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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LXPN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00848

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/28/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **75** (L18)
13.Total Certified Beds **75** (L17)

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 06/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/09/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/15/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245363

August 9, 2016

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

Dear Ms. Matalamaki:

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

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

Effective June 28, 2016 the above facility is certified for or recommended for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 skilled nursing facility beds located in rooms .

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 19, 2016

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

RE: Project Number S5363025

Dear Ms. Matalamaki:

On June 2, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 19, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On June 28, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 27, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 19, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 19, 2016, effective June 28, 2016 and therefore remedies outlined in our letter to you dated June 2, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245363 Y1	A. Building B. Wing Y2	6/28/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0242	Correction	ID Prefix F0248	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.15(f)(1)	Completed
LSC	06/28/2016	LSC	06/28/2016	LSC	06/28/2016
ID Prefix F0274	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.20(b)(2)(ii)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/28/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TA/mm	07/19/2016	29433	06/27/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/19/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245363	A. Building 01 - AICOTA NURSING HOME B. Wing	6/27/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 06/01/2016	ID Prefix Reg. # NFPA 101 LSC K0154	Correction Completed 06/01/2016	ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 06/01/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) TL/mm	DATE 07/18/2016	SIGNATURE OF SURVEYOR 27200	DATE 06/27/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
5/17/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LXPN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00848

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/19/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **75** (L18)
13.Total Certified Beds **75** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 07/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5363

On may 19, 2016 a standard survey was completed by the Departments of Health and Public Safety to determine if the facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in the facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), whereby corrections are
required. The facility has been given and opportunity to correct before remedies would be imposed.

In addition, at the time of the May 19, 2016 standard survey an investigation of complaint number H5363007 was conducted and found to be unsubstantiated. Refer to the CMS 2567 for both health and life safety code along with the facility's plans of correction. Post Certification Revvisit (PCR) to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 2, 2016

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

RE: Project Number S5363025, H5363007

Dear Ms. Matalamaki:

On May 19, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the May 19, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5363007 that was found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 28, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 19, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 19, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING _____ B. WING _____	05/19/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. H complaint H5363007 was investigated and not substantiated.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safe self-administration of medications (SAM) for 2 of 3 residents (R73, R91) observed for self-administration of a nebulizer treatment. Findings include: R73's Medical Diagnosis list dated 5/18/16, indicated R73's diagnoses included cerebral	F 176	F 176 Aicota will ensure that an individual resident may self-administer drugs if the interdisciplinary team has determined that this practice is safe. R73 has a diagnosis of CVA with dysphagia, heart failure, dementia, pneumonitis related to swallowing food or vomit and is on hospice, receiving end of	6/28/16

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

Electronically Signed | 06/09/2016

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

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F 176	Continued From page 1 infarction (stroke), heart failure, pneumonia due to the inhalation of food, chronic obstructive pulmonary disease (COPD), asthma, and dementia. The physician's orders dated 5/6/16, directed to administer Duoneb (an inhaled medication that relaxes muscles in the airways and increases air flow to the lungs) inhalation four times a day. The orders lacked direction for R73 to SAM. The medication administration record (MAR) dated 5/16, included Duoneb (2.5 - 0.5 milligrams [mg]) inhale 3 milliliters (ml) nebulizer four times a day for COPD. The MAR lacked direction for R73 to SAM. The SAM-Self Administration of Medications assessment dated 5/2/16, indicated R73 did not have the mental and physical ability to self administer medications. The section asking if R73 could administer inhalant medications with proper procedure was blank. The assessment further indicated R73 was not granted approval to SAM because R73 and/or the family requested the facility administer all medications and treatment and R73 had impaired cognitive function. On 5/17/16, at 3:41 p.m. R73 was observed alone in his room seated in the recliner. The nebulizer was running, with a face mask. The mask was on R73's forehead. R73 was observed to place the mask over his mouth then move the mask back to his forehead four times. R73 would leave the mask on his forehead for approximately one to two minutes before returning the mask over his mouth. The nurse was observed outside the next room and worked her way down the hall to the	F 176	life care. He is alert and able to follow directions. Due to his swallowing difficulties, he produces a copious amount of secretions. He has difficulty managing the secretions and frequently removes his mask during nebulizer treatments to 'spit out' his phlegm. R73 was reassessed for self-administration of mediations (SAM) on 05/17/16 by RN/Resident Care Coordinator (RCC) and found to be safe with hand held nebulizer use after set up by staff. R91 was admitted on 04/25/16 with diagnoses of CHF, Malaise, Parkinson's Disease, HTN, COPD, ASHD, Esophageal Obstruction and Chronic Kidney Disease. Resident appeared weak and fragile, however was alert and oriented and able to make his own decisions. On 05/02/16, R91 was sent back to the hospital and admitted with chest pain. On 05/05/16, R91 was readmitted to Aicota. SAM assessment was completed on 05/17/16 where it was determined that R91 was able to be left alone during nebulizer treatments after being set up by staff. R91 was weak and chose to spend most of his time in bed resting during nebulizer treatments. He was capable of taking his mask on and off as he desired and was able to use the call light for assistance as needed. On 05/19/16, R91 was hospitalized and expired 05/20/16. On 06/02/16, all residents that	

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F 176	Continued From page 2 opposite end of the hall. The nurse did not check on R73 during the observation. At 3:58 p.m. registered nurse (RN)-D entered R73's room and removed the mask from R73's forehead and turned off the nebulizer machine. RN-D stated she had gotten involved in processing orders. RN-D could not state if R73 could be left alone to self-administer the nebulizer. At 4:05 p.m. RN-A stated R73 could be left alone as the previous SAM assessment indicated R73 could SAM after set up. RN-A verified the new assessment dated 4/5/16, did not indicate R73 could SAM after set up. RN-A stated she would redo the SAM assessment and add it. R91's Diagnoses List dated 5/18/16, indicated diagnoses that included congestive heart failure and COPD. The physician's orders dated 5/6/16, directed to administer Duoneb three times a day per nebulizer for COPD. The orders lacked direction for R91 to SAM. The MAR dated 5/16, indicated Duoneb three times a day per nebulizer for COPD. The MAR lacked direction for R91 to SAM. The medical record lacked an assessment for R91 to SAM. On 5/17/16, at 9:30 a.m. R91 was observed alone in his room. Staff were not present in the hall or near R91's room. R91 was observed with a nebulizer running via face mask. R91's eyes were closed and appeared to be sleeping. At 9:36 a.m. RN-B entered R91's room, turned off the nebulizer machine and removed the face mask.	F 176	self-administer their misty nebulizer treatments were reviewed and observed for proper ability to self-administer their nebulizer treatments. Aicota's computer software was updated to automatically generate a SAM to be completed on admission and readmission to ensure assessments are completed timely. Every resident at Aicota will be assessed for SAM on admission, readmission, significant change and as needed per Aicota's policy. All nurses will be inserviced by reviewing Aicota's Self Administration of Medication Evaluation policy. RCC's will monitor for compliance by completing monthly audits and report results to the QA Committee quarterly until compliance is sustained.	

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F 176	Continued From page 3 On 5/17/16, at 3:30 p.m. R91 stated staff always left him alone with the nebulizer. R91 further stated he had removed the nebulizer himself in the past because it was done. R91 puts the call light on if he removed the nebulizer himself or to let staff know the nebulizer was done. On 5/18/16, at 12:15 p.m. RN-C stated she completed the SAM assessment on 5/17/16. On 5/18/16, at 12:45 p.m. licensed practical nurse (LPN)-A stated it indicated on the MAR if the resident could be left alone with the nebulizer. The LPN stated she thought there was only one resident on the north unit that could be left alone with their nebulizer. On 5/19/17, at 10:50 a.m. the director of nursing (DON) verified the Duoneb order was written on 5/6/16, by the nurse practitioner, the day after R91 was readmitted from the hospital. The DON stated a SAM assessment was done every three months, on admissions and with significant changes. If an assessment determined a resident was not to be left alone to SAM the DON would expect staff to stay with them. The facility's Self Administration of Medication Evaluation policy dated 10/8/13, indicated the purpose of the policy was to ensure all oral, liquid and topical medication were administered safely. All residents would be assessed for the ability to SAM upon admission and as needed there after.	F 176		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or	F 242		6/28/16

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F 242	Continued From page 4 her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accommodate resident bathing preferences for 1 of 3 residents (R86) who voiced concerns regarding bathing preferences. Findings include: R86's quarterly Minimum Data Set (MDS) dated 3/8/16, identified R86 had intact cognition, was independent with all areas of daily living (ADL) and required limited assistance with transfer for bathing. On 5/17/16, at 9:08 a.m. R86 stated he received a shower once a week and indicated once a week was not often enough. R86 verbalized he would like to shower everyday and stated, "Even twice a week would be better." R86 indicated he did not require additional showers per week because he felt dirty, however, stated, "It would feel good." On 5/18/16, at 12:44 p.m. registered nurse (RN)-A identified on admission to the facility residents are given a bath/shower schedule. RN-A stated, "The resident is plugged in to the spot" the previous resident that resided in that room had. RN-A indicated if a resident voiced concerns the facility would make changes, however, facility practice was not to ask the resident with exception of on admission.	F 242	F242 All residents at Aicota have the right to choose activities, schedules and health care consistent with his or her interests, assessments and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. R86 was interviewed on 05/20/16 and he voiced that he would like a second weekly shower. His shower/bath schedule was adjusted to his preference of bi-weekly shower/bath. A second shower was added to his schedule on 05/20/16 and he now receives a shower/bath on Wednesday and Saturday. We have many residents at Aicota who receive multiple baths/showers weekly, per their wishes. Residents have the opportunity to voice their wishes regarding their personal cares at every care conference. Every resident will be assessed for their bathing preference, personal care routines and sleeping habits during the	

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F 242	Continued From page 5 The facility form titled Admission Nursing Assessment dated 12/1/15, the question at letter "M. Preferences #5. If multiple bathing times are wanted, specify wishes: (including AM/HS bathing)" was left blank. On 5/18/16, at 1:16 p.m. nursing assistant (NA)-A indicated being unaware R86 had concerns regarding his/her bathing schedule. NA-A identified the bathing schedule at the South nursing station to be the current resident schedule. Review of the facilty weekly bath schedule, identified R86 received one bath each week, on Tuesday. On 5/19/16, at 9:36 a.m. the social services director (SSD) identified nursing was responsible for managing residents bathing schedules and would refer requests to RN-A or RN-C. On 5/19/16, at 9:41 a.m. RN-A verified there was no documentation regarding discussion of bathing preference with R86. On 5/19/16, at 12:55 p.m. the director of nursing (DON) indicated being unaware R86 wanted more than one bath/shower per week. The DON stated, "[R86] certainly can have more, we have others that receive more than one bath per week." The facility policy subject titled Nursing Process dated 10/10/13, identified the following: Purpose: The process of assessment, planning, implementation and evaluation of all aspects of nursing care delivered to ensure the highest	F 242	admission process. These areas are reassessed with every conference and any changes are made as they arise to provide residents' personalized care. DON/Designee will monitor for compliance by monthly audits. Results will be reported to the QA Committee quarterly until compliance is sustained.	

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F 242	Continued From page 6 quality of care possible. Collect subjective date and description by the resident. Bathing; does resident prefer tub or shower, how often?	F 242		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide meaningful activities consistently for 1 of 1 residents (R34) reviewed for activities. Findings include: R34's Admission Record included diagnoses of psychosis, anxiety, macular degeneration, glaucoma, and legal blindness. R34's quarterly Minimum Data Set (MDS) dated 2/7/16, indicated R34 had severe vision and hearing impairments, had no symptoms of depression and no behavioral signs. The MDS further indicated R34 required total dependence on others for all forms of locomotion on and off the unit. The MDS also indicated R34 had moderately independence with decision making skills (some difficulty with new situations only). R34's undated care plan indicated R34 had limited participation and attendance to organized	F 248	F248 Aicota provides for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. R34 was admitted on 05/09/14 with diagnoses of HTN, heart failure, psychosis, insomnia, anxiety disorder, legal blindness, osteoarthritis and mixed incontinence. Resident is very hard of hearing and wears bilateral hearing aids. She is alert, oriented and able to make her own choices. According to her comprehensive assessment, meaningful activities for R34 include: spending time in her room listening to her radio, 1:1 assistance with mail, manicures, social hour, visiting and hand holding with friends from her home town, church, bingo, birthday parties, spending time outside and programs with a defined staff	6/28/16

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F 248	Continued From page 7 activities related to vision and hearing deficits, as well as her desire to spend time in her room. The care plan directed staff to provide 1:1 assist with mail, manicures, social hour, visit and hand holding (with residents from R34's hometown). The care plan further identified activities including church, bingo and a preference for organized activities such as birthday parties, bingo, outside activities, reading with a defined staff member and programs with another defined staff member. On 5/7/16, at 11:45 a.m. family member (FM)-A was interviewed, and stated the facility does not provide activities geared towards R34's disabilities. FM-A stated she has to remind staff to include R34 in activities. FM-A further stated she has asked staff to bring R34 outside, but it doesn't seem to happen. R34's activity log completed for 12/15, indicated R34 had no activity participation for twenty days. Refusal of activities was documented twice for these twenty days. One to one visit times were documented twice with durations of five to ten minutes each. R34 attended a music program on 12/3, bingo on 12/8, a birthday party on 12/9, and had visitors on 12/11. R34 also attended a special dinner and music on 12/17, a Santa program on 12/18, a holiday dinner on 12/25, and a New Year's party on 12/31. Manicures, bingo and parties (activities identified as an interest to R34) were listed on the activity calendar on 12/2, 12/7, 12/15, 12/16, 12/23, 12/28, and 12/30, with no attendance or refusal for these activities documented for R34. R34's activity logs completed for 1/16, indicated R34 had no activity participation documented for twenty-one days. Refusal of activities was	F 248	member. On 06/03/16, Activity Director interviewed R34. She stated that she likes to have her nails done for 'special things', dislikes evening bingo and she likes to choose what activities on the activity schedule that she likes to participate in. Of the 33 dates that there is no documentation of attendance or refusal by activities staff, 28 of these were manicure opportunities. Since R34 stated that she likes manicures for 'special things', Activity Director developed an individual appointment calendar for R34. Activities staff will continue to invite R34 to appropriate activities and physically assist her to them per R34's wishes. On 06/03/16, current residents had their most recent attendance records reviewed to ensure they were offered appropriate activities to benefit their interests and needs. During the admission interview, Activity staff establishes resident interests, likes and preferences. This process includes reaching out to family members to gather additional information to further individualize the resident's activity program. Appropriate activities and interests for residents are reassessed at quarterly care conferences and when needs are identified by residents, staff or family members. All activity staff will review the Philosophy of the Activities Department policy and will	

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F 248	Continued From page 8 documented twice for these twenty one days. One to one visit times were documented twice with duration times of ten and fifteen minutes. R34 attended music/social hour and care help on 1/1, church on 1/3, bingo on 1/5, music on 1/11, a birthday party on 1/13, school kids crafts on 1/15, church on 1/28, and 1/31. Manicures, bingo and parties (activities identified as an interest to R34) were listed on the activity calendar on 1/6, 1/11, 1/20, 1/21, 1/25, 1/27, 1/28, with no attendance or refusal for these activities documented for R34. R34's activity logs completed for 2/16, indicated R34 had no activity participation documented for fourteen days. Refusal of activities was documented three times. One to one visit times were documented four times with duration times of ten, ten, fifteen and twenty minutes. R34 had visitors on 2/5, attended an activity with Sunday school children on 2/7, a rhythm band on 2/8, bingo on 2/9, a birthday party on 2/10, a sweetheart lunch on 2/16, had visitors and attended a birthday party on 2/18, attended a school kids program on 2/19, volunteer program on 2/21, current events on 2/22, had visitors on 2/26, and 2/27, and attended church on 2/28. Manicures, bingo and parties (activities identified as an interest to R34) were listed on the activity calendar on 2/1, 2/3, 2/17, 2/22, 2/24, and 2/25 with no attendance or refusal for these activities documented for R34. R34's activity logs completed for 3/16, indicated R34 had no activity participation documented for fourteen days. Refusal of activities was documented three times. One to one visit times were documented three times with duration times of fifteen minutes. R34 attended bingo on 3/1, a special party on 3/2, had visitors on 3/3, attended	F 248	be inserviced on the importance of offering activities of interest to residents and documenting the attendance or refusal. The monthly activity calendar is posted in every resident room and in the central hall for all residents, visitors and family members. Any resident with vision or hearing problems will have the calendars read to them by Activity and Nursing staff. The activity calendar was reviewed to assure that Aicota offers a variety of appropriate activities for all residents. Activity Director/designee will monitor for compliance by completing monthly audits and task observation. Results will be reported to the QA committee quarterly until compliance is sustained.	

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F 248	Continued From page 9	F 248		

a birthday party on 3/9, a music program on 3/12, and 3/14, happy hour on 3/17, church on 3/20, music on 3/22, and 3/24, a special program on 3/25, music on 3/25, Easter dinner and church on 3/27, music on 3/28, and 3/31. Manicures, bingo, church and parties (activities identified as an interest to R34) were listed on the activity calendar on 3/2, 3/16,3/23, 3/25, 3/28, with no attendance or refusal for these activities documented for R34.

R34's activity logs completed for 4/16, indicated R34 had no activity participation documented for sixteen days. Refusal of activities was documented once and R34 was documented as unavailable once. A one to one visit time was documented once with a duration time of ten minutes. R34 attended current events and a music program on 4/4, music on 4/9, church on 4/10, music programs twice on 4/11, hand massage on and a birthday party on 4/13, school kids crafts on 4/15, had visitors on 4/16 and 4/18, attended a music program on 4/18, bingo on 4/19, music on 4/21, had visitors on 4/22, attended a music program on 4/23, and a special dinner on 4/27. Manicures,bingo and parties (activities identified as an interest to R34) were listed on the activity calendar on 4/4, 4/6, 4/20, 4/25, and 4/27, with no attendance or refusal for these activities documented for R34.

R34's activity logs completed 5/1/16, through 5/18/16, indicated R34 had no activity participation documented for ten of eighteen days. Refusal of activities was documented once. One to one visit times were documented two times with duration times of ten minutes each. R34 had visitors and attended church on 5/8, attended a special lunch and a music program on

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F 248	Continued From page 10 5/9, attended happy hour on 5/10, a special luncheon and bingo on 5/12, church on 5/15, and a music program on 5/16. Manicures, bingo and parties (activities identified as an interest to R34) were listed on the activity calendar on 5/11, 5/16, 5/18, with no attendance or refusal for these activities documented for R34. R34 was not observed in individual or group activities during the survey on 5/16/16, 5/17/16, and 5/18/16. On 5/19/16, at 8:35 a.m. the activity director (AD)-A was interviewed and stated days documented with no activities on R34's activity record were days with group activities R34 didn't enjoy. AD-A said R34 was informed of activities she has enjoyed in the past and may not be aware of all activities. AD-A stated one to one activities for R34 should have a duration of at least ten minutes or probably more to be a meaningful activity. AD-A further stated that not all activities or refusal of activities were documented for R34. AD-A also said R34 did not converse well with some activity staff and said attempts could be made to try other activity staff for longer and more often one to one interactions. The facility policy Philosophy of the Activities Department dated 8/17/16, directed an objective of planning, organizing and implementing a program of activities to meet the individual needs and interests of residents, giving residents entertainment, inter-communication, exercise and an opportunity to fulfill basic psychological, social and spiritual needs. The policy further directed activity staff to invite residents to each activity. The policy also directed daily activity attendance to be charted on monthly activity logs.	F 248		

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	245363	A. BUILDING _____ B. WING _____	05/19/2016

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F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a comprehensive assessment within 14 days after the facility determined, or should have determined there was a significant change in the resident's physical or mental condition for 1 of 1 residents (R76) reviewed with a change in activities of daily living (ADLs). Findings include: R76's admission Minimum Data Set (MDS) dated 3/22/16, identified R76 had moderate cognitive impairment and required extensive assistance with all areas of daily living (ADL). R76's 14 day MDS dated 3/28/16, identified R76 had intact cognition and was independent with bed mobility, transfers and walking in room.	F 274	F274 Aicota conducts a comprehensive assessment of a resident within 14 days after it is determined, or should have been determined that there is a significant change in the resident's physical or mental condition. R75 was admitted on 03/05/16 with diagnoses of vascular dementia, wandering, insomnia, major depressive disorder, multiple falls with head contusion and lacerations, head injuries, poly neuropathy, CHF, PVD, HTN, glaucoma and OA. R75 is alert and oriented to self and place. She is able to perform simple tasks. She has poor decision making skills and poor safety judgement skills.	6/28/16

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F 274	Continued From page 12 R76's current undated careplan directed the following: "Staff will offer assist when they see resident up in room" "Staff will SBA [stand by assist] and supervise resident when noted to be up and about." On 5/18/16, at 7:47 a.m. R76 exited her room independently with the use of a walker. R76 exited her room and closed the door. LPN-A approached R76 and walked beside her to the dining room. R76 walked independently with the use of a walker and no hands on physical assistance from staff. On 5/18/16, at 7:50 a.m. licensed practical nurse (LPN)-A identified R76 was independent to walk in her room, however, staff walked beside R76 when outside of the room. LPN-A verified staff stocked R76's room with needed supplies and R76 was able to use the call light if anything was needed. LPN-A verified R76 was able to wash and dress herself. On 5/18/16, at 8:28 a.m. nursing assistant (NA)-J walked beside R76 from the dining room to her room. R76 entered the room independently with the walker. NA-J stopped at the door to R76's room, wished R76 a good day and turned to walk away. R76 had walked independently with NA-J walking beside with out physically touching R76. On 5/18/16, at 9:35 a.m. NA-J stated, "[R76] tends to pop up at times and I like to walk and chat" beside her. NA-J further stated, "We get [R76] from point A to point B." On 5/18/16, at 11:45 a.m. physical therapy	F 274	A significant change MDS was completed with ARD date of 06/01/16. R75's care plan was updated and a significant change care conference was held 06/06/16. Assessments still indicate that R75 requires some assistance with ongoing personal cares like bathing, combing hair and dressing. R75 is frequently seen walking with tops buttoned incorrectly, belt open, clothes mismatched and occasionally has stool smears on clothing. She is unable to completely put herself together. She is a very dignified and private lady with good communication skills. She is pleasantly confused and covers her cognitive impairment very well. She frequently and very nicely declines assistance with personal cares and bathing. All residents at Aicota with a potential change in condition are reviewed and discussed every Tuesday and Thursday mornings at scheduled Medicare meetings. On 06/06/16, all current residents were reviewed for potential significant change improvement or decline with none being identified. All nursing staff will be educated on the importance of reporting any observed changes in activities of daily living to RCC's and Teamleaders. RCC's will monitor for compliance by completing monthly audits and report the	

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	245363	A. BUILDING _____ B. WING _____	05/19/2016

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F 274	Continued From page 13 assistant (PTA) verified R76 had received therapy services for strength and mobility with balance. PTA identified R76's final therapy visit was March 30, 2016. PTA identified R76 was independent while in her room and when outside of her room staff was to walk with R76. On 5/18/16, at 1:31 p.m. R76 verified she was able to get herself washed and dressed in the morning. On 5/19/16, at 9:57 a.m. NA-G verified she woke R76 this morning, however, had not assisted R76 to get out of bed or to completed cares including hygiene, oral cares or dressing. On 5/19/16, at 9:43 a.m. registered nurse (RN)-A verified the changes in R76's physical ability documented on the admission MDS dated 3/22/16 and the 14 day MDS dated 3/28/16. RN-A indicated an improvement in physical ability was expected at that time because of therapy, and did not believe a significant change MDS was needed. RN-A identified a quarterly MDS would be completed in June. RN-C verified the responsibility of managing the MDS schedule. RN-C indicated a significant change MDS would be considered when a resident had two changes in condition, for example changing from extensive assistance with transfer and bed mobility to independent. RN-C did not agree a significant change MDS was required for R76 and verified R76 would be billed at the same rate of pay from the time of the admission assessment until a review with a quarterly assessment is completed in June. The facility policy titled Policy and Procedure for	F 274	results to the QA committee quarterly until compliance is sustained.	

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F 274	Continued From page 14 Completion of the Minimum Data Set and Quarterly reviews dated 6/11/10, "4. Significant change assessments are completed when there is a major decline or improvement in the residents status that will not normally resolve itself without further intervention."	F 274		

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	245363	A. BUILDING **01 - AICOTA NURSING HOME** B. WING _____	**05/17/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Aicota Health Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/09/2016

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	K 000		

By e-mail to both:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Aicota Health Care Center, is a 1-story building with no basement. The original building was constructed in 1969 and was determined to be of Type II(111) construction. In 1983 an addition was constructed to the building that was determined to be of Type II(111) construction. In 2007 an assisted living facility was attached, that is properly 2 hour fire rated separated. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building.

The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code.

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	245363	A. BUILDING **01 - AICOTA NURSING HOME** B. WING _____	**05/17/2016**

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K 000	Continued From page 2 The facility has a capacity of 75 beds and had a census of 65 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.1.2, during the last 12-month period. This deficient practice could affect 65 of 65 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 AM and 12:30 PM on 05/17/2016, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility had the following deficient conditions	K 050	Fire drills will be randomly conducted in accordance with NFPA 101 Life Safety Code standards. Fire drill dates and times will be reviewed monthly by the Safety Committee. The Maintenance Supervisor will be responsible for performing/monitoring drills for compliance.	6/1/16

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K 050	Continued From page 3 affecting the facility's fire drills: 1. The facility failed to vary the times of the fire drills by conducting 3 of 4 fire drills for the overnight shift in the 10 AM hour. 2. The facility failed to vary the times of the fire drills by conducting 3 of 4 fire drills for the evening shift in the 2 PM hour. This deficient practice was confirmed by the Maintenance Supervisor.	K 050		
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 65 of 65 residents, visitors and staff. Findings include: On facility tour between 9:30 AM to 12:30 PM on 05/17/2016, observations made during a review of available documentation and an interview with	K 154	The Fire Protections Systems out of Service Policy has been corrected to include current contact information in accordance with NFPA 101 Life Safety Code standards. In addition, the policy will follow the example provided in the Life Safety Code Manual currently being followed. The Maintenance Supervisor will be responsible for continued compliance.	6/1/16

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K 154	Continued From page 4 the Maintenance Supervisor, it was found that the facility could not provide a complete automatic fire sprinkler system out of service policy that contained current contact information. This deficient practice was confirmed by the Maintenance Supervisor.	K 154		
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all 65 of 65 residents, visitors and staff. Findings include: On facility tour between 9:30 AM to 12:30 PM on 05/17/2016, observations made during a review of available documentation and an interview with the Maintenance Supervisor, it was found that the facility could not provide an complete and updated automatic fire alarm system out of service policy that contained current contact information.	K 155	The Fire Protections Systems out of Service Policy has been corrected to include current contact information in accordance with NFPA 101 Life Safety Code standards. In addition, the policy will follow the example provided in the Life Safety Code Manual currently being followed. The Maintenance Supervisor will be responsible for continued compliance.	6/1/16

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K 155	Continued From page 5 This deficient condition was verified by the Maintenance Supervisor.	K 155		