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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: O9W4
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 **05/22/2017** (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

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE　Date :
Teresa Ament, Unit Supervisor　06/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL　Date:
Joanne Simon, Certification Specialist　07/31/2017 (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
06/05/2017
(L33)

Posted 07/31/2017 Co.

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered   June 28, 2017

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

RE: Project Number S5363026

Dear Ms. Matalamaki:

On April 14, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 30, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 22, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 2, 2017 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 March 30, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 9, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 30, 2017, effective May 9, 2017 and therefore remedies outlined in our letter to you dated April 14, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161   Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

An equal opportunity employer.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

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Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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

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Facility ID: 00848

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(L4) **850 SECOND STREET NORTHWEST**
(L5) **AITKIN, MN** (L6) **56431**

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

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6. DATE OF SURVEY **03/30/2017** (L34)

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FISCAL YEAR ENDING DATE: (L35)
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And/Or Approved Waivers Of The Following Requirements:
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__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

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

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

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

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NE II 04/25/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/05/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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(L44)
B. Rescind Suspension Date:
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26. TERMINATION ACTION: (L30)

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00-Active

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29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/05/2017
(L33)

DETERMINATION APPROVAL

Electronically delivered
April 14, 2017

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

RE: Project Number S5363026

Dear Ms. Matalamaki:

On March 30, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567), has been electronically delivered.

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 May 9, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 16, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

• 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 June 30, 2017 (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 September 30, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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, 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 ______	03/30/2017

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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money	F 278		5/9/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 04/20/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING ______ B. WING ______	03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 278	Continued From page 1 penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) identified dental status for 1 of 3 residents (R47) reviewed for dental. Findings include: R47's annual Minimum Data Set (MDS) dated 2/1/17, indicated R47 was moderately cognitively impaired, and required extensive assistance with personal hygiene. The MDS further indicated R47 had no oral/dental issues. R47's care plan dated 2/13/17, directed staff to brush R47's upper dentures. R47's Admission Nursing Assessment (ANA) dated 1/30/16, indicated R47 had a full upper denture and own lower teeth in poor repair, with evidence of cavities/decay. R47's ANA further indicated R47 had 2 teeth in the front lower right and 2 broken teeth at gum level on the left. On 3/27/17, at approximately 7:00 p.m. R47 was observed seated in wheelchair in his room. R47 was missing several of his lower teeth. R47 was interviewed and stated he wore an upper denture,	F 278	The facility does assess residents using the Minimum Data Set (MDS) review instrument specified by the State and approved by CMS not less frequently than once every 3 months. R47's annual MDS was corrected on 4/17/17 and his ARD date for his upcoming quarterly MDS is 5/4/17. Resident is presently in stable condition, denies oral/mouth discomfort or pain. Resident and family have declined dental exams since his admission on 1/29/2016. R47's MDS was coded incorrectly due to a transmission error from paper to electronic medical assessments. The admission nursing assessment on paper dated 1/30/2016 showed the dental status was correctly assessed. All residents most current MDS' were reviewed for accuracy. Resident Care Coordinators will make sure that MDS' are correct and correlate with nursing assessments. MDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 278	Continued From page 2 and confirmed he only had a few teeth remaining on the bottom. On 3/30/17, at 1:33 p.m. during an interview, registered nurse (RN)-B stated a full oral assessment was completed for residents upon admission and with the annual MDS. RN-B confirmed R47 had no dental work completed since admission to the facility on 1/30/16, and had not lost any remaining lower teeth. RN-B further confirmed R47's annual MDS dated 2/1/17, was inaccurate related to R47's oral/dental status.	F 278	coordinator will monitor for compliance. Results will be reported to the QA committee.	
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oral care was provided for 1 of 3 residents (R47) reviewed for dental. Findings include: R47's annual Minimum Data Set (MDS) dated 2/1/17, indicated R47 was moderately cognitively impaired, and required extensive assistance with personal hygiene. The MDS further indicated R47 had no oral/dental issues. R47's care plan dated 2/13/17, directed staff to brush R47's upper dentures.	F 311	Every resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. R47's care plan was reviewed and corrected on 3/30/2017 to brush full upper dentures and assist brushing remaining lower teeth using toothbrush and toothpaste per residents wishes. All residents charts were reviewed by nursing on 4/3/17 – 4/20/17 to assure that residents with own teeth receive the appropriate oral care.	5/9/17

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

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F 311	Continued From page 3 R47's Admission Nursing Assessment (ANA) dated 1/30/16, indicated R47 had a full upper denture and own lower teeth in poor repair, with evidence of cavities/decay. R47's ANA further indicated R47 had 2 teeth in the front lower right and 2 broken teeth at gum level on the left. On 3/27/17, at approximately 7:00 p.m. R47 was observed seated in wheelchair in his room. R47 was missing several of his lower teeth. R47 was interviewed and stated he wore an upper denture, and confirmed he only had a few teeth remaining on the bottom. On 3/30/17, at 12:31 p.m. nursing assistant (NA)-B confirmed she had assisted R47 with oral cares. NA-B stated the night shift would clean R47's upper plate, and the day shift rinsed and applied adhesive prior to placing the denture into R47's mouth. NA-B was unsure if R47 had any of his own teeth on the bottom. NA-B confirmed she had never brushed R47's lower teeth, though would provide him with a toothette dipped in water so he could independently swab/cleanse his mouth when he was willing to do so. On 3/30/17, at 12:48 p.m. R47 stated he utilized a "foam thing" on his teeth. R47 stated it wasn't like using a toothbrush as it didn't have much abrasion. R47 further stated he would rather use a toothbrush and toothpaste. On 3/30/17, at 1:15 p.m. the director of nursing (DON) was interviewed and stated she was unaware R47 did not have a toothbrush and thought one may be in his nightstand. The DON confirmed R47 should have had access to a toothbrush as they have them available for	F 311	Nursing Assistants were encouraged to offer toothbrushes to residents with own teeth to provide optimal oral hygiene. In-service/Education to deliver optimal daily oral care for residents is scheduled for nursing staff from 4/25/17 – 4/27/2017. Team leaders will audit oral cares on a weekly basis, DON/designee will monitor for compliance. Results of the audits will be reported to the QA committee.	

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

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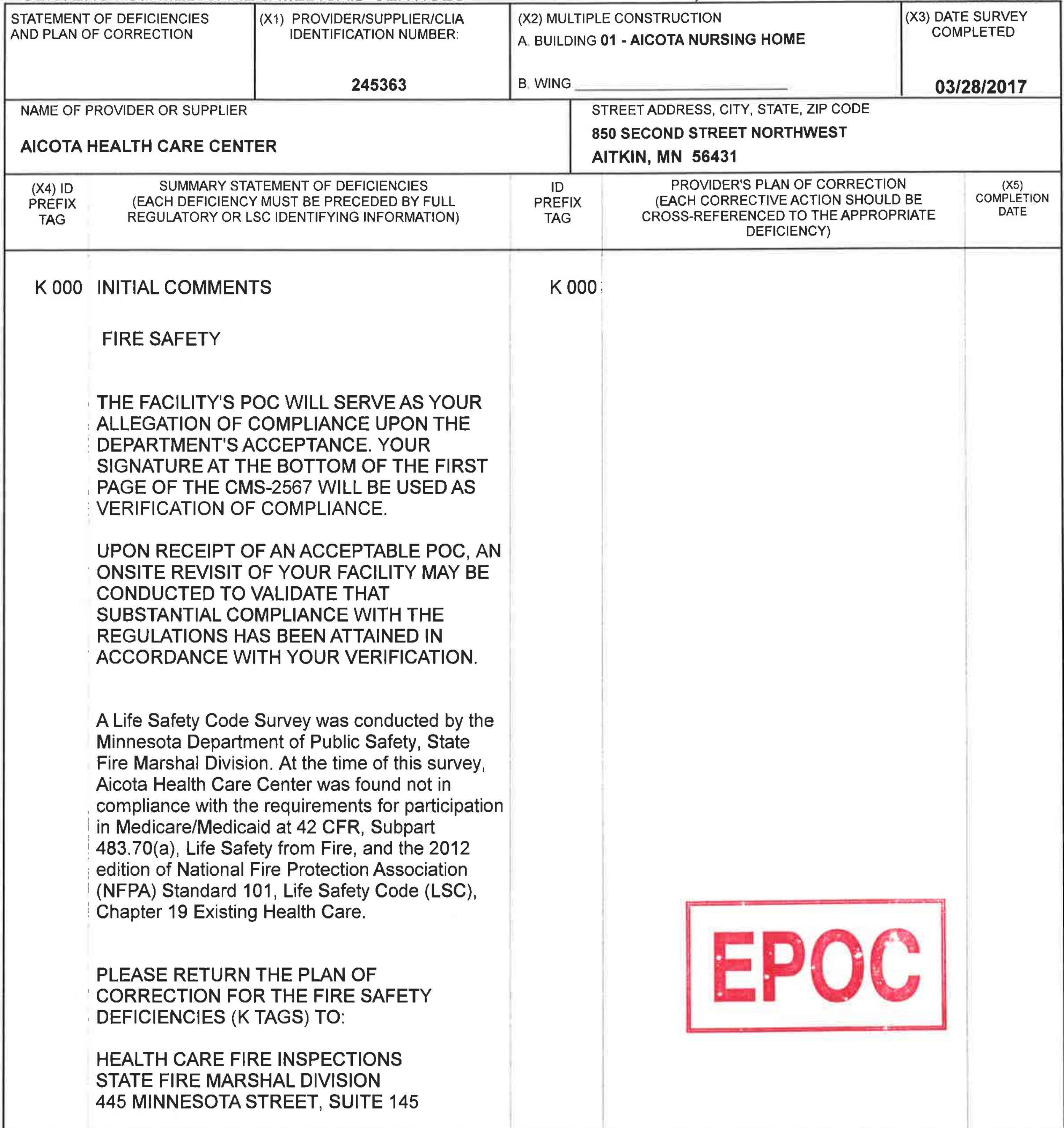
F 311	Continued From page 4 residents. On 3/30/17, at 1:33 p.m. during an interview, registered nurse (RN)-B stated a full oral assessment was completed for residents upon admission and with the annual MDS. RN-B verified R47 had no dental work completed since admission to the facility on 1/30/16, and had not lost any remaining lower teeth.	F 311		



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING **01 - AICOTA NURSING HOME** B. WING _______	**03/28/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/21/2017

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 ST. PAUL, MN 55101-5145, or 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. The facility was inspected as one building. 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	K 000		

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K 000	Continued From page 2 have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 75 beds and had a census of 57 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 111 SS=F	NFPA 101 Building Rehabilitation Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 18 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire	K 111		4/20/17

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K 111	Continued From page 3 doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8) This STANDARD is not met as evidenced by: Based on observations and staff interview the major renovation and construction projects are not maintained in compliance with NFPA 101 "The Life Safety Code" 2012 edition sections 4.6.10 and NFPA 214 the Standard for safeguarding Construction, Alteration, and Demolition Operations 2009 edition, section 8.6. The failure to maintain required safe construction operations could allow a decrease in the fire protection and life safety capability in the event of an emergency that could affect 57 of 57 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:00 a.m. to 4:00 p.m. on 03/28/2017, the following observations were made: 1. There were multiple construction are located throughout the facility that were not provided with the required fire rated construction separations. At the time of the inspection the contractors had affixed two layers of poly with tape to the under side of ceiling tile as their construction separation. When the contractors were ask where is the 1 hour fire rated construction separation the contractors were unable to provide an answer. After the observations were made the	K 111	As already stated in the deficiency, a 1 hour construction separation was constructed in the area of concern the same day it was identified. The contractor has continued to do this as the construction moves to different areas of the building. This will ensure not only the fire safety but also resident safety to help prevent entering construction areas. Glass has been installed in fire rated doors and the same doors have been adjusted to correct installation including closures interlocked with fire alarm system. Doors are completely operable as required by NFPA 101. The Maintenance Supervisor along with cooperation of contractor is responsible for continued compliance.	

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K 111	Continued From page 4 construction company started installing a 1 hour construction separation which they completed prior to the end of the facility's Life Safety Code inspection. 2. It was also observed that in the southwest hall a resident in a reclining style wheelchair that was not capable of self preservation and could not wheel herself out of the area was seen in an area that had ceiling tiles removed for work that was being conducted in the ceiling space. The resident was removed from the area after the observation was identified. 3. The set of fire rated doors located in the smoke barrier at the entry of the southwest wing were not equipped with fire rated windows and were not self closing. The contractors installed two layers of 5/8 inch gypsum into the window openings and also installed a door closer to both of the fire doors. 4. There is a gap greater than 1/8 of an inch between the fire rated double doors installed in the Smoke barrier wall at the entrance to the southwest wing of the facility that is under construction. This deficient condition was verified by a Maintenance Supervisor.	K 111		
K 342 SS=F	NFPA 101 Fire Alarm System - Initiation Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of	K 342		4/6/17

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K 342	Continued From page 5 egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This **STANDARD** is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition, sections 19.3.4.2.1 and 9.6, as well as 2010 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 57 of 57 residents, as well as an undetermined number of staff, and visitors Findings include: On facility tour between 9:00 a.m. to 4:00 p.m. on 03/28/2017, observations revealed that the facility is replacing their fire alarm system which has been ongoing for more than 24 hour. The facility also stated that the fire sprinkler system will sound an alarm but the early notification capabilities of smoke detection manual fire alarm pull boxes that are located throughout the corridors and spaces open to the corridors were not functioning or were limited to a zone on the fire alarm system. It was also noted that during the facility inspection that none of the manual fire	K 342	Maintenance to the existing fire alarm system has been completed and is fully operational. Maintenance Supervisor is responsible to monitor for continued compliance.	

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K 342	Continued From page 6 alarm pull stations were either in place or functioning at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 342		
K 346 SS=F	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to implement a fire watch in the event that the fire alarm system being 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 57 of 57 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 9:00 a.m. to 4:00 p.m. on 03/28/2017, observations revealed that the facility is installing a new fire alarm system and there are multiple zone within the facility that do not have smoke detectors functioning and they do not have any manual fire alarm pull stations operational throughout the facility. The fire alarm system has	K 346	A continuous fire watch was implemented the same day of the tour. This watch was utilized each time the fire alarm system was shut down for maintenance for an extended time as required under NFPA 101. This watch will continue to be utilized in the future whenever maintenance of the fire alarm system forces a shutdown of the system. Fire alarm system maintenance is complete and fully operational. Maintenance Supervisor is responsible to monitor for continued compliance.	4/6/17

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K 346	Continued From page 7 been incomplete with no smoke detection in multiple zones for more than 4 hours in a 24 hour period. The facility at the time of the inspection had not implemented a continuous fire watch as per their fire watch policy. The maintenance supervisor did provide documentation that he had completed 2 fire watch walks in the facility but that he had failed to ensure that the fire watch walks of the facility had been completed on a continuous basis at least every 30 minutes. This deficient condition was verified by a Maintenance Supervisor.	K 346		
K 347 SS=F	NFPA 101 Smoke Detection Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition, sections 19.3.4.5.2, 19.3.6.1 and 9.6, as well as 2010 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 57 of 57 residents, as well as an undetermined number of staff, and visitors Findings include:	K 347	Communication between fire alarm contractor and Aicota maintenance personnel became a priority that same day of survey. Contractor communicated to maintenance personnel each time an area of the building would not have the complete fire safety functioning so that a continuous fire watch could be implemented for that area until that area's fire safety maintenance was completed. Maintenance Supervisor is responsible to monitor for continued compliance.	4/6/17

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K 347	Continued From page 8 On facility tour between 9:00 a.m. to 4:00 p.m. on 03/28/2017, observations revealed that the facility is replacing their fire alarm system which has been ongoing for more than 24 hour. The facility also stated that the fire sprinkler system will sound an alarm but the early notification capabilities of smoke detection that is located throughout the corridors and spaces open to the corridors were not functioning or were limited to a zone on the fire alarm system. The following deficient conditions were also noted during the inspection related to the fire alarms system as it was at the time of the inspection: 1. The facility was replacing an old fire alarm system out with a new fire alarm by replacing it in zoned sections. At the time of the inspection the fire alarm contractor nor the maintenance supervisor could provide a zone map of what smoke detectors were not activated or functioning. 2. There were multiple zones of smoke detection that were not connected to the fire alarm panel or functioning at the time of the inspection. When the fire alarm installer or the Maintenance Supervisor was questioned about the smoke detectors located in different parts of the facility, they stated that the smoke detectors were not working or connected to the fire alarm system. This deficient condition was verified by a Maintenance Supervisor.	K 347		
K 351 SS=D	NFPA 101 Sprinkler System - Installation Spinkler System - Installation	K 351		4/3/17

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

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K 351	Continued From page 9 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (10) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 20 of 57 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:00 a.m. to 4:00 p.m. on 03/28/2017, observations revealed that there was a missing sprinkler escutcheon ring from a sprinkler head that is located in the northeast exit vestibule.	K 351	Sprinkler escutcheon ring was installed on the identified sprinkler. A walk through of the entire building was completed by the maintenance department to ensure there were no other rings missing. Maintenance Supervisor is responsible to monitor for continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING 01 - AICOTA NURSING HOME B. WING	03/28/2017

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

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K 351	Continued From page 10 This deficient condition was verified by a Maintenance Supervisor.	K 351		
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire	K 363		3/31/17

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	245363	A. BUILDING **01 - AICOTA NURSING HOME** B. WING	**03/28/2017**

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

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K 363	Continued From page 11 protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 2 of several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition. This deficient practice could affect 20 of 57 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 9:00 a.m. to 4:00 p.m. on 03/28/2017, observations revealed that resident room 239 has a corridor door that did not fully close and latch into the door frame. This deficient condition was verified by a Maintenance Supervisor.	K 363	The identified door was adjusted to close and latch properly. A walkthrough of the building was completed by the maintenance department to ensure all doors close and latch properly. Maintenance Supervisor is responsible to monitor for continued compliance.	
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system	K 372		4/3/17

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING **01 - AICOTA NURSING HOME** B. WING ______	**03/28/2017**

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K 372	Continued From page 12 in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of 5 several smoke barrier walls in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 19-3.7.3 and 8.3. This deficient practice could affect 12 of 57 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 9:00 a.m. to 4:00 p.m. on 03/28/2017, observations and staff interviews revealed that the smoke barrier wall located by the main office had penetrations found around a sections of conduit that are passing through the smoke barrier wall above the ceiling tile over the double doors. This deficient condition was verified by a Maintenance Supervisor.	K 372	The identified smoke barrier penetration was filled and contractors have been instructed to fill any penetrations immediately upon completion of their tasks in any areas. Maintenance Supervisor along with cooperation of contractor is responsible to monitor for continued compliance.	

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 14, 2017

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5363026

Dear Ms. Matalamaki:

The above facility was surveyed on March 27, 2017 through March 30, 2017 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, Health Regulation 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 only a suggestion 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.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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.

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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 Teresa Ament at: (218) 302-6151 or email: teresa.ament@state.mn.us**.

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.

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

Sincerely,

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00848	A. BUILDING: ______ B. WING ______	03/30/2017

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 3/27/17 to 3/30/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oral care was provided for 1 of 3 residents (R47) reviewed for dental. Findings include: R47's annual Minimum Data Set (MDS) dated 2/1/17, indicated R47 was moderately cognitively	2 915	Corrected.	5/9/17

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2 915	Continued From page 3	2 915		

impaired, and required extensive assistance with personal hygiene. The MDS further indicated R47 had no oral/dental issues.

R47's care plan dated 2/13/17, directed staff to brush R47's upper dentures.

R47's Admission Nursing Assessment (ANA) dated 1/30/16, indicated R47 had a full upper denture and own lower teeth in poor repair, with evidence of cavities/decay. R47's ANA further indicated R47 had 2 teeth in the front lower right and 2 broken teeth at gum level on the left.

On 3/27/17, at approximately 7:00 p.m. R47 was observed seated in wheelchair in his room. R47 was missing several of his lower teeth. R47 was interviewed and stated he wore an upper denture, and confirmed he only had a few teeth remaining on the bottom.

On 3/30/17, at 12:31 p.m. nursing assistant (NA)-B confirmed she had assisted R47 with oral cares. NA-B stated the night shift would clean R47's upper plate, and the day shift rinsed and applied adhesive prior to placing the denture into R47's mouth. NA-B was unsure if R47 had any of his own teeth on the bottom. NA-B confirmed she had never brushed R47's lower teeth, though would provide him with a toothette dipped in water so he could independently swab/cleanse his mouth when he was willing to do so.

On 3/30/17, at 12:48 p.m. R47 stated he utilized a "foam thing" on his teeth. R47 stated it wasn't like using a toothbrush as it didn't have much abrasion. R47 further stated he would rather use a toothbrush and toothpaste.

On 3/30/17, at 1:15 p.m. the director of nursing

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2 915	Continued From page 4 (DON) was interviewed and stated she was unaware R47 did not have a toothbrush and thought one may be in his nightstand. The DON confirmed R47 should have had access to a toothbrush as they have them available for residents. On 3/30/17, at 1:33 p.m. during an interview, registered nurse (RN)-B stated a full oral assessment was completed for residents upon admission and with the annual MDS. RN-B verified R47 had no dental work completed since admission to the facility on 1/30/16, and had not lost any remaining lower teeth. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure oral cares are provided. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar	21942		4/5/17

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21942	Continued From page 5 year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview, the facility failed to attempt to form a family council. This had the potential to affect all 56 residents in the facility. Findings include: On 3/29/17, at 2:22 p.m. the social services director (SSD) verified the facility does not have a family council and has not attempted to form an official family council. SSD stated she sends out a letter yearly to invite families to attend an annual meeting the facility called family council. SSD stated the meeting is focused on a specific topic; hospice was discussed this year and previously the topic was dementia. The facility was unable to provide a policy and procedure for family council. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee and social service director could develop, review, and/or revise policies and procedures to ensure a family council is formed or attempted to be formed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942	Corrected.	

Minnesota Department of Health

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