Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 8, 2022

Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

RE: CCN: 245363
Cycle Start Date: September 29, 2022

Dear Administrator:

On December 1, 2022, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 8, 2022

Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

Re: Reinspection Results
Event ID: P4M312

Dear Administrator:

On December 1, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 29, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Electronically delivered
October 14, 2022

Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

RE: CCN: 245363
Cycle Start Date: September 29, 2022

Dear Administrator:

On September 29, 2022, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 29, 2022 (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).

In addition, if substantial compliance with the regulations is not verified by March 29, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 _____	09/29/2022

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 On 9/26/22 to 9/29/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5363022C (MN00076448), with a deficiency cited at F689. The following complaints were found to be UNSUBSTANTIATED: H53634763C (MN00083783). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 567 SS=C	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to	F 567		11/11/22

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

Electronically Signed | 10/21/2022

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

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F 567	Continued From page 1 deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to have residents personal funds available after hours and on weekends for 2 of 2 residents (R21, R29) reviewed for personal funds. This had the potential to affect 37 residents who	F 567	R29 and R21 were educated on how to access resident funds. All residents will be educated on how to access resident trust accounts. Update resident trust policy and resident handbook to include that trust	

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F 567	Continued From page 2 had funds held by the facility in a trust account. Findings include: During an interview on 9/27/22, at 8:39 a.m. R29 stated he had no idea if the facility was holding any money for him and said his daughter was handling his money. During an interview on 9/27/22, at 9:06 a.m. R21 stated the facility was holding money for her but she stated she had "no idea" if anyone was getting statements. During an interview on 9/28/22, at 12:15 p.m. patient accounts/billing (PA)-A confirmed R21 had a trust account and her son was getting the statements. PA-A confirmed R29 had a trust account with the facility and his daughter was getting the statements. During an interview on 9/28/22, at 12:25 p.m. registered nurse (RN)-A confirmed she worked weekends. RN-A stated she was not sure if a resident had access to the money in their trust account on a weekend. RN-A confirmed there was not a cash box with money for residents at the nurses station or in the locked medication room. During an interview on 9/28/22, at 12:28 p.m. licensed practical nurse (LPN)-A confirmed she worked weekends. LPN-A stated she didn't think residents had any access to their money on a weekend. During an interview on 9/29/22, at 12:30 p.m. RN-B stated residents were only able to access their personal funds during business hours	F 567	funds are available 24/7 via nurse. All staff will be educated on how residents can access personal funds. Audits will be completed with new residents to determine if they know how to access resident funds. Audit results will be brought to QAPI for further review and recommendations.	

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F 567	Continued From page 3 Monday through Friday. RN-B stated residents were made aware of this when they were admitted and signed a statement acknowledging this policy. During an interview on 9/29/22, at 1:08 p.m. the director of nursing (DON) stated the policy indicated funds could only be obtained Monday through Friday during business hours. The DON stated residents signed a paper acknowledging they understood this. Facility Form A no date, indicated resident funds would be available from "8:00 a.m. to 4:00 p.m. Monday - Friday. On holidays, weekends and after the aforementioned (sp) hours, moneys may be available from the Charge Nurse for an amount up to $10.00". The facility's Resident Handbook dated 5/2021, indicated resident funds would only be available from the Business Office from 8:00 a.m. to 4:30 p.m. Monday through Friday.	F 567		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify use of continuous positive air way pressure (CPAP) therapy on the Minimum Data Set (MDS) for 1 of 1 resident (R51) reviewed for accurate MDS. Findings include:	F 641	Order was obtained for R51's CPAP, CPAP was added to the plan of care, MDS modified to include use of CPAP. All residents with CPAP/admitted with CPAP will be assessed for MDS accuracy in relation to obstructive sleep apnea and use of CPAP. Education provided to	11/11/22

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F 641	Continued From page 4 R51's Admission Record printed on 9/29/22, identified a diagnosis of obstructive sleep apnea. R51's five day admission MDS, dated 9/19/22, did not identify R51's CPAP use. R51's Nursing-Admission/Readmission Evaluation dated 9/12/22, and completed by registered nurse (RN)-B indicated R51 used CPAP therapy. On 9/27/22, at 10:06 a.m. R51 stated the staff donned personal protective equipment at night when she was wearing her CPAP. On 9/27/22, at 4:10 p.m. outside of R51's door was a three drawer bin with PPE supplies. The sign on the door indicated she was in contact and droplet precautions at night. On 9/28/22, at 8:35 a.m. R51 stated she takes her CPAP off herself in the morning when she woke up. R51 stated staff wore PPE when she had her CPAP running at night. During an interview on 9/29/22, 12:31 p.m. RN-B stated R51 was in isolation for CPAP use. RN-B stated she completed R51's admission MDS but stated during the completion window R51 was not wearing her CPAP. During an interview on 9/29/22, at 3:46 p.m. the director of nursing (DON) stated CPAP therapy should have been noted on the admission MDS. The DON stated if CPAP therapy was indicated on the admission assessment it should have been on the admission MDS. The DON stated accuracy of the MDS was important for care of	F 641	Neighborhood Team Leaders regarding coding of CPAP, and this was discussed with Minnesota Dept of Health Case Mix. CPAP/BIPAP policy reviewed with no changes. DON or designee will audit MDS for all resident's using CPAP/BIPAP for proper coding of CPAP/BIPAP whenever an MDS is done for a resident who has one for the next 3 months. Audit results will be brought to QAPI for review and recommendation.	

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F 641	Continued From page 5 the resident and for payment. The facility policy titled Policy and Procedure for Completion of the Minimum Data Set and Quarterly Reviews dated 7/20/22, indicated all persons completing a portion of the MDS were responsible for the accuracy of that information and would verify by signing/dating in the appropriate section of the MDS.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		11/11/22

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F 656	Continued From page 6 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop and implement a care plan intervention for the monitoring and management of continuous positive airway pressure (CPAP) therapy for 1 of 1 resident (R51) reviewed for careplans. Findings include: R51's Admission Record printed on 9/29/22, identified a diagnosis of obstructive sleep apnea. R51's five day admission Minimum Data Set (MDS), dated 9/19/22, did not identify R51's CPAP use, therefore there were not any Care Area Assessments (CAAs) for respiratory therapy. R51's care plan initiated on 9/12/22, did not address R51's CPAP therapy. R51's Order Summary Report dated 9/29/22, did not have any orders for CPAP therapy.	F 656	Order was obtained for R51's CPAP, CPAP was added to the resident plan of care. All residents with CPAP/admitted with CPAP will be assessed for MDS accuracy in relation to obstructive sleep apnea and use of CPAP. Education provided to Neighborhood Team Leaders on care planning policy and regarding care planning process and items that should be included on the care plan. All staff educated on CPAP/BIPAP policy and changes to care planning policy. Care planning policy was reviewed and revised per current regulations and standard of care. DON or designee will audit care plans for respiratory focus on residents with Obstructive Sleep Apnea and/or CPAP/BIPAP use 3/wk X4 weeks, then once weekly for 4 weeks, Audit results will be brought to QAPI for further review and recommendation.	

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F 656	Continued From page 7 R51's progress note dated 9/12/22, 3:19 p.m. indicated a Nursing Admission/Readmission Assessment had been completed. The assessment completed by registered nurse (RN)-B indicated R51 used CPAP therapy. R51's progress note dated 9/12/22, 4:34 p.m. indicated "A transmission based precaution assessment has been completed on R51. Resident is on Droplet Precautions for the following S/S: OR Resident is on Contact Precautions for the following items:. No specimen needed at this time. Resident is alert and oriented and able to understand and follow the appropriate precautions. Resident does use appropriate hand hygiene. Interventions that have been implemented: Precaution stand has been placed. Covered hamper and trash cans now placed. Supplies for the room have been gathered. Sign placed on room door." There were no progress notes to indicate R51 used CPAP therapy at night. On 9/27/22, at 10:06 a.m. R51 stated the staff donned personal protective equipment at night when she was wearing her CPAP. On 9/27/22, at 4:10 p.m. outside of R51's door was a three drawer bin with PPE supplies. The sign on the door indicated she was in contact and droplet precautions at night. On 9/28/22, at 8:38 a.m. R51 stated she was told she was in isolation when she was admitted because she did not have her COVID-19 booster. R51 was told the isolation precautions would be for seven days. R51 stated the staff wore personal protective equipment (PPE) when she	F 656		

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F 656	Continued From page 8 had her CPAP running. She stated she had never been told her door should be shut if she was wearing her CPAP. R51 stated she would remove her CPAP when she woke in the morning. During an interview on 9/29/22, at 12:31 p.m. RN-B stated R51's isolation precautions were for her CPAP use at night. RN-B reviewed R51's care plan and verified CPAP therapy was not part of the care plan nor were there any interventions related to R51's isolation precautions. RN-B verified the careplan was used to direct resident care. RN-B stated she completed R51's admission MDS. During an interview on 9/29/22, at 12:44 p.m. RN-D stated staff knew they needed to wear an N95 mask whenever there was an aerosolizing procedure, which would include CPAP use. RN-D verified CPAP therapy and PPE use should have been included in R51's care plan. During an interview on 9/29/22, at 3:46 p.m. the director of nursing (DON) stated CPAP therapy and need for isolation during therapy should have been part of R51's care plan. The facility policy titled Care Planning Policy and Procedure dated 8/6/21, indicated the purpose of the care plan was to provide a care plan for the resident's total care, to promote continuity of care, and to communicate vital information to all staff providing direct resident care. The facility policy titled Policy and Procedure for BI-PAP/CPAP Policy dated 2/4/15, included indications for use, procedures to follow, mask adjustment, cleaning, safety precautions, and trouble shooting.	F 656		

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	245363	A. BUILDING _____ B. WING _____	09/29/2022

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care plans for falls were being followed for 2 of 3 residents (R24, R42) reviewed for falls. Findings include: Resident #24 R24's significant change Minimum Data Set (MDS) dated 7/16/22, indicated severe cognitive impairment. R24 required extensive assistance with transferring and toileting. Diagnoses included Alzheimer's disease, hip fracture, and presence of right artificial hip. R24's care plan dated 8/7/22, indicated R24 was at moderate/high risk for falls related to impulsiveness, had a fall on 7/5/22, resulting in a left hip fracture and required surgery. Interventions included do not leave in room unattended in wheelchair, do not leave unattended in bathroom, and high/low bed in low position. A progress note for 7/5/22, indicated R24 was self-transferring from bed to wheelchair when he	F 689	R24's care plan regarding fall prevention strategies was reviewed and revised based on current status of resident. R42 care plan reviewed with no changes. Staff were re-educated on fall interventions for R24 and R42. All Kardex's are reprinted and reviewed to be current with fall interventions. Care planning policy and procedure reviewed and revised to include method of notifying staff with changes to the Kardex/plan of care. Neighborhood team leaders educated on change in policy and procedure. All staff will be educated regarding the change. All staff will be educated on following the care plan and where to find current interventions/Kardex. DON or designee will audit staff following interventions for fall interventions as well as rest of Kardex with 3 residents/week X4 weeks and then 1 resident per week X4 weeks, audit results will be brought to QAPI for further review and recommendations.	11/11/22

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F 689	Continued From page 10 stated his leg twisted and he slipped. R24 had pain with movement of left lower extremity and was sent to the emergency room. A progress note later in the day indicated R24 was admitted back to the facility with a left hip fracture. The facility investigation dated 7/8/22, indicated R24 was self-transferring from his bed to his wheelchair when his left leg twisted. R24 did not identify why he was transferring due to pain in left leg. Interventions were in place. Following R24's return after hospitalization the care plan was updated to pace a bed alarm (silent for R24) to identify movement in his room. Also restated to not leave R24 unattended in room or bathroom while in wheelchair. During observation on 9/28/22, at 11:33 R24 was in his room watching TV while in his wheelchair. There were not staff in the room with R24 and staff was observed to walk the room and not check on R24. During observation on 9/29/22, at 9:00 a.m. R24 was in his room and nursing assistant (NA)-A walked by R24's room without looking in. At 9:03 a.m. R24 moved his wheelchair next to his bed, moved his call light out of the way, and then R24 self-transferred to the bed. During an interview on 9/29/22, at 9:35 a.m. NA-A stated R24 has frequently self-transferred himself between the wheelchair, bed, and bathroom. R24 does not use the call light with most of his transfers. NA-A stated she did not see R24 in the room until after he self-transferred to bed. She stated she should have looked in R24's room as she went by.	F 689		

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F 689	Continued From page 11 During an interview on 9/29/22, at 9:49 a.m. NA-B stated R24 interventions for falls included low bed, bed against wall, call light in reach, and a fall mat on the floor. NA-B stated it was okay for R24 to be alone in his room. NA-B then checked the care plan and stated he was not supposed to be left alone in his room and should have been redirected out of his room. During an interview on 9/29/22, at 2:44 p.m. registered nurse (RN)-B stated she would expect staff to review R24's Kardex (abbreviated care plan) to ensure the correct interventions were being used. During an interview on 9/29/22, at 4:00 p.m. the director of nursing (DON) stated it was the expectation of all staff to follow the care plan for R24. If R24 was in the room, then staff should have checked in the room as they were going by. The DON stated the staff should have checked on R24 as they were walking by his room. Resident #42 R42's admission Minimum Data Set (MDS) dated 8/21/22, indicated R42 had severe cognitive impairment and required extensive assist with transferring, toileting, and bed mobility. The MDS indicated R42 had falls in the six months prior to admission, but none since admission. R42 Care Area Assessment (CAA) dated 8/31/22 indicated R42 had a history of actual fall with major injury on 6/28/22, (prior to admission) related to weakness and decreased mobility.	F 689		

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F 689	Continued From page 12 R42's care plan dated 8/26/22, indicated R42 was at risk for falls and an intervention included high/low bed in low position. During observation on 09/27/22, at 9:01 a.m. R42 was laying in the bed and the bed was in high position During continuous observation on 9/28/22, from 7:32 a.m. through 8:29 a.m. R42 was in bed and the bed was in a high position. During an interview on 9/29/22, at 9:35 a.m. nursing assistant NA-A stated R42 did have an intervention for falls on his care plan to have bed in low position when R42 was alone in room. NA-A stated whenever she went by R42's room and the bed was in the high position, she would stop and make sure the bed was lowered. R42 had moved his legs out of bed in the past and was a falls risk and needed the bed in the low position. During an interview on 9/29/22, at 2:44 p.m. registered nurse (RN)-B stated staff were expected to review R42's Kardex when there were question about fall interventions. The expectation was the care plan would be followed. During an interview on 9/29/22, at 4:00 p.m. the director of nursing (DON) stated staff should not have left R42's room with the bed in high position while R42 was in bed. The expectation was that staff would have followed the care plan to ensure R42 would have remained safe. The facility's undated policy for Fall Prevention and Management indicated the facility would provide appropriate interventions needed to	F 689		

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F 689	Continued From page 13 improve safety of the resident and was to be identified on the care plan. Staff would deliver safe and personalized care to the residents.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		11/11/22

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F 690	Continued From page 14 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document, review the facility failed to the develop interventions for the use of an indwelling urinary to prevent complications for 1 of 2 residents (R24) reviewed for urinary catheter care. Findings include: R24's significant change Minimum Data Set (MDS) dated 7/16/22 indicated severe cognitive impairment. R24 was an extensive assist with toileting and had an indwelling urinary catheter. Diagnoses included Alzheimer's disease, benign prosthetic hyperplasia (BPH) (enlarged prostate), obstructive uropathy, and urethral stricture (unable to void properly due to narrowing of the urethra). R24's care plan dated 8/7/22 indicated he had a urinary catheter due to BPH and urinary obstruction. Interventions included staff should provide catheter cares every shift, and straight drain at all times. During observation on 9/26/22, at 3:13 p.m. R24 had a dignity bag holding an urinary catheter bag hanging on the left armrest of his wheelchair above the level of the bladder. The catheter tubing going thorough the bottom of left pants leg looped down below the left foot rest and before going to urinary catheter bag. During observation on 9/27/22, at 9:04 a.m. R24's dignity bag holding the urinary catheter bag was tied to the left armrest of his wheelchair.	F 690	R24's catheter bag was placed lower than the bladder. All residents with urinary catheters were assessed to assure that their drainage device was lower than the level of the bladder, no additional issues were identified. Catheter Care policy reviewed with no changes made as it reflects current standard of practice in relation to indwelling catheters. Alternative dignity covers researched and ordered to assist with easier placement of catheter bag below the level of the bladder. All staff will be educated on catheter care policy and procedure and care of indwelling catheters. DON or designee will complete audits on residents with an indwelling catheter 3 times a week X4 weeks and 1 time a week X 4 weeks. Results of Audits will be brought to QAPI for further review and recommendation.	

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F 690	Continued From page 15 During observation on 9/28/22, at 9:05 a.m. R24 had urinary catheter Foley bag in a dignity bag tied to the left arm rest of the wheelchair. This had the tubing going through his left pants leg and coming out of the bottom of the pants leg and looped up to the Foley catheter bag which was above the level of R24's bladder. During observation on 9/28/22, at 12:23 p.m. R24 was sitting in the hall outside of the dining room. R24's dignity bag holding the urinary catheter bag was tied to the left armrest of his chair and the catheter tubing, which was was filled with a yellow cloudy urine, was going through left pants leg and looped up to the urinary catheter bag. During observation on 9/29/22, at 8:50 a.m. R24 was wheeling himself down the hall and approximately 10 inches of the catheter tubing, which was filled with yellow cloudy urine, was dragged on the floor under R24's wheelchair. During an interview on 9/29/22, at 9:35 a.m. nursing assistant (NA)-A stated R24 had a urinary catheter, and it should be below the level of the resident's bladder so it would drain properly, and the tubing should remain off the floor for cleanliness. R24 should not have had the urinary catheter bag tied to the arm of the wheelchair. During an interview on 9/29/22, at 9:49 a.m. NA-B stated R24 had a urinary catheter, and it should be attached to the wheelchair below the level of the bladder and the tubing should not be on the floor. The urinary catheter bag was attached to the arm rest of the wheelchair and they would reposition it the next time they drain his catheter, but may be tied to the arm rest for a couple of	F 690		

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F 690	Continued From page 16 hours. During an interview on 9/29/22, at 2:44 p.m. registered nurse (RN)-B stated R24 had a urinary catheter, and the urinary catheter bag should be below the level of the bladder and the tubing should not be dragging on the floor. R24 tried to drain the urinary catheter bag frequently and would not place it in the correct position. According to RN-B, it was important for the urinary catheter bag to be below the level of the bladder to encourage the flow of urine and empty the bladder. If the urinary catheter bag was higher, it could cause urinary tract infection (UTI). urine retention or possible blockage of the urinary catheter. RN-B would expect staff ensure proper placement of the urinary catheter bag and to keep the tubing off the floor. During an interview on 9/29/22, at 4:00 p.m. the director of nursing (DON) stated the urinary catheter bag should be positioned below the level of the bladder to ensure the bladder would empty correctly, that urine would not back flow back into the bladder, and a have an increased risk of a UTI. The DON expected if staff saw R24's urinary catheter bag tied to the armrest staff would stop and place the urinary catheter bag lower than the bladder and made sure the tubing was not dragging on the floor. The facility policy Catheter Care dated 9/1/22, identified the urinary catheter bag must be kept below the level of the bladder and the urinary catheter drainage bad and tubing must be kept from touching the floor.	F 690		

Electronically delivered
October 14, 2022

Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

Re: State Nursing Home Licensing Orders
Event ID: P4M311

Dear Administrator:

The above facility was surveyed on September 26, 2022 through September 29, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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 contact:

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

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 feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 _____	C 09/29/2022

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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: On 9/26/22 to 9/29/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: . 0510,0565	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5363022C (MN00076448), with a licensing order issued at 0830. The following complaints were found to be UNSUBSTANTIATED: H53634763C (MN00083783). 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box	2 000		

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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop and implement a care plan intervention for the monitoring and management of continuous positive airway pressure (CPAP) therapy for 1 of 1 resident (R51) reviewed for careplans. Findings include: R51's Admission Record printed on 9/29/22, identified a diagnosis of obstructive sleep apnea.	2 565	Corrected	11/10/22

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	00848	A. BUILDING: _____ B. WING _____	C 09/29/2022

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2 565	Continued From page 3 R51's five day admission Minimum Data Set (MDS), dated 9/19/22, did not identify R51's CPAP use, therefore there were not any Care Area Assessments (CAAs) for respiratory therapy. R51's care plan initiated on 9/12/22, did not address R51's CPAP therapy. R51's Order Summary Report dated 9/29/22, did not have any orders for CPAP therapy. R51's progress note dated 9/12/22, 3:19 p.m. indicated a Nursing Admission/Readmission Assessment had been completed. The assessment completed by registered nurse (RN)-B indicated R51 used CPAP therapy. R51's progress note dated 9/12/22, 4:34 p.m. indicated "A transmission based precaution assessment has been completed on R51. Resident is on Droplet Precautions for the following S/S: OR Resident is on Contact Precautions for the following items:. No specimen needed at this time. Resident is alert and oriented and able to understand and follow the appropriate precautions. Resident does use appropriate hand hygiene. Interventions that have been implemented: Precaution stand has been placed. Covered hamper and trash cans now placed. Supplies for the room have been gathered. Sign placed on room door." There were no progress notes to indicate R51 used CPAP therapy at night. On 9/27/22, at 10:06 a.m. R51 stated the staff donned personal protective equipment at night when she was wearing her CPAP. On 9/27/22, at 4:10 p.m. outside of R51's door	2 565		

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2 565	Continued From page 4 was a three drawer bin with PPE supplies. The sign on the door indicated she was in contact and droplet precautions at night. On 9/28/22, at 8:38 a.m. R51 stated she was told she was in isolation when she was admitted because she did not have her COVID-19 booster. R51 was told the isolation precautions would be for seven days. R51 stated the staff wore personal protective equipment (PPE) when she had her CPAP running. She stated she had never been told her door should be shut if she was wearing her CPAP. R51 stated she would remove her CPAP when she woke in the morning. During an interview on 9/29/22, at 12:31 p.m. RN-B stated R51's isolation precautions were for her CPAP use at night. RN-B reviewed R51's care plan and verified CPAP therapy was not part of the care plan nor were there any interventions related to R51's isolation precautions. RN-B verified the careplan was used to direct resident care. RN-B stated she completed R51's admission MDS. During an interview on 9/29/22, at 12:44 p.m. RN-D stated staff knew they needed to wear an N95 mask whenever there was an aerosolizing procedure, which would include CPAP use. RN-D verified CPAP therapy and PPE use should have been included in R51's care plan. During an interview on 9/29/22, at 3:46 p.m. the director of nursing (DON) stated CPAP therapy and need for isolation during therapy should have been part of R51's care plan. The facility policy titled Care Planning Policy and Procedure dated 8/6/21, indicated the purpose of the care plan was to provide a care plan for the	2 565		

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2 565	Continued From page 5 resident's total care, to promote continuity of care, and to communicate vital information to all staff providing direct resident care. The facility policy titled Policy and Procedure for BI-PAP/CPAP Policy dated 2/4/15, included indications for use, procedures to follow, mask adjustment, cleaning, safety precautions, and trouble shooting. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate all staff to follow each resident's care plan. The DON or designee could then perform random audits to ensure each residents care plan is being followed by all staff. The DON could report the findings to the Quality Assurance committee. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		11/10/22

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2 830	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care plans for falls were being followed for 2 of 3 residents (R24, R42) reviewed for falls. Findings include: Resident #24 R24's significant change Minimum Data Set (MDS) dated 7/16/22, indicated severe cognitive impairment. R24 required extensive assistance with transferring and toileting. Diagnoses included Alzheimer's disease, hip fracture, and presence of right artificial hip. R24's care plan dated 8/7/22, indicated R24 was at moderate/high risk for falls related to impulsiveness, had a fall on 7/5/22, resulting in a left hip fracture and required surgery. Interventions included do not leave in room unattended in wheelchair, do not leave unattended in bathroom, and high/low bed in low position. A progress note for 7/5/22, indicated R24 was self-transferring from bed to wheelchair when he stated his leg twisted and he slipped. R24 had pain with movement of left lower extremity and was sent to the emergency room. A progress note later in the day indicated R24 was admitted back to the facility with a left hip fracture. The facility investigation dated 7/8/22, indicated R24 was self-transferring from his bed to his wheelchair when his left leg twisted. R24 did not	2 830	Corrected	

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2 830	Continued From page 7 identify why he was transferring due to pain in left leg. Interventions were in place. Following R24's return after hospitalization the care plan was updated to pace a bed alarm (silent for R24) to identify movement in his room. Also restated to not leave R24 unattended in room or bathroom while in wheelchair. During observation on 9/28/22, at 11:33 R24 was in his room watching TV while in his wheelchair. There were not staff in the room with R24 and staff was observed to walk the room and not check on R24. During observation on 9/29/22, at 9:00 a.m. R24 was in his room and nursing assistant (NA)-A walked by R24's room without looking in. At 9:03 a.m. R24 moved his wheelchair next to his bed, moved his call light out of the way, and then R24 self-transferred to the bed. During an interview on 9/29/22, at 9:35 a.m. NA-A stated R24 has frequently self-transferred himself between the wheelchair, bed, and bathroom. R24 does not use the call light with most of his transfers. NA-A stated she did not see R24 in the room until after he self-transferred to bed. She stated she should have looked in R24's room as she went by. During an interview on 9/29/22, at 9:49 a.m. NA-B stated R24 interventions for falls included low bed, bed against wall, call light in reach, and a fall mat on the floor. NA-B stated it was okay for R24 to be alone in his room. NA-B then checked the care plan and stated he was not supposed to be left alone in his room and should have been redirected out of his room. During an interview on 9/29/22, at 2:44 p.m.	2 830		

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2 830	Continued From page 8 registered nurse (RN)-B stated she would expect staff to review R24's Kardex (abbreviated care plan) to ensure the correct interventions were being used. During an interview on 9/29/22, at 4:00 p.m. the director of nursing (DON) stated it was the expectation of all staff to follow the care plan for R24. If R24 was in the room, then staff should have checked in the room as they were going by. The DON stated the staff should have checked on R24 as they were walking by his room. Resident #42 R42's admission Minimum Data Set (MDS) dated 8/21/22, indicated R42 had severe cognitive impairment and required extensive assist with transferring, toileting, and bed mobility. The MDS indicated R42 had falls in the six months prior to admission, but none since admission. R42 Care Area Assessment (CAA) dated 8/31/22 indicated R42 had a history of actual fall with major injury on 6/28/22, (prior to admission) related to weakness and decreased mobility. R42's care plan dated 8/26/22, indicated R42 was at risk for falls and an intervention included high/low bed in low position. During observation on 09/27/22, at 9:01 a.m. R42 was laying in the bed and the bed was in high position During continuous observation on 9/28/22, from 7:32 a.m. through 8:29 a.m. R42 was in bed and the bed was in a high position.	2 830		

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2 830	Continued From page 9 During an interview on 9/29/22, at 9:35 a.m. nursing assistant NA-A stated R42 did have an intervention for falls on his care plan to have bed in low position when R42 was alone in room. NA-A stated whenever she went by R42's room and the bed was in the high position, she would stop and make sure the bed was lowered. R42 had moved his legs out of bed in the past and was a falls risk and needed the bed in the low position. During an interview on 9/29/22, at 2:44 p.m. registered nurse (RN)-B stated staff were expected to review R42's Kardex when there were question about fall interventions. The expectation was the care plan would be followed. During an interview on 9/29/22, at 4:00 p.m. the director of nursing (DON) stated staff should not have left R42's room with the bed in high position while R42 was in bed. The expectation was that staff would have followed the care plan to ensure R42 would have remained safe. The facility's undated policy for Fall Prevention and Management indicated the facility would provide appropriate interventions needed to improve safety of the resident and was to be identified on the care plan. Staff would deliver safe and personalized care to the residents. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents avoid falls, falls that occur are fully analyzed for root cause and appropriate interventions are put into place to	2 830		

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2 830	Continued From page 10 avoid future falls 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.	2 830		

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	245363	A. BUILDING **01 - AICOTA NURSING HOME** B. WING _____	**09/27/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted, on 09/27/2022, 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, and the 2012 edition of the Health Care Facilities Code (NFPA 99). THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

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

Electronically Signed | 10/21/2022

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

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

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K 000	Continued From page 2 this facility was surveyed as a single building. The building is fully sprinkled throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 75 beds and had a census of 51 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 291 SS=C	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the battery-operated emergency lights per NFPA 101 (2012 edition) Life Safety Code, sections 7.9.2.1, 7.9.3.1.1, and 19.2.9.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/27/2022, at 10:30 AM, it was revealed by observation that there are battery-operated emergency lights that are located within the	K 291	Facility failed to provide proper documentation at time of survey regarding testing of emergency lighting. All battery-operated emergency lighting will be tested to ensure compliance. Facility policy updated to include all documentation will be available at survey and all facility staff will be educated. Facility committee will review Life Safety Code items at quarterly meetings for compliance. Facility will comply on or before 11/11/2022.	11/11/22

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K 291	Continued From page 3 facility. It was also revealed during the review of all available battery operated emergency light test/inspection documentation and interview with the Maintenance Supervisor, that at the time of the survey, the battery operated emergency light test and inspection documentation did not annotate when the annually for 90 minute test had been conducted. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 291		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors	K 363		11/11/22

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K 363	Continued From page 4 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 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/27/202, at 11:11 AM, it was revealed by observation that that the bathing spa room 200 had double doors open to the corridor that has a roller latch between the two door leaves. It was also observed after several tries to open these doors that the roller latch did not provide adequate resistance to maintain the doors in the closed position. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 363	Facility failed to keep corridor door in proper working order in accordance with NFPA 101 by allowing corridor door to open with less than 5 pounds if applied to latch side of door. Facility will inspect all doors with roller latch to determine compliance. Facility will correct deficiency by repairing or replacing latch to proper working order. Facility will ensure continued compliance by inspecting door latch to ensure compliance and reporting at quarterly meeting. Facility will comply on or before 11/11/2022.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		11/11/22

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	245363	A. BUILDING **01 - AICOTA NURSING HOME** B. WING _____	**09/27/2022**

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K 761	Continued From page 5 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the fire door inspections per NFPA 101 (2012 edition), Life Safety Code, sections 8.3.3.1, 19.7.6, and NFPA 80 (2010 edition) Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/27/2022, at 10:33 AM, it was revealed by a review of available fire door test and inspection documentation and an interview with the Maintenance Supervisor that the facility could not provide documentation verifying what NFPA 80 required elements of a fire door were inspected and the results for each element of the fire door inspections.	K 761	Facility failed to provide proper documentation at time of survey regarding testing of fire doors. All fire doors have been tested and in compliance in accordance with NFPA 80. Facility policy updated to include all documentation will be available at survey and all facility staff will be educated. Facility committee will review Life Safety Code items at quarterly meetings for compliance. Facility will comply on or before 11/11/2022.	

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K 761	Continued From page 6 An interview with the Maintenance Supervisor verified this deficient finding at the time of the discovery.	K 761		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the annual electrical outlet testing and maintenance per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2 and 6.3.4.1.3. This deficient finding could have a widespread impact on the residents within the facility.	K 914	Facility failed to provide proper documentation at time of survey regarding testing of electrical outlets in resident rooms. All outlets have been tested and in compliance in accordance with NFPA 99. Facility policy updated to include all documentation will be available at survey and all facility staff will be educated.	11/11/22

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K 914	Continued From page 7 Findings include: On 09/27/2022, at 10:40 AM, during the review of all available electrical outlet maintenance and testing documentation and an interview with the Maintenance Supervisor, it was revealed that the facility had failed to conduct the annual electrical outlet inspection of all electrical outlets located within the patient/resident care areas within the last 12 months. At the time of the survey the last provided annual electrical outlet inspection report was dated 07/20/2021. An interview with the Administrator verified this deficient finding at the time of the discovery.	K 914	Facility committee will review Life Safety Code items at quarterly meetings for compliance. Facility will comply on or before 11/11/2022.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of	K 918		11/11/22

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K 918	Continued From page 8 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/27/2022 at 10:24 AM, it was revealed by a review of available emergency generator test and inspection documentation and an interview with the Maintenance Supervisor, at the time of the survey the facility did not provide documentation for 17 of 52 weekly generator inspections were performed during the last 12 months An interview with the Maintenance Supervisor	K 918	Facility failed to provide proper documentation at time of survey regarding testing of generator. All generator testing had been completed and in compliance. Facility policy updated to include all documentation will be available at survey and all facility staff will be educated. Facility committee will review Life Safety Code items at quarterly meetings for compliance. Facility will comply on or before 11/11/2022.	

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K 918	Continued From page 9 verified this deficient finding at the time of discovery.	K 918		