DEPARTMENT OF HEALTH AN	ND HUMAN	SERVICES			CENTERS FOR MI	EDICARE & MEDICAID SERVICES		
					AND TRANSMITTAL	ID: O5FJ		
	PART I	- TO BE COMP	LETED BY T	HE STA	TE SURVEY AGENCY	Facility ID: 00002		
1. MEDICARE/MEDICAID PROVIDER NO (L1) 245119		3. NAME AND AI (L3) AITKIN HE				<ol> <li>TYPE OF ACTION: <u>7</u> (L8)</li> <li>Initial 2. Recertification</li> </ol>		
2.STATE VENDOR OR MEDICAID NO.		(L4) 301 MINNE	SOTA AVENUH	E SOUTH		1. Initial     2. Recentilication       3. Termination     4. CHOW		
(L2) <b>231247600</b>		(L5) AITKIN, MI	N		(L6) <b>56431</b>	5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNE	RSHIP	7. PROVIDER/SUPPLIER CATEGORY			<u>02</u> (L7)	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
(L9)	<b>a</b> (124)	01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA			
6. DATE OF SURVEY 08/12/201		02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
<ol> <li>ACCREDITATION STATUS:</li> <li>0 Unaccredited</li> <li>1 TJC</li> <li>2 AOA</li> <li>3 Other</li> </ol>	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/III 12 RHC	15 ASC 16 HOSPICE	06/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	6:				
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of Th	e Following Requirements:		
To (b):			Requirements nce Based On:		2. Technical Personnel	6. Scope of Services Limit		
12.Total Facility Beds	<b>44</b> (L18)		Acceptable POC		<ul> <li>3. 24 Hour RN</li> <li>4. 7-Day RN (Rural SNF</li> <li>5. Life Safety Code</li> </ul>	7. Medical Director    8. Patient Room Size     9. Beds/Room		
13.Total Certified Beds	<b>44</b> (L17)		mpliance with Prog ents and/or Applied		* Code: A*	(L12)		
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
44	-,				(-)(-)(-)(-)			
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS	(IF APPLICABL	E SHOW LTC CANC	ELLATION DATE	):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:		
<u>Pat Halverson, Unit Sup</u>	pervisor		08/21/2013	(L19)	Shellae Dietrich, Program Specialist 12/26/2013			
PAR	T II - TO BH	E COMPLETED	BY HCFA RE	EGIONA	L OFFICE OR SINGLE ST.	ATE AGENCY		
19. DETERMINATION OF ELIGIBILITY		20. COM	MPLIANCE WITH	CIVIL	21. 1. Statement of Finan	cial Solvency (HCFA-2572)		
<b>X</b> 1. Facility is Eligible to Partici	nate	RI	GHTS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	l Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible	pare				5. Dom of the fibore			
	(L21)							
22. ORIGINAL DATE 23	3. LTC AGREEM	IENT 2	4. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Е	<u>VOLUNTARY</u> <u>00</u>	INVOLUNTARY		
03/09/1967					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	6		
25. LTC EXTENSION DATE: 27	. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)	D.D. 10		(L44)			00-Active		
	B. Rescind Sus	spension Date:	<b>7.15</b>					
28. TERMINATION DATE:	20	. INTERMEDIARY/	(L45)		30. REMARKS			
	2)	03001						
	(L28)	0.0001		(L31)				
	/			()	-			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	ATE				
	(L32)	08/23/2013		(L33)		OVAL		
	(132)			(L33)	DETERMINATION APPR	UVAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES	<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		
MEDICARE/MEDICAID CERTIFICATION AND T	RANSMITTAL	ID: O5FJ	
PART I - TO BE COMPLETED BY THE STATE SU	RVEY AGENCY	Facility ID: 00002	

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

#### CCN# 24-5119

At the time of the standard survey completed June 27, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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. The facility was given an opportunity to correct before remedies were imposed.

On August 12, 2013 the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on June 27, 2013 effective July 30, 2013, therefore the remedies outlined in our letter to you dated July 12, 2013, will not be imposed.

See attached CMS-2567B form for the results of August 12, 2013 revisit.



Protecting, Maintaining and Improving the Health of Minnesotans

August 21, 2013

Ms. Carol Raw, Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, Minnesota 56431

RE: Project Number S5119021

Dear Ms. Raw:

On July 12, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 27, 2013. 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 August 12, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 27, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 30, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 27, 2013, effective July 30, 2013 and therefore remedies outlined in our letter to you dated July 12, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Colleen Jeach

Colleen Leach, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Enclosure cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5119

December 26, 2013

Ms.. Carol Raw, Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, Minnesota 56431

Dear Ms.. Raw:

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 July 30, 2013 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone #: (651) 201-4106 Fax #: (651) 215-9697 cc: Licensing and Certification File

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245119	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/12/2013
Nam	e of Facility		Street Address, City, State, Zip Code	
Aľ	TKIN HEALTH SERVICES		301 MINNESOTA AVENUE SOL AITKIN, MN 56431	JTH

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

(Y4) Item	(Y:	5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix	F0441	Correction Completed 07/30/2013	ID Prefix		Correction Completed	ID Prefix		Correction Completed
	483.65	_	Reg. # LSC			Reg. # _ LSC _		
Reg. #		Correction Completed	Reg. #		Correction Completed	Reg. #		Correction Completed
ID Prefix Reg. # LSC		Correction Completed			Correction Completed	Reg. #		
Reg. #			Reg. #		Correction Completed	Reg. #		
ID Prefix Reg. # LSC			ID Prefix			<b>–</b> "		
Reviewed E State Agen Reviewed E CMS RO			Date: 08/21/2013 Date:	Signature of Sur Signature of Sur	•	12835	Date: Date:	08/12/2013
Followup to Survey Completed on: 6/27/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?					NO	

DEPARTMENT OF HEALTH	AND HUMAN	SERVICES			CENTERS FOR M	EDICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: O5FJ
	PART I	- TO BE COMP	PLETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00002
1. MEDICARE/MEDICAID PROVIDER           (L1)         245119           2.STATE VENDOR OR MEDICAID NO.         (L2)           (L2)         231247600	NO.	<ol> <li>NAME AND AI</li> <li>(L3) AITKIN HE</li> <li>(L4) 301 MINNE</li> <li>(L5) AITKIN, MI</li> </ol>	ALTH SERVIC SOTA AVENUI	CES	(L6) <b>56431</b>	4. TYPE OF ACTION:       2 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint
<ol> <li>EFFECTIVE DATE CHANGE OF OW:</li> <li>(L9) 07/01/2006</li> <li>DATE OF SURVEY 06/27,</li> <li>ACCREDITATION STATUS:</li> <li>0 Unaccredited 1 TJC 2 AOA 1 Other</li> </ol>	<b>/2013</b> (L34) (L10)	<ol> <li>PROVIDER/SU</li> <li>01 Hospital</li> <li>02 SNF/NF/Dual</li> <li>03 SNF/NF/Distinct</li> <li>04 SNF</li> </ol>	IPPLIER CATEGO 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	RY 09 ESRD 10 NF 11 ICF/III 12 RHC	(L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 06/30
<ul> <li>11. LTC PERIOD OF CERTIFICATION</li> <li>From (a): To (b):</li> <li>12.Total Facility Beds</li> <li>13.Total Certified Beds</li> <li>14. LTC CERTIFIED BED BREAKDOWI</li> </ul>	<b>44</b> (L18) <b>44</b> (L17)	Compliar 1. B. Not in Co		ram	And/Or Approved Waivers Of TI 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI 5. Life Safety Code * Code: B 15. FACILITY MEETS	6. Scope of Services Limit 7. Medical Director
14. LIC CERTIFIED BED BREAKDOW	N				15. FACILII I MEEIS	
18 SNF 18/19 SNF 44 (L37) (L38) 16. STATE SURVEY AGENCY REMAR	19 SNF (L39) KS (IF APPLICABL	ICF (L42) E SHOW LTC CANC	IID (L43) ELLATION DATE	):	1861 (e) (1) or 1861 (j) (1):	(L15)
At the time of the Standard su along with the facility's plan of					th Federal Certification Regu	alations. Please refer to the CMS 2567B
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Cheryl Johnson, HFE NE	II		07/03/2013	(L19)	Colleen B. Leach, Pro	gram Specialist 08/22/2013
PA	ART II - TO BE	E COMPLETED	BY HCFA RI	EGIONA	L OFFICE OR SINGLE ST	ATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBILITY         <ol> <li>Facility is Eligible to Par</li> <li>Facility is not Eligible</li> </ol> </li> </ol>	ticipate	20. COM	MPLIANCE WITH GHTS ACT:		21. 1. Statement of Finan	ncial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE	23. LTC AGREEM	IENT 2	4. LTC AGREEN	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 03/09/1967	BEGINNING		ENDING DAT		VOLUNTARY     0(       01-Merger, Closure     0(	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	6
25. LTC EXTENSION DATE:	27. ALTERNATT A. Suspension	VE SANCTIONS n of Admissions:			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
(L27)	B. Rescind Sus	spension Date:	(L44) (L45)			ou neuve
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS	
		03001				
	(L28)			(L31)	Posted 8/23/2013 - ML	
31. RO RECEIPT OF CMS-1539	(L32)	DETERMINATION	UI AFFRUVAL D	(L33)	DETERMINATION APPR	OVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 3564

July 12, 2013

Ms. Carol Raw, Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, Minnesota 56431

RE: Project Number S5119021

Dear Ms.. Raw:

On June 27, 2013, 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.

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

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

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

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

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

# <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

# <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

## DEPARTMENT CONTACT

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

Pat Halverson Minnesota Department of Health Duluth Technology Village 11 East Superior Street, Suite 290 Duluth, Minnesota 55802

Telephone: (218) 302-6151 Fax: (218) 723-2359

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. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205 Fax: (651) 215-0541

# **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 August 6, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

Aitkin Health Services July 12, 2013 Page 3

# PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

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

If an acceptable PoC 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 PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

Aitkin Health Services July 12, 2013 Page 4

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

### VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

#### **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 September 27, 2013 (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 December 27, 2013 (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 Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.

Aitkin Health Services July 12, 2013 Page 6

Sincerely,

Pat Halveron

Pat Halverson, Unit Supervisor Licensing and Certification Program Division of Compliance Monitoring Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

TATEMENT	SFOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE	0938-039 SURVEY PLETED
		245119	B.WING		JUL 2 9 2013	0.010	7/0040
AME OF P	ROVIDER OR SUPPLIER		Divinc_	r · · · ·	EET ADDRESS, CITY,STAPENZIP CODE	06/2	27/2013
AITKIN H	EALTHSERVICES			30	1 MINNESOTA AVENUE SOUTH TKIN, MN 56431		
(X4)1D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	I ID I PREFID TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(XS) COMPLETIO DATE
F 000	INITIAL COMMENT	S	F (	000	· .		
	WILL SERVE AS YO COMPLIANCE UPO ACCEPTANCE. YO				014,13 1-30,13 ALH		
	AN ONSITE REVIS BE CONDUCTED 1 SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, IT OF YOUR FACILITY MAY O VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.					
	SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and c	I CONTROL, PREVENT tablish and maintain an ogram designed to provide a omfortable environment and development and transmission ction.	F4	441	RN E was educated on non-steril dressing changes June 26, 2013. R23's dressing changes were performed by policy and procedure. R23 expired on July 2 2013.	-	07/30/13
	<ul> <li>(a) Infection Contro The facility must esi Program under whi</li> <li>(1) Investigates, con in the facility;</li> <li>(2) Decides what pr should be applied to</li> <li>(3) Maintains a reco actions related to in</li> </ul>	I Program tablish an Infection Control ch it - ntrols, and prevents infections ocedures, such as isolation, o an individual resident; and ord of incidents and corrective ifections.			All resident's requiring non-steri dressing changes could be affected this deficient practice. All licensed staff will be educated on non-sterile dressing changes policy and procedure by July 30, 2013.	ed by d	
	(b) Preventing Spre	ad of Infection on Control Program		1			

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
		245119	B, WING			06/	27/2013
NAME OF P	ROVIDER OR SUPPLIER	I	<b>!</b>	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	EALTH SERVICES			t	1 MINNESOTA AVENUE SOUTH TKIN,MN 56431		,
{X4) ID · PREFIX TAG	(EACH DEFICENCY	NTEMENT OF DEFICIENCES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THEAPPF DEFICIENCY)	uld be	(X5) COMPLETION DATE
F 441	Continued From page 1 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.		F 441 Director of Nursing Service designee will audit non-stea dressing technique 2x week weeks, then 1x weekly for then monthly thereafter. Au will be brought to the QAP Committee for further recommendations. Staff wi educated on an ongoing bas on results of audits.			le y x 4 weeks, lit results be re-	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not provided appropriate gloving and handwashing during a dressing change for 1of 1 residents (R23) observed for stoma care. R23 was observed on 6/26/13, at 7:49 a.m. during a dressing change to the peritoneal catheter site. The registered nurse (RN)-E, the surveyor and R23 donned surgical masks. RN-E						
	on a second 4 X 4 and donned glove contaminated cath abdomen and cle	sterile 4 X 4 gauze and water gauze, then washed hands is. RN-E removed the neter site dressing from R23's aned the skin around the prepared soap and water gauze.			acility D:00002	ontinuation she	

FORM CMS-2567(02-99) Previous Versions Obsolete

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (M) PROVIDERSUPPUENCIA DENTIFICATION NUMBER       (M) DENTIFICATION NUMBER       (M) DENTIFIC			AND HUMAN SERVICES				FORM	07/30/2013 APPROVED 0938-0391
MAKE OF PROVIDER OR SUPPLIER     In double of a street address, citry, state, 2P code       AITKIN HEALTH SERVICES     301 MINNESOTA AVENUE SOUTH       MARE OF PROVIDER OR SUPPLIER     SUMMARY STATEMENT OF DEFICIENCIES     In MINNESOTA AVENUE SOUTH       YAG     SUMMARY STATEMENT OF DEFICIENCIES     In GROUP SPLAN OF CORRECTION     epsect       YAG     SUMMARY STATEMENT OF DEFICIENCIES     In GROUP SPLAN OF CORRECTION     epsect       YAG     Continued From page 2     In GROUP SPLAN OF CORRECTION     epsect       (antibiotic) cream to the skin around the catheter.     Without changing gloves or performing hand     F 441       Vigiene, RN-E applied the clean gauze dressing     F 441       RN-E, Interviewed on 6/28/13, at 8:10 a.m.,     stated there was no need for hand hygiene or       glove change between removing the old dressing     and appling a new dressing because it was not a       sterile procedure.     RN-F, unit manager, was interviewed on 6/28/13, at 8:20 a.m., and stated that facility policy       directed hand washing between removal of the     old dressing       old dressing and application of the new dressing.       On 8/28/13, at 8:25 a.m. the director of nursing       (DON) stated staff should have changed gloves       and washing between her dirty and clean       tacks of the dressing change.       Review of the policy for Peritoneal Dialysis       Cathedre date 1/31/13, indicated staff were to <tr< td=""><td>STATEMENT</td><td>OF DEFICIENCIES</td><td>(X1) PROVIDER/SUPPLIER/CLIA</td><td></td><td></td><td>LE CONSTRUCTION</td><td colspan="2"></td></tr<>	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION		
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS. CITY, STRE, ZP CODE       AITKIN HEALTH SERVICES     301 MINNESOTA AVENUE SOUTH       ATKIN HEALTH SERVICES     INNNESOTA AVENUE SOUTH       PRETX     CACID REFIGURORY WUST DE PRECEDED BY PULL REQUIATORY OR LSC IDENTIFYING INFORMATION)     PREVIDER SCITY, STRE, ZP CODE       F 441     Continued From page 2 (antibiotic) cream to the skin around the catheter. without changing gloves or performing hand hyglene, RN-E applied the clean gauze dressing around the catheter site and placed a protective dressing over the gauze dressing to secure the catheter. RN-E, interviewed on 6/26/13, at 8:10 a.m., stated there was no need for hand hyglene or glove change between removing the old dressing and applying a new dressing because it was not a sterile procedure.     RN-F, unit manager, was interviewed on 6/26/13, at 8:20 a.m., and stated thaf facility policy directed hand washing between removal of the old dressing and application of the new dressing.     On 8/26/13, at 8:25 a.m. the director of nursing (DON) stated staff should have changed gloves and washed hands between the dity and clean tasks of the dressing change.     Review of the policy for Peritoneal Dialysis Catheter dataff 3/3/13, indicated staff were to follow this policy for dressing nange. a. Mask, wash hands and don gloves, b. Remove dressing, c. Remove gloves and wash hands, d.			245119	B. WING	i		06/2	27/2013
ATIKIN HEALTH SERVICES       ATKIN, MN 56431         (W) ID TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST UE NECEDED BY FULL REGULATIORY OR LSC DENTIFYING INFORMATION)       PROVIDENTIFY INFORMATION PREFIX (EACH DEFICIENCY MUST UE NECEDED BY FULL REGULATIORY OR LSC DENTIFYING INFORMATION)       PROVIDENTIFY TAG       PROVIDENTIFY INFORMATION (EACH DEFICIENCY MUST UE NECEDED BY FULL REGULATIORY OR LSC DENTIFYING INFORMATION)       PROVIDENTIFY TAG       PROVIDENTIFY INFORMATION (EACH DEFICIENCY MUST UE NECEDED BY FULL REGULATIORY OR LSC DENTIFYING INFORMATION)       PROVIDENTIFY TAG       PROVIDENTIFY INFORMATION (EACH DEFICIENCY)       OPROVIDENTIFY TAG         F 441       Continued From page 2 (antibiotic) cream to the skin around the catheter. without changing gloves or performing hand hygiene, RN-E applied the clean gauze dressing around the catheter site and placed a protective dressing over the gauze dressing to secure the catheter. RN-E removed hor gloves at hand highene or glove change between removing the old dressing and applying a new dressing because it was not a sterile procedure.       F 441         RN-F, unit manager, was interviewed on 6/26/13, at 8:20 a.m., and stated that facility policy directed hand washing between removal of the old dressing and application of the new dressing.       On 8/26/13, at 8:25 a.m. the director of nursing (DON) stated staff should have changed gloves and washed hands between the dirty and clean tasks of the dressing change.       Review of the policy for Peritoneal Dialysis Catheter date 1/31/13, indicated staff were to follow this policy for dressing change.       Review of the policy for dressing change.         Review of the policy for dressing change.       Review of	NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
Pričejk       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       Pričejk       TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       Pričejk       CROSR-REFERENCES TO THE APPROPRIATE       Configure       Completion       Continued       Continued </td <td>AITKIN H</td> <td>IEALTH SERVICES</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	AITKIN H	IEALTH SERVICES						
<ul> <li>(antibiotic) cream to the skin around the catheter. without changing gloves or performing hand hygiene, RN-E applied the clean gauze dressing around the catheter site and placed a protective dressing over the gauze dressing to secure the catheter. RN-E removed her gloves at that time, tied up garbage, and washed her hands.</li> <li>RN-E, interviewed on 6/26/13, at 8:10 a.m., stated there was no need for hand hygiene or glove change between removing the old dressing and applying a new dressing because it was not a sterile procedure.</li> <li>RN-F, unit manager, was interviewed on 6/26/13, at 8:20 a.m., and stated that facility policy directed hand washing between removal of the old dressing and application of the new dressing.</li> <li>On 8/26/13, at 8:25 a.m. the director of nursing (DON) stated staff should have changed gloves and washed hands between the dirty and clean tasks of the dressing change.</li> <li>Review of the policy for Peritoneal Dialysis Catheter dated 1/3/1/3, indicated staff were to follow this policy for dressing change: a. Mask, wash hands and don gloves, b. Remove dressing. dressing c. Remove gloves and wash hands, d.</li> </ul>	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETION
Don gloves, e. Clean exit siteapply Gentamicin cream to exit site, f. Allow to dry for 1 minute, g. Apply Telfa dressing over site.	F 441	(antibiotic) cream to without changing gl hygiene, RN-E app around the catheter dressing over the g catheter. RN-E rem tied up garbage, an RN-E, interviewed a stated there was no glove change betwo and applying a new sterile procedure. RN-F, unit manage at 8:20 a.m., and si directed hand wash old dressing and ap On 8/26/13, at 8:25 (DON) stated staff and washed hands tasks of the dressin Review of the polic Catheter dated 1/3 follow this policy for wash hands and do dressing, c. Remov Don gloves, e. Clea cream to exit site,	<ul> <li>b the skin around the catheter. loves or performing hand lied the clean gauze dressing r site and placed a protective auze dressing to secure the hoved her gloves at that time, and washed her hands.</li> <li>con 6/26/13, at 8:10 a.m., b need for hand hygiene or even removing the old dressing r dressing because it was not a</li> <li>cr, was interviewed on 6/26/13, tated that facility policy hing between removal of the oplication of the new dressing.</li> <li>a.m. the director of nursing should have changed gloves between the dirty and clean hig change.</li> <li>y for Peritoneal Dialysis 1/13, indicated staff were to r dressing change: a. Mask, on gloves, b. Remove ye gloves and wash hands, d. an exit siteapply Gentamicin f. Allow to dry for 1 minute, g.</li> </ul>	F	441			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00002

If continuation sheet Page 3 of 3

ENTERENT OF DEFICIENCIES AND PLAN OF CORRECTION     (X) PROVIDERSUPPLIER UDENTIFICATION NUMBERS:     (X) DUILIPLE CONSTRUCTION A BUILING OF - MAIN BUILIDING OF BUILING OF - MAIN BUILIDING OF BUILING OF - MAIN BUILIDING OF BUILING OF CORRECTION     (X) DUILIPLE CONSTRUCTION     (X) DUILIPLE CONSTRUCTION     (X) DUILIPLE CONSTRUCTION     (X) DUILIPLE BUILING OF - MAIN BUILIDING OF BUILING OF - MAIN BUILIDING OF BUILING OF CORRECTION     (X) DUILIPLE CONSTRUCTION     (X) DUILIPLE CONSTRUCTION     (X) DUILIPLE BUILING OF CORRECTION     (X) DUILIPLE CONSTRUCTION     (X) DUILIPLE BUILING OF CORRECTION     (X) DUILIPLE CONSTRUCTION     (X) DUILIPLE CONSTRUCTION     (X) DUILIPLE BUILIPLE BUILIPLE CONSTRUCTION     (X) DUILIPLE CONSTRUCTION     (X) DUILI		MENT OF HEALTH			F51	19021	FORM	07/10/2013 APPROVED 0.0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS. CITY. STATE.2P CODE       ATKIN HEALTH SERVICES     STREET ADDRESS. CITY. STATE.2P CODE       301 MINNESDTA AVENUE SOUTH ATKIN, NM 56431     SUMMARY STATEMENT OF DEFICIENCES       (CACH DEFICIENCY ON USS & REACEDED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TAG       (CACH DEFICIENCY OWNESS ENANGED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TAG       (CACH DEFICIENCY OWNESS ENANGED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TAG       (CACH DEFICIENCY OWNESS ENANGED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TAG       (CACH DEFICIENCY OWNESS ENANGED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TAG       (CACH DEFICIENCY OWNESS ENANGED BY ULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TAG       (CACH DEFICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX PREFIX       (					1			
AITKIN HEALTH SERVICES     301 MINNESOTA AVENUE SOUTH ATKIN, MM 56431            (xq) ID PREFIX           SUMMARY STATEMENT OF DEFICIENCES           PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE EACH CORRECTIVE ACTION SHOULD BE EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES           OCONSTANTS			245119		B. WING		06/2	6/2013
Préčix TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       PRÉCIX TAG       (EACH CORRECT ACTION SIGULD BE CROSS-REFERENCED TO THE APPROPRIATE       COMPLETION DEFICIENCY         K 000       INITIAL COMMENTS       K 000         A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey. Altkin Health Services was found in substantial compliance with the requirements for participation in Medicare/Medicare/Medicat 442 CFR, Subpart 483.70(a). Life Safety Form Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing 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 III(111) construction.         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 of44 beds and had a census of 41 at the time of the survey.         At this time, the conditions of 42 CFR, Subpart 483.70(a) is met.	1			301 MI	NNESOTA	AVENUE SOUTH		
Surveyor: 03005 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Aitkin Health Services was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Attkin 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. 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 of44 beds and had a census of 41 at the time of the survey. At this time, the conditions of 42 CFR, Subpart 483.70(a) is met.	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY	YFULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE	COMPLETION
A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Attkin Health Services was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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. 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 41 at the time of the survey. At this time, the conditions of 42 CFR, Subpart 483.70(a) is met.	K 000	INITIAL COMMEN	ſS		K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE		A Life Safety Code Minnesota Departm time of this survey, found in substantial requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 1 Chapter 19 Existing Aitkin Health Service a full basement. Th constructed in 1955 dining room main e the existing building II(111) construction The building is fully facility has a comple smoke detection in open to the corridor automatic fire depa has a licensed capa census of 41 at the At this time, the cor	ent of Public Safety. Aitkin Health Service compliance with the articipation in at 42 CFR, Subpart ety from Fire, and the Fire Protection Association 01, Life Safety Code Health Care. The original building was with additions in 19 ntry was added in 20 and the addition are sprinkler protected. ete fire alarm system the corridors and sp that is monitored for the notification. The acity of 44 beds and time of the survey.	At the es was e 2000 ciation (LSC), (LSC), lding with as 62, and a 002. Both e type The n with aces or The facility had a				
	LABORATO	RY DIRECTOR'S OR PROV	DER/SUPPLIER REPRESE	ENTATIVE'S SIG	GNATURE	TITLE		(X6) DATE

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

	MENT OF HEALTH			FSI	19021	FORM	: 07/10/2013 APPROVED ). 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI			PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245119		B. WING		06/2	6/2013	
	ROVIDER OR SUPPLIER				STATE, ZIP CODE			
	IEALTH SERVICES			NNESOTA I, MN 5643	AVENUE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
K 000	INITIAL COMMENT	ſS		K 000				
LABORATO	Minnesota Departm time of this survey, found in substantial requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 1 Chapter 19 Existing Aitkin Health Service a full basement. Th constructed in 1955 dining room main e the existing building II(111) construction The building is fully facility has a comple smoke detection in open to the corridor automatic fire depa has a licensed capa census of 41 at the	at 42 CFR, Subpart ety from Fire, and the Fire Protection Assoc 01, Life Safety Code Health Care. The original building was with additions in 19 ntry was added in 20 and the addition are sprinkler protected. ete fire alarm system the corridors and sp that is monitored for timent notification. The acity of 44 beds and time of the survey. Inditions of 42 CFR, S	At the es was 2000 ciation (LSC), lding with as 62, and a 002. Both e type The n with aces or 'he facility had a Subpart	JNATURE	TITLE		(X6) DATE	
LABORATO	DIRECTOR S OR PROV	DEMOUPPLIER REPRESE	ENTATIVE'S SIG	JNAIURE	IIILE		(XO) DATE	

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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 3564

July 12, 2013

Ms. Carol Raw, Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, Minnesota 56431

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5119021

Dear Ms. Raw:

The above facility was surveyed on June 24, 2013 through June 27, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Aitkin Health Services July 12, 2013 Page 2

### PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

# THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to Pat Halverson at Minnesota Department of Health, 11 East Superior Street, Suite 290, Duluth, Minnesota 55802. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Pat Halveum

Pat Halverson, Unit Supervisor Licensing and Certification Program Division of Compliance Monitoring Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

Minneso	ta Department of He	ealth					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE		. ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
				A. BUILDING:		00111	
		00002		B. WING		06/2	7/2013
NAME OF P	ROVIDER OR SUPPLIER	00001	STREET AD	DRESS, CITY, 3	STATE, ZIP CODE	00/2	1/2010
			301 MINN AITKIN, N		ENUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORE	)ER				
	In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.						
	You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.						
Minnesota D	Department's staff, the following correct corrections are corr make a copy of the original to the Minn	TS: gh 06/27/13, surveyo , visited the above pro- ction orders are issue npleted, please sign ese orders and return lesota Department of ance Monitoring, Lice	ovider and ed. When and date, the Health,		Minnesota Department of Health is documenting the State Licensing Correction Orders using the federa software. Tag numbers have beer assigned to Minnesota state statu for nursing homes. The assigned to number appears in the far left colu	al 1 tes/rules tag	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

6899

TITLE

(X6) DATE

Minnesc	ta Department of He	alth				FORM APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00002		B. WING		06/27/2013
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	
AITKIN H	IEALTH SERVICES			NESOTA AVI MN 56431	ENUE SOUTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM#	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
2 000	Continued From pa	ge 1		2 000		
	<ul> <li>Continued From page 1</li> <li>Certification Program; 11 East Superior Street; Suite 290, Duluth, MN 55802</li> </ul>			entitled "ID Prefix Tag." The state statute/rule number and the corre- text of the state statute/rule out of compliance is listed in the "Summ Statement of Deficiencies" column replaces the "To Comply" portion correction order. This column also includes the findings which are in of the state statute after the stater "This Rule is not met as evidence Following the surveyors findings a Suggested Method of Correction a Time Period for Correction. PLEASE DISREGARD THE HEAI THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN O CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT T SUBMIT A PLAN OF CORRECTI VIOLATIONS OF MINNESOTA S STATUTES/RULES.	sponding ary n and of the violation ment, d by." ure the and the DING OF F F TO . THIS	
21385	MN Rule 4658.0800 Staff assistance	0 Subp. 3 Infection C	ontrol;	21385		
	Personnel must be infection control pro the residents and n	istance with infection assigned to assist w ogram, based on the ursing home, to imp ocedures of the infect	ith the needs of lement			
Minnesota D	by: Based on observati review, the facility o	ent is not met as evi on, interview and doo lid not provided appro ashing during a dress	cument opriate			
STATE FOR	-			6899	O5FJ11	If continuation sheet 2 of 4

FORM API Minnesota Department of Health									
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUF		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00002		B. WING		06/2	27/2013		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET.			DDRESS, CITY, STATE, ZIP CODE					
				NESOTA AVENUE SOUTH 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE		
21385	Continued From page 2			21385					
	change for 1 of 1 residents (R23) observed for stoma care.								
	R23 was observed on 6/26/13, at 7:49 a.m. during a dressing change to the peritoneal catheter site. The registered nurse (RN)-E, the surveyor and R23 donned surgical masks. RN-E applied soap on a sterile 4 X 4 gauze and water on a second 4 X 4 gauze, then washed hands and donned gloves. RN-E removed the contaminated catheter site dressing from R23's abdomen and cleaned the skin around the catheter with the prepared soap and water gauze. RN-E used sterile Q tips to apply Gentamicin (antibiotic) cream to the skin around the catheter. without changing gloves or performing hand hygiene, RN-E applied the clean gauze dressing around the catheter site and placed a protective dressing over the gauze dressing to secure the catheter. RN-E removed her gloves at that time, tied up garbage, and washed her hands.								
	glove change between removing the old dressi and applying a new dressing because it was no sterile procedure.								
	RN-F, unit manager, was interviewed on 6/26/ at 8:20 a.m., and stated that facility policy directed hand washing between removal of the old dressing and application of the new dressing								
	(DON) stated staff	a.m. the director of should have changed between the dirty an	d gloves						

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Minnesc	ta Department of He	alth							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
00002			B. WING		06/27/2013				
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DDRESS, CITY, STATE, ZIP CODE					
				NESOTA AVENUE SOUTH 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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
21385	Continued From page 3			21385					
	tasks of the dressing change.								
Vinnesota D	<ul> <li>Review of the policy for Peritoneal Dialysis Catheter dated 1/31/13, indicated staff were to follow this policy for dressing change: a. Mask, wash hands and don gloves, b. Remove dressing, c. Remove gloves and wash hands, d. Don gloves, e. Clean exit siteapply Gentamicin cream to exit site, f. Allow to dry for 1 minute, g. Apply Telfa dressing over site.</li> <li>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise policies and procedures to ensure infection control procedures and standards are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance.</li> <li>TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.</li> </ul>								

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