DON stated she would need to review the facility policy regarding confirmatory testing to determine if R3 should have had a PCR collected.
- At 3:21 p.m. the DON stated they suspected COVID-19 on 10/2/21, and collected a COVID-19 antigen test which was negative. According to facility policy, after that, measures would be put into place and that included possible quarantine. However, if a resident was fully vaccinated, no quarantine was needed, and they would monitor the resident. The DON further explained R3 had spiked that temperature and it went down; R3 had no other symptoms. At that time the nurse consultant stated, "It really was not much of a temperature." The DON continued that 10/2/21, was a Saturday and R3's fever was gone by Monday. The DON stated she expected nursing staff to call and speak with an on-call doctor during weekend hours for next steps when a resident was symptomatic but had a negative rapid antigen COVID-19 test. The DON stated the doctor came to the facility on 10/4/21. The DON also stated there were no notes in the paper chart, in the electronic medical record or the communication binder that documented R3 was evaluated by the doctor or that the doctor determined R3 did not need a confirmatory test to rule out COVID-19. The DON stated she didn't know if the doctor had seen R3 on Monday

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AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 886	Continued From page 51 10/4/21. During an interview on 10/14/21, at 8:13 a.m. the DON stated R3 had been exposed to nurse practitioner (NP)-A who was at the facility on 9/28/21, and later tested positive. NP-A sent her a text on 9/30/21, after testing positive which stated to pull the NP-A's billing statements to determine which residents had been exposed. On 10/1/21, unvaccinated exposed residents were given PCR tests for COVID. However, R3 was not in the sample due to being fully vaccinated. An antigen test was collected on 10/2/21 and the DON expected staff to contact the provider for next steps such as to collect a PCR or for isolation. During the routine testing on 10/12/21, two staff did return as positive. Registered nurse (RN)-A worked with R3 on 10/2/21, 10/3/21, 10/5/21, and 10/6/21. NA-B last worked with R3 on 9/30/21. The DON stated the last positive resident was in January 2021. For discontinuation of isolation precautions, if a resident had signs/symptoms of COVID-19 they would need to be 72 hours without a fever without medication, and 24 hours of resolution of other symptoms. If the resident was positive for COVID-19, they would be placed in a COVID-19 unit for 20 days. Nurse practitioner (NP)-A was in the facility on 9/28/21, 9/29/21, and 9/30/21. NP-A saw R3, R27, R36, and R39 in the dining room. NP-A also saw R22, R35, and R40 in their rooms per the billing statement. According to document review, none of these residents were placed on quarantine precautions. The DON also stated the facility was routinely testing unvaccinated staff on Tuesdays and Fridays. Staff testing dates were 9/17/21, 9/21/21, 10/1/21, 10/5/21, 10/8/21, and 10/12/21. The facility initiated outbreak testing on 10/1/21, which included all unvaccinated staff and, additionally, a	F 886		

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F 886	Continued From page 52	F 886		

licensed practical nurse who had close contact with the positive staff. However, the facility was not performing house-wide testing for residents. The DON also stated the facillity was testing residents who were unvaccinated and/or had direct exposure to positive staff.

During a phone interview on 10/14/21, at 11:10 a.m. NP-A stated she contacted the facility via text on 9/30/21, to inform them of her positive COVID test. She worked in the facility on 9/28/21 and 9/29/21 but became symptomatic that evening. Because 10/2/21, was a weekend, the facility should have contacted the on-call provider for a PCR test for R3. Additionally, a note should have been placed in the provider book for the provider to review during rounds on Monday. In the least, R3 should have been placed into isolation when she became symptomatic until the provider was at the facility on Monday to evaluate R3.

The facility policy COVID-19 Testing reviewed 9/17/21, indicated the facility would test residents and staff based on parameters defined by Center for Medicare and Medicaid Services (CMS), Minnesota Department of Health (MDH), and the Center for Disease Control and Prevention (CDC). The policy also indicated COVID-19 testing frequency would be determined and implemented based on individual symptoms, outbreak, or county prevalence. The policy further indicated any symptomatic individuals, vaccinated or unvaccinated, with signs or symptoms would be tested. Additionally, the policy indicated the facility could meet the testing requirements through two diagnostic testing methods:
- Molecular laboratory test (RT-PCR) was

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considered the gold standard for testing. RT-PCR testing was conducted through arrangement with an offsite laboratory.
i. Laboratories used were those that can quickly process large numbers of tests with rapid reporting of results (for example, within forty-eight hours).
ii. Laboratory supplies will be provided through the contracted services.
iii. Facility staff would conduct the testing and submit completed tests to the designated lab.
iv. Results would be provided to the designated person without the facility.
v. All attempts would be made to have results within forty-eight hours, if unable to receive results in this timeframe, documentation of the reason for the delay and methods to address the testing result delay would occur.

- An antigen test used the rapid point-of-care diagnostic testing devices that CMS distributed to facilities. The Point-of-Care (POC) antigen devices would be used in the event that a RT-PCR (molecular) tests were unavailable or during serial testing of staff or residents:
i. Antigen tests quickly detect fragments of proteins found on or withing the virus by testing samples collected from the nasal cavity using swabs.
ii. FDA authorized antigen detection tests include:
1. Sofia SARA Antigen FIA manufactured by Quidel Corporation (Quidel).
2. Veritor System for Rapid Detection of SARS-CoV-2 manufactured by Becton, Dickenson, and Company.
3. BinaxNOW COVID-19 Ag Card manufactured by Abbott Laboratories.
The policy continued to indicate positive results from antigen tests were highly accurate but there

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F 886	Continued From page 54 was a chance of false negatives, so negative results did not rule out infection. The policy directed a negative rapid antigen test result may need to be confirmed using a RT-PCR test, especially if the results of the antigen test was inconsistent with the clinical symptoms. When confirming an antigen test result with a RT_PCR testing, it was important that the time interval between the two sample collections was less than forty-eight hours, and there had not been any opportunities for new exposures between the two tests. If more than forty-eight hours separated the two tests, or there had been opportunities for new exposures between the two tests, the RT-PCR should be considered a separate test, not a confirmatory test.	F 886		

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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 not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, the NFPA 101 (2012 edition), Life Safety Code, Chapter 19 Existing Health Care, and the NFPA 99 (2012 edition), Health Care Facilities Code. THE FACILITY'S POC 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/17/2021

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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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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.	K 000		

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K 000	Continued From page 2 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 38 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain the fire alarm per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.4.5.3.2, 14.5.2, and 14.6.2.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 10/13/2021, at 10:30 AM, during a review	K 345	"1. The semiannual inspection of all AHS Initiating Devices will be conducted within 6 months of the annual inspection the fire alarm inspection vendor. The semi-annual inspection was completed on 11/11/2021. Fire alarm inspection vendor will complete sensitivity tests annually and the facility will be provided with annual inspect report. A sensitivity report will be completed by 11/23/2021 2. & 3. An electronic calendar due date will be set up in both the Environmental Services Director and Administrator's	11/23/21

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K 345	Continued From page 3 of all available fire alarm test and inspection documentation and an interview with Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed. 2. On 10/13/2021, at 10:30 AM, during a review of all available fire alarm test and inspection documentation and an interview with Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that a smoke detector sensitivity test had been conducted since 02/27/2019. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 345	computer calendars with reminders due dates 4. The ESD or designee is responsible for monitoring for compliance. 5. 11/23/2021. "	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 712		11/23/21

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K 712	Continued From page 4 Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 19.7.1.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 10/13/2021, at 11:20 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct a fire drill for the overnight shift in the second calendar quarter within the last 12 months. 2. On 10/13/2021, at 11:20 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct a fire drill for the evening shift in the third calendar quarter within the last 12 months. 3. On 10/13/2021, at 11:20 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not verify that a fire alarm signal had been transmitted to the fire alarm monitoring company for 3 of the completed fire drills conducted within the last 12 months. An interview with the Maintenance Supervisor verified these deficient findings at the time of the discovery.	K 712	"1. The Environmental services director will fill out an anticipated, pre-planned fire drill record each year annually to ensure that fire drills are conducted 1 time quarterly for each nursing shift; day, evening, and night. 2. The fire drill event will be overseen by the AHS Administrator or designee to ensure that drills are done within a reasonable timeframe of the documented time and date. The proposed document will also ensure that drills are done at varying dates so that drills are not anticipated by staff and maintain the element of surprise to simulate as best as possible an unplanned fire emergency. The document will not be shared with other staff in order to keep the drill dates and times unknown to staff. 3. The Environmental services director or designee will fill out a drill document record sheet for each respective drill that is conducted. "	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		11/23/21

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K 761	Continued From page 5 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the fire door inspections per NFPA 101 (2012 edition), Life Safety Code, sections 8.3.3.1, 19.7.6 , and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/13/2021, at 11:40 AM, during the review of all available fire door test and inspection documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that the fire door inspection had been completed. The last date that the fire doors were inspected was on 06/18/2020.	K 761	"1. Annual fire door inspections of Aitkin Health Services will be completed prior to 11/23/2021 and all subsequent inspections will take place no greater than 365 days from the previous inspection. 2. & 3. An electronic calendar due date will be set up in both the ESD's and Administrator's computer calendars with reminders due dates 4. The environmental services director or designee is responsible for conducting Annual Fire Door Inspections and recording of results. 5. The annual fire door inspection will be completed by 11/23/2021. "	

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K 761	Continued From page 6 An interview with the Maintenance Supervisor verified this finding at the time of discovery.	K 761		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/13/2021, at 11:52 AM, during a review of available documentation and an interview with Maintenance Supervisor, it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. The utility risk assessment that was provided at the time of the inspection did not clarify the facility's systems or equipment to be	K 901	"1. Facility Environmental Services director consulted with deputy state fire marshal James Anderson and Corporate compliance advisor Ben Ryan on 10/16/2021 to ensure the proper utility risk assessment form was acquired. The new form will be completed prior to 11/23/2021 2. & 3. The risk assessment will be reviewed annually or within 365 days of the prior inspection for changes and updates. An electronic calendar due date will be set up in both the Environmental Services Director and Administrator's computer calendars with reminders due dates 4. The environmental services director or designee is responsible for conducting the risk assessments and recording of results. 5. The risk assessment will be completed	11/23/21

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K 901	Continued From page 7 assessed or the impact of the systems and equipment will have on patient/residents or rooms/spaces within the facility as detailed in NFPA 99 (2012 edition) Health Care Facilities Code, chapter 6 - Electrical Systems, chapter 9 - Heating, Ventilation, and Air Conditioning Systems, chapter 10 - Electrical Equipment, and chapter 11 - Gas Equipment. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 901	by 11/23/21 "	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)	K 914		11/23/21

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 _____	**10/13/2021**

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
K 914	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the annual electrical outlet testing and maintenance per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/13/2021, at 11:33 AM, during the review of all available electrical outlet maintenance and testing documentation and an interview with the Maintenance Supervisor, the facility could not provide any current documentation for the completion of the annual inspection and testing of the electrical outlets within patient/resident care areas located throughout the facility. The last date that the electrical outlet maintenance and testing was completed is 05/04/2020. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 914	"1. Annual electrical system testing of Aitkin Health Services will be completed prior to 11/23/2021 and all subsequent inspections will take place no greater than 365 days from the previous inspection. 2. & 3. An electronic calendar due date will be set up in both the environmental services director and administrator's computer calendars with reminders due dates 4. The environmental services director or designee is responsible for conducting Annual Electrical System testing and recording of results. 5. The deficiency was corrected 10/21/2021 "	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer	K 916		11/23/21

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	245119	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/13/2021**

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

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K 916	Continued From page 9 system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to monitor the emergency generator per NFPA 99 (2012 edition), Healthcare Facilities Code, section 6.4.1.1.17. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/13/2021, at 12:50 PM, during the facility tour, observations revealed that the facility did not have a remote annunciator panel installed for monitoring the operating status of the facility's emergency generator at any locations outside of the generating room or in any locations readily observed by operating personnel at a regular work station. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 916	The generator annunciator panel is in place and was installed prior to the annual survey, but was not identified during the survey. The annunciator panel is installed at the garden terrace nursing station and is functioning as normal.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or	K 923		11/23/21

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	245119	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/13/2021**

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K 923	Continued From page 10 within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to store oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5.2 and 11.6.5.3. This deficient condition could have an isolated impact on the residents within the facility. Findings include:	K 923	"1. Designated EMPTY, FULL, and IN USE system has been put in place for oxygen container storage. 2. Proper training of Nursing Staff to take place at next available Nursing Staff meeting on November 16, 2021. 3. The environmental services director or designee will make periodic inspections of	

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	245119	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/13/2021**

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K 923	Continued From page 11 On 09/23/2021 at 12:42 PM, during the facility tour observations revealed in the oxygen storage room located by the social services office there are oxygen cylinders that were not properly tagged to avoid confusion nor separated by full and empty status at the time of the inspection. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 923	the oxygen room. 4. The environmental services director, resident care coordinators, and/or designee are responsible for monitoring the oxygen room. 5. 11/16/2021 "	