DEPARTMENT OF HEAL						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: RWDR
	PART I -	TO BE COMPL	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00002
1. MEDICARE/MEDICAID PROVI	DER NO.	3. NAME AND AI (L3) AITKIN HE				4. TYPE OF ACTION: $\underline{7}$ (L8)
(L1) 245119		(L3) ATT KIN HE (L4) 301 MINNE			I	1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAII (L2) 231247600	DNO.			E 500 11	(L6) 56431	3. Termination 4. CHOW 5. Validation 6. Complaint
		(L5) AITKIN, M	IN		~ /	5. Validation6. Complaint7. On-Site Visit9. Other
5. EFFECTIVE DATE CHANGE O	FOWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	8. Full Survey After Complaint
(L9) 07/01/2006		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	
	09/2015 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray 08 OPT/SP	11 ICF/II		06/30
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OF 1/SP	12 RHC	16 HOSPICE	00/50
11LTC PERIOD OF CERTIFICATI	ON	10.THE FACILITY	Y IS CERTIFIED	AS:		
From (a):		X A. In Complia			And/Or Approved Waivers Of	The Following Requirements:
To (b):		Program R	equirements		2. Technical Personnel	6. Scope of Services Limit
		-	e Based On:		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	44 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	NF)8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	44 (L17)	B. Not in Con	npliance with Pro	gram	5. Life Safety Code	9. Beds/Room
15. Total Certified Beas	44 (E17)	Requirem	ents and/or Appl	ied Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKI	DOWN	I			15. FACILITY MEETS	
18 SNF 18/19 SN	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
44						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Chris Campbell, Un	it Supervisor	1	10/08/2015		Mark meath	, Enforcement Specialist
	it ouper visor		10/00/2015	(L19)		10/08/2015 (L20)
P	ART II - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIE	BILITY	20. COM	IPLIANCE WIT	H CIVIL		ncial Solvency (HCFA-2572)
X 1. Facility is Eligible to	Participate	RIGI	HTS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligi	-				5. Dour of the Abow	
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION	BEGINNINC	DATE	ENDING DA	TE	VOLUNTARY 00	<u>INVOLUNTARY</u>
03/09/1967					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)			(L44)			00-Active
(L27)	B. Rescind St	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	21	. DETERMINATION		DATE		
51. NO RECEIPT OF CM3-1559	52	09/23/2015	V OF AFFRU VAL	DALE		
	(L32)	07/23/2013		(L33)	DETERMINATION APP	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245119

October 8, 2015

Ms. Jolynn Kullhem, Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, Minnesota 56431

Dear Ms. Kullhem:

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

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

Effective September 1, 2015 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 8, 2015

Ms. Jolynn Kullhem, Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, Minnesota 56431

RE: Project Number S5119023

Dear Ms. Kullhem:

On August 13, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 30, 2015. 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 September 9, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 18, 2015 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 July 30, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 1, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 30, 2015, effective September 1, 2015 and therefore remedies outlined in our letter to you dated August 13, 2015, will not be imposed.

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

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

Sincerely,

Mark Meath, 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

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245119	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/9/2015
Name	e of Facility		Street Address, City, State, Zip Code	
Aľ	TKIN HEALTH SERVICES		301 MINNESOTA AVENUE SOL AITKIN, MN 56431	JTH

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item	(Y5)	Date
	F0314 483.25(c)	((Correction Completed 09/01/2015		F0441 483.65		Correction Completed 09/01/2015				
ID Prefix Reg. #		(Correction Completed	ID Prefix Reg. #			Correction Completed		ID Prefix		Correction Completed
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed				Correction Completed
Reg. #		(Correction Completed	Reg. #			Correction Completed		Reg. #		Correction Completed
ID Prefix Reg. # LSC		(Correction Completed	Reg. #					D		
Reviewed I State Agen		wed	Ву	Date:	Signature	of Sur	veyor:			Date:	
	3y Review	wed	Ву	Date:	Signature	of Sur	veyor:			Date:	
Followup t	o Survey Completer 7/30/2015	d on:		 	Check for any Uncorrecte		rected Defic			YES	NO

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245119	(Y2) Multiple Construction A. Building B. Wing 01 - MA	IN BUILDING 01	(Y3) Date of Revisit 9/18/2015
Name of Facility		Street Address, City, State, Zip Code	
AITKIN HEALTH SERVICES		301 MINNESOTA AVENUE SOU AITKIN, MN 56431	ITH

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

(Y4) Item	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 08/30/2015	ID Prefix		Correction Completed 08/30/2015	ID Prefix		Correction Completed
-	NFPA 101 K0044		•	NFPA 101 K0050		Reg. # LSC		
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed			
Reg. #		Correction Completed			Correction Completed	Reg. #		
Reg. #		Correction Completed	Reg. #		Correction Completed	D "		Correction Completed
ID Prefix Reg. # LSC			Reg. #					
		_	Date: Date:	Signature of Sur Signature of Sur			Date: Date:	
CMS RO Followup t	o Survey Completed of 7/29/2015	on:		Check for any Unco Uncorrected Defic				NO

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245119	(Y2) Multiple Construct A. Building B. Wing 02	(IN HEALTH SERVICES	(Y3) Date of Revisit 9/18/2015
Name of Facility		Street Address, City, State, Zip Code	
AITKIN HEALTH SERVICES		301 MINNESOTA AVENUE SOU AITKIN, MN 56431	TH

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

(Y4) Item	(Y5)) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 08/30/2015	ID Prefix		Correction Completed 08/30/2015	ID Prefix		Correction Completed
-	NFPA 101			NFPA 101		Reg. #		
LSC	K0044		LSC	K0050		LSC _		
		Correction Completed			Correction Completed			Correction Completed
		-						
Reg. # LSC			Reg. # LSC			Reg. # LSC		
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction Completed			
						LSC		
ID Prefix Reg. #		Correction Completed			Correction Completed			Correction Completed
ID Prefix Reg. # LSC			Reg. #					
Reviewed E	By Reviewed	Ву	Date:	Signature of Sur	veyor:		Date	:
State Agen	су							
Reviewed E CMS RO	By Reviewed	Ву	Date:	Signature of Sur	veyor:		Date	:
	o Survey Completed or 7/29/2015	1:		Check for any Unco Uncorrected Defic				NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ICARE/MEDICA T I - TO BE COMI						ID: RWDR Facility ID: 00002
1. MEDICARE/MEDICAID PROVIDER (L1) 245119 2.STATE VENDOR OR MEDICAID NO (L2) 231247600		3. NAME AND ADE (L3) AITKIN HEA (L4) 301 MINNES (L5) AITKIN, MN	ALTH SERVICES		(L6)	56431	 TYPE OF ACTION Initial Termination Validation 	2. Recertification 4. CHOW 6. Complaint
 5. EFFECTIVE DATE CHANGE OF OV (L9) 07/01/2006 	VNERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After C	9. Other omplaint
6. DATE OF SURVEY 07/3 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	60/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	G DATE: (L35)
 LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	44 (L18) 44 (L17)	X B. Not in Comp	ce With quirements Based On: cceptable POC	Vaivers:	2. Tech 3. 24 H 4. 7-Da 5. Life * Code:	nical Personnel our RN y RN (Rural SNF) Safety Code B *	Following Requirements: 6. Scope of Serv 7. Medical Direc 8. Patient Room 9. Beds/Room (L12)	ctor
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF		ICF	IID		15. FACILITY MI		(L15)	
(L37) (L38)	(L39)	(L42)	(L43)		1861 (e) (1) or	1861 (J) (1):	(E15)	
16. STATE SURVEY AGENCY REMAN	KS (IF APPLICABLE S	SHOW LIC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :				VEY AGENCY APP		Date:
Jennifer Bahr, HFE N	IEII	0	08/28/2015	(L19)	Enfo	rcement Specia	alist	09/16/2015 (L20)
	PART II - TO	BE COMPLETEI) BY HCFA RE	GIONAI	LOFFICE OR S	SINGLE STAT	E AGENCY	
 DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to P 2. Facility is not Eligible 			PLIANCE WITH CI TS ACT:	VIL	2. (al Solvency (HCFA-2572) nterest Disclosure Stmt (HCF	'A-1513)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 24	4. LTC AGREEME	NT	26. TERMINAT	ION ACTION:		(L30)
OF PARTICIPATION 03/09/1967	BEGINNING	DATE	ENDING DATE		<u>VOLUNTARY</u> 01-Merger, Closu	00		<u>TARY</u> leet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction 03-Risk of Involu	W/ Reimbursemen	t 06-Fail to M	feet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV A. Suspension		(L44)		04-Other Reason 1		<u>OTHER</u> 07-Provide 00-Active	r Status Change
(L27)	B. Rescind Sus	pension Date:	(111)					
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/CA	ARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	· · ·	. DETERMINATION O	F APPROVAL DAT					



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 13, 2015

Ms. Jolynn Kullhem, Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, Minnesota 56431

RE: Project Number S5119023

Dear Ms. Kullhem:

On July 30, 2015, 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) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor Duluth Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: chris.campbell@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 September 8, 2015, 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 September 8, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (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. Aitkin Health Services August 13, 2015 Page 4

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 October 30, 2015 (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 Aitkin Health Services August 13, 2015 Page 5

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 January 30, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us

Telephone: (651) 201-7205 Fax: (651) 215-0525 Aitkin Health Services August 13, 2015 Page 6

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

Sincerely,

Mark meeth

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

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE	
	F CORRECTION	IDENTIFICATION NUMBER:		3	COMF	PLETED
		245119	B. WING		07/3	0/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	IEALTH SERVICES			301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	F 00	ס		
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.				
F 314 SS=D	on-site revisit of yo validate that substa regulations has be your verification. 483.25(c) TREATM	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with IENT/SVCS TO PRESSURE SORES	F 31	4		9/1/15
	resident, the facility who enters the fac does not develop p individual's clinical they were unavoid pressure sores rec	prehensive assessment of a y must ensure that a resident ility without pressure sores pressure sores unless the condition demonstrates that able; and a resident having wives necessary treatment and e healing, prevent infection and from developing.				·
	by: Based on observa review, the facility comprehensive re- determine if appro place when a new	NT is not met as evidenced ation, interview, and document failed to ensure a assessment was conducted to priate interventions were in pressure ulcer developed for 1 8) identified with current		F: 314 AHS ensures a comprehensive assessment is conducted (with analysis) for any new skin ulcer appropriate intervention are in promote healing, prevent infect prevent new sores from develo R48 had a comprehensive reas	root cause to ensure place to ion, and ping.	

Electronically Signed

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

- - - - - - - -

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COMPLETED	
		245119	B. WING _			80/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
	IEALTH SERVICES			301 MINNESOTA AVENUE SOUTH	ł	
	IEALIH SERVICES			AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 314	Findings include: R48's admission M assessment dated severe cognitive im assist of two staff f dressing, and toiled of one staff for per- frequently incontine MDS further indica pressure ulcer whi and was at risk for ulcers. R48's hospital disc identified R48 had history of a cerebro congestive heart fa disease. Review of R48's h dated 6/26/15, ind pressure ulcer (pa shallow ulcer withow white tissue that a right medial buttoo ulcer on the left m Review of the faci documentation for identified R48 had with stage 2 press region, which was changes and skin Further, the form to help determine score was 13, ind	linimum Data Set (MDS) 7/8/15, indicated R48 had pairment, required extensive for bed mobility, transfers, t use, and extensive assistance sonal hygiene, and was ent of bowel and bladder. The ted R48 had one stage 2 ch was present on admission development of pressure charge summary, dated 7/1/15, diagnoses which included ovascular accident (stroke), ailure, and degenerative joint ospital wound documentation icated R48 had a Stage 2 artial thickness of skin loss, but slough, which is yellow or dheres to the ulcer bed) on the ck. and a Stage 2 pressure	F 3		/29/15 by the d it was n the crease cility skin and tissue to all RN¿s and ssment (RCA) urrent resident 15. A ent (RCA) will be sidents admitted I as any current a new open area. uct audits on a dents with open for completion of and a Audit results	

Facility ID: 00002

If continuation sheet Page 2 of 11

PRINTED: 08/28/2015

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM OMB NO	08/28/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245119	B. WING			07/	30/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	repositioned using were floated off the reducing cushion of documentation fur and repositioned eximattress had been with reduction of prentry note correcte clarification that the located on the lower coccyx. Review of R48's SI Progression notes revealed the follow - on 7/1/15 identified lower buttocks whit (cm) x 2.5 cm with 10% yellow colored the wound, and an buttocks measurin on the edges of the -on 7/10/15, dress and right lower buttocks wou in color and R48 h with cleansing of the scant clear drainage a dressing was charea (tail bone/basidentified R48 reported R48	a draw sheet in bed, heels mattress, and had a pressure in the wheelchair. The ther indicated R48 was turned very 2 hours and an air placed on the bed to assist ressure. On 7/29/15, a late d the documentation with a e stage 2 pressure ulcers were er buttocks and not on the extract and not on the left ch measured 2.5 centimeters the wound bed 90% pink and d material in different spots of open lesion on the right lower g 0.5 cm x 0.5 cm with dry skin e open area. Ing change done at both left tocks open areas. Both left and nd beds were noted to be white ad reported slight discomfort		314			

Facility ID: 00002

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/28/2015 APPROVED 0.0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		245119	B. WING	≩		07	/30/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	E	
AITKIN H	IEALTH SERVICES				301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	٦X	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 314	wound beds had ap 10% or less of yello drainage present of skin surrounding w reported slight disc cleansed. -on 7/21/15, both ri lower buttocks ope note on 7/21/15, ide identified R48 had which measured 2. no drainage or odo was closed, fragile -on 7/29/15, area of moisture associate -on 7/29/15, area of moisture associate -on 7/29/15, an add area on the coccyx determined to not f evidenced by the h pressure ulcers on which healed on 7/ preventative interva- indicated R48 had incontinence. The cm, and on 7/21/19 The documentation bed had a whitish- edges with the cern pinkish-red in color On 7/29/15 at 10:1 R48 at the facility a Stage 2 verses wo coccyx and descril lesion 20% granu	oproximately 90% pink with ow slough present. Clear in gauze when changed and ound was slightly red. R48 had omfort when open areas ght lower buttocks and left in areas were healed. Also, a entified as a first recording a open area on the coccyx 5 cm long by 0.4 cm wide with r. The note indicated the area and pink in color. on the coccyx identified as id skin damage (MASD). ditional noted identified the a was a MASD and was be a pressure-related as realing of two previous the left and right buttocks, '21/15 with the use of current entions. The documentation a MASD related to wound measured 2.4 cm x 1.0 5, it measured 2.5 cm x 0.4 cm. in further indicated the wound colored film present on wound iter of the wound noted to be		314	4		

Facility ID: 00002

If continuation sheet Page 4 of 11

		AND HUMAN SERVICES				FORM	08/28/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245119	B. WING	;		07/3	30/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	і ПХ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	History of buttock le changed the treatm ulcer. A Tissue Tolerance 7/2/15, indicated R area and tolerated hours without reduc prominence's. An observation indicat and tolerated 3 hou for 3 hours with red The Tissue Toleran form did not identifi stage 2 pressure u would be reposition sitting and lying po developed a new p facilty had not com reposition observat assessment was a Review of R48's S identified R48's coo 7/20/15 to 7/29/15, the presence of slo R48's care plan da impaired skin integ ulcer will be resolve plan listed various assess pressure u	Il left lateral of midline lesion. esions healed." The physician nent orders for the pressure Reposition Observation dated 48 had a reddened perineal the same sitting position for 3 ess over the bony undated tissue tolerance ed R48 had no skin concerns urs of lying in the same position thess over bony prominence's. the Reposition Observation the presence of the two lcers. The form indicated R48 ned every 3 hours for both sitions. Even though R48 tressure ulcer on 7/21/15, the plete a new tissue tolerance tion to determine if the current dequate for R48.	F	314			
	infection, pressure	reducing cushion on d, and turn and reposition					

If continuation sheet Page 5 of 11

CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥2) MU			FORM A	08/28/2015 APPROVED 0938-0391 SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:					PLETED
		245119	B. WING	i		07/3	30/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN F	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 314	Continued From pa every 2 hours and a	age 5 as needed for comfort.	F	314			
	Assignment Sheet every 2 hours, use	ty's NAR (nursing assistant) directed staff to reposition R48 assist of 2 staff for bed ot to use the toilet before and ilet at 1:00 p.m.					
	director of nursing R48's dressing from had a small amount through the 4x4 ga pressure ulcer mea- another small press lower edge of the la 0.4 cm. The bed of covered with a thic DON stated it was jue edges were regula skin surrounding the blanchable. No main immediately surrou DON stated she fe area and indicated physician had iden a stage 2 pressure two stage 2 pressure	on 7/30/15, at 9:47 a.m. the (DON) and LPN-A removed in the coccyx. The dressing at of serosanguineous drainage uze dressing. The primary asured 2.5 cm x 1.0 cm with sure area on the side of the arger area measuring 0.5 cm x of the wound was 100% v slough with the lower half ker, darker yellow slough. The darker than the previous day. ust a film yesterday. The r and deep red and the red he pressure area was acceration was observed unding the pressure area. The It it was a maceration-related she was not aware the tified the area on the coccyx as a ulcer. She confirmed R48 had are ulcers, which had just eal tuberosity areas of the					
	LPN-A stated R48' 2.4 cm x 1 cm with measuring 0.5 cm 80% slough. LPN-	w on 7/29/15, at 11:54 a.m. s coccyx open area measured an open area on the side of it x 0.2 cm with 20% red and -A stated the smaller area may r an extension of the old area.					

Facility ID: 00002

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 08/28/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVI COMPLETED	
		245119	B. WING	;		07/	30/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	IEALTH SERVICES				301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	LPN-A indicated the last week During an interview DON stated a comp includes skin, bowe pain is completed b admission. The DC admitted with press assess it immediate current facility polic developed a new p 7/21/15. The DON had indicated R48 repositioning during though was not sur tested at 3 hours w pressure ulcers we that would have pu stated she would e ulcers and the nurs risk factors and def The facility policy a Protocol updated 2 care and services w treat, and monitor p The policy and pro- pressure ulcers as resident's clinical c risk factors were mont interventions were wound documentar monitoring and we and procedure indi moderate to high r	ge 6 e area had been closed in the or 7/30/15, at 12:29 p.m. the orehensive assessment which and bladder, fall risk, and by the eighth day after on verified if a resident is sure ulcers, the RN should ely. The DON confirmed the y and confirmed R48 had ressure ulcer on the coccyx on stated the tissue testing form had tolerated 3 hours without g the tissue tolerance testing, e why R48 would have been ithout repositioning when re already present and verified t him more at risk. The DON xpect nurses to measure skin be manager would consider the termine initial interventions. Ind procedure for Skin Ulcer /1/15, indicated appropriate would be provided to prevent, progress of all healing ulcers. cedure identified avoidable those that developed when a ondition was not evaluated, bt identified, interventions were and the effectiveness of not monitored or revised. The tion was to include daily ekly assessment. The policy cated residents identified at sk by the Braden scale would sive pressure ulcer risk leted to determine appropriate		314			

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TATEMENT	OF DEFICIENCIES F CORRECTION	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> TE SURVEY MPLETED
		245119	B. WING		07.	/30/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314 F 441 SS=E	interventions for pr pressure ulcers. F evaluated for each and modified, stab Conditions contribu- pressure ulcers ind dehydration, edem wound nurse was complete a root ca Braden and tissue anytime a new are round documentat wound, staging, m presence of pain, of wound edges at The policy indicate individualized inter Review of the Tis Observation Proce assessment form would be complete the development of 483.65 INFECTIO SPREAD, LINENS The facility must en Infection Control F safe, sanitary and to help prevent the of disease and inf (a) Infection Control Program under w	revention and treatment of Risk factors were to be skin assessment, identified ilized, or removed if possible. uting to the development of cluded prolonged illness, na, emaciation. The DON or to be notified of new areas and nuse analysis in addition to a tolerance test to be done a develops. Weekly wound ion was to include the type of easurements, exudates, wound base tissue, description nd surrounding tissue, odor. ed consistent, routine, of rventions must be in place. ssue Tolerance/Repositioning edure on the back of the revealed a new tissue tolerance ed in both lying and sitting with of a new skin ulcer. N CONTROL, PREVENT Setablish and maintain an Program designed to provide a comfortable environment and e development and transmission fection.	F	441		9/1/15

If continuation sheet Page 8 of 11

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CENTER STATEMENT	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				FORM A MB NO. ((X3) DATE	08/28/2015 PPROVED 0938-0391 SURVEY LETED
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILC	ING _			
		245119	B. WING			07/3	0/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	IEALTH SERVICES				1 MINNESOTA AVENUE SOUTH ITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	 (2) Decides what prishould be applied to (3) Maintains a record actions related to in (b) Preventing Spree (1) When the Infect determines that a reprevent the spread isolate the resident (2) The facility must communicable dise from direct contact will tr (3) The facility must hands after each d hand washing is in professional practice (c) Linens Personnel must hands the spread must hands after washing is the spread isolate the spread determines that a reprevent the spread isolate the resident (2) The facility must communicable dise from direct contact will tr (3) The facility must hands after each d hand washing is into the spread determines that a must hands after washing is into the spread determines that a must hands after washing is into the spread determines that a must hands after washing is into the spread determines that a must hands after washing is into the spread determines that a must hands after washing is into the spread determines that a must hands after washing washing is into the spread determines the spread determines that a must hands after washing w	rocedures, such as isolation, o an individual resident; and ord of incidents and corrective infections. ead of Infection tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. t require staff to wash their irect resident contact for which dicated by accepted	F	441			
	by: Based on observa review, the facility for rinsing of soiled washing in the clea potential to affect 3 the facility. Findings include: During an observa	NT is not met as evidenced tion, interview, and document failed to have separate areas I personal laundry and hand an laundry room. This had the 32 of 36 residents residing in tion of the Clean Laundry at 9:40 a.m., a clean double			F: 441 AHS will handle, store, process ar transport linens so as to prevent th spread of infection. The facility Linen Handling Policy reviewed and revised on 8/14/15 t indicate all soiled linen and clothin rinsed in the hopper in the soiled to room on the unit prior to being broc laundry. A separate area has been designa	ne was o ug will be utility ought to	

Facility ID: 00002

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ATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245119				07/3	80/2015
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIOI DATE
F 441	wash sink was observed eye wash station w dirty personal linear the left of the sink was In an interview on 7 Housekeeper (H)-A next to the washing Laundry Room was clothing. H-A state station and that no laundry area. H-A of "mess" every da bowel movements occasionally vomit. In addition, in the ir a.m., H-A stated th available in the lau a face mask was a use a face mask to During an observa H-A pointed out thr resident care areas linens, gloves, face available in all thre In a follow-up inter H-A stated she use Clean Laundry Roo drain. H-A stated th andwashing. H-A	erved. On the right of sink an as located and bins of sorted s (clothing and blankets). To were two washing machines. a hand soap dispenser. 7/30/15, at 9:40 a.m., A explained that the double sink g machines in the Clean s where she rinsed soiled d she used the sink as a wash hopper was available in the stated that there is some kind y. H-A stated that she rinses into the sink daily, and heterview on 7/30/15, at 9:40 at there were no gowns ndry area. H-A showed where vailable, but stated she did not o sort laundry. tion on 7/30/15, at 9:57 a.m., ee soiled utility rooms in s. Hoppers for rinsing soiled e masks and gowns were e rooms. view on 7/30/15, at 12:07 p.m., ed both sides of the sink in the om to rinse "messes" down the the sink is also used for A stated the sink was washed end of the day, but not between ses.	F 4	.41	the laundry room with a dirty sink PPE is available in this area. A cl for hand washing has also been designated in the clean area of th laundry room. All Nursing, Housekeeping, and L staff will be re-educated on Linen Handling Policy by 8/28/15. Laundry will log any instance of re un-rinsed soiled linen and include instructions to notify nursing staff soiled linen is brought back to the be rinsed in the hopper by nursing with appropriate PPE. DON/Desi audit Laundry logs on a weekly ba follow up to ensure compliance w updated Linen Handling Procedur Audit results will be brought to Q/ further review and recommendati Completion Date 9/1/15	ean sink e aundry cceiving s when unit to g staff gnee will asis and ith es. API for	

Facility ID: 00002

If continuation sheet Page 10 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	ARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · · · · · · · · · · · · · · · · · ·	0938-0391
		A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245119	B. WING	G		07/3	0/2015
NAME OF PROVIDER OR SUPP	IER			REET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN HEALTH SERVIC	S			1 MINNESOTA AVENUE SOUTH ITKIN, MN 56431		
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	-IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
hoppers in the laundry room of soiled laundry Clean Laundry cross-contami A Linen Handli directed to not clothing in resi	osed to be done upstairs in the soiled utility rooms, not in the ownstairs. M-A stated having the insed into the multi-use sink in the Room could be a source of ation. Ing policy provided by the policy pre-rinse or wash out any linens or lent care areas. However, the ddress where soiled linen or		441			

Facility ID: 00002

If continuation sheet Page 11 of 11

		AND HUMAN SERVICES & MEDICAID SERVICES	Ŧ	F5119023	FORM OMB NO	: 08/27/2015 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DAT CON	E SURVEY IPLETED
		245119	B. WING		07/	/29/2015
NAME OF P	PROVIDER OR SUPPLIER		· · · · ·	STREET ADDRESS, CITY, STATE, ZIP CODE		
				301 MINNESOTA AVENUE SOUTH		
	EALTH SERVICES			AITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K 0	000	ø	
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.		λ 4 : <u></u>		
	ON-SITE REVISIT CONDUCTED TO Y SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departm Marshal Division. A Aicota Health Care substantial complia participation in Med Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	Survey was conducted by the nent of Public Safety, Fire t the time of this survey, Center was found not in nce with the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection Standard 101, Life Safety ter 19 Existing Health Care.		EPO(
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	R THE FIRE SAFETY				
	Health Care Fire In State Fire Marshal 444 Cedar St., Suit St. Paul, MN 55101	Division e 145		×		
	By email to:					
	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
	ically Signed					08/21/2015
		an antarial (*) denotes a deficiency wh	ich the ine	stitution may be excused from correcting provi	dina it is dete	ermined that

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.

		AND HUMAN SERVICES & MEDICAID SERVICES			;4 	FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	SURVEY PLETED
		245119	B. WING			07/2	29/2015
NAME OF F	PROVIDER OR SUPPLIER						
	EALTH SERVICES		1		01 MINNESOTA AVENUE SOUTH NTKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	КO	00			
	Marian Whitney@s	tate.mn.us					
		RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION:					
2	1. A description of v to correct the defici	vhat has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	Minnesota Departm time of this survey, found not in substa requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),					
	a full basement. Th constructed in 1955 dining room main e	es is a one story building with e original building was with additions in 1962, and a ntry was added in 2002. Both g and the addition are type			27		
	facility has a compl	sprinkler protected. The ete fire alarm system with the corridors and spaces					

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Facility ID: 00002

If continuation sheet Page 2 of 5

PRINTED: 08/27/2015

TATEMENT		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY
	- Connection				
		245119	B. WING		/29/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AITKIN H	IEALTH SERVICES	5		301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 000 K 044 SS=F	open to the corridor automatic fire depa has a licensed capa census of 36 at the At this time, the corr 483.70(a) is NOT m NFPA 101 LIFE SA Horizontal exits, if u 7.2.4. 19.2.2.5	r, that is monitored for rtment notification. The facility acity of44 beds and had a time of the survey. Inditions of 42 CFR, Subpart net. FETY CODE STANDARD used, are in accordance with s not met as evidenced by: tion and testing the horizontal	K 000	κ 044	8/30/15
	area would not prop deficient practice co occupants in the ev Findings include: During the facility to double cross corrid not properly close a LSC(00) Section 19 double doors would the magnetic hold of	our on 7-29-15 at 9:00 AM, the or horizontal exit doors would and latch as required by 0.2.2.2.6. One leaf of the I not close when released from open. ice was confirmed by the ance (MC) and the		 Aitkin Health Services will provide latching corridor horizontal exit doors in accordance to NFPA 101 Life Safety Code Standard 7.2.4 19.2.2.5 The double doors between the "new" and the old building had one leaf that would not self-close. The leaf was removed, trimmed at the bottom, and reinstalled. Repeated opening and closing revealed the set of double doors now self-close properly. Other areas in the facility were inspected and found those areas to positively latch. Staff will be made aware of this requirement and to monitor during fire drills and other times of non-latching double doors and report this to the Environmental Services Director immediately. The Environmental Services Director is responsible for ongoing monitoring of K 044 	e

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Event ID: RWDR21

Facility ID: 00002

If continuation sheet Page 3 of 5

PRINTED: 08/27/2015 FORM APPROVED

COLUMN TWO IS NOT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01 - MAIN BUILDING 01	СОМ	PLETED
		245119	B. WING		07/	29/2015
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	EALTH SERVICES			01 MINNESOTA AVENUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
K 044	Continued From pa	ge 3	K 044			
K 050 SS=F	NFPA 101 LIFE SA	FETY CODE STANDARD	K 050	Correction Date: 8/30/15		8/30/15
	varying conditions, The staff is familiar that drills are part o Responsibility for p assigned only to co qualified to exercise conducted between	at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. lanning and conducting drills is impetent persons who are e leadership. Where drills are of 9 PM and 6 AM a coded y be used instead of audible				
	Based on a review determined that the conducted fire exit National Fire Protect "The Life Safety Co section 19.7.1.2. Co approximately the s gives a false sense negatively impact a a fire emergency. Findings include: At the conclusion o 10:00AM, documer drills are not being within the shifts. All	s not met as evidenced by: of fire drill records, it was e facility staff have not drills in accordance with ction Association (NFPA) 101 ode" (LSC) 2000 edition onducting fire drills at same time during the shift of security which would ill occupants of the building in f the facility tour on 7-29-15 at nation revealed that fire exit conducted at varying times il drills are being conducted ach other during the shifts.		K 050 Aitkin Health Services will condu drills at varying times in complia NFPA 101, 2000 edition, section A yearly fire drill schedule was of by the Environmental Services D conduct fire drills at various time the shifts. This schedule is kno the Environmental Services Dire drill times will continue to be doo in the fire drill log. The Environmental Services Dire responsible for compliance with conducting fire drills at varying ti required by K 050. Correction Date: 8/30/15	nce with 19.7.1.2. leveloped Director to is within wn only to ctor. Fire sumented ector is	

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Facility ID: 00002

If continuation sheet Page 4 of 5

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT CON	E SURVEY IPLETED		
		245119	B. WING		1	07/29/2015			
	PROVIDER OR SUPPLIER	K		STREET ADDRESS, CITY, STATE, ZIP CODE 301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ON SHOULD BE COMPLE E APPROPRIATE DATI			
K 050	Continued From pa Administrator (JK))	-	κc)50					
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							6		
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Event ID: RWDR21

Facility ID: 00002

If continuation sheet Page 5 of 5

PRINTED: 08/27/2015

		AND HUMAN SERVICES & MEDICAID SERVICES	F	5			PPROVED 938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE (COMPL	SURVEY .ETED
F.		245119	B, WING			07/29	9/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
AITKIN H	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	K	000			
	addition This addi basement. It is sep	ly covers the 2009-2010 tion is one story with a fully arated from the rest of the e rated construction. The s Type II (111).					
	facility has a fire all smoke detection ar that is monitored fo notification. All res station smoke dete	sprinkler protected. The arm system, with full corridor and spaces open to the corridor, or automatic fire department ident rooms have single ctors that are interconnect with ransmit to the nurses station.			EPOC]	
	and had a census o	censed capacity of 44 beds of 36 at the time of the survey.				1	
	NOTmet.	42 CFR Subpart 483.70(a) is					200/45
K 044 SS=F		FETY CODE STANDARD	K)44		C	3/30/15
	Based on observa exit doors going int area would not pro- deficient practice c occupants in the ex- Findings include: During the facility to	our on 7-29-15 at 9:00AM, the			K 044 Aitkin Health Services will provide latch corridor horizontal exit doors in accordance to NFPA 101 Life Safety C Standard 7.2.4 19.2.2.5 The double doors between the "new" a the old building had one leaf that would not self-close. The leaf was removed, trimmed at the bottom, and reinstalled	Code and Id	
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		K6) DATE
Electror	nically Signed					C)8/21/201

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.

PRINTED: 08/27/2015

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION (X	3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	02 - AITKIN HEALTH SERVICES	COMPLETED
		245119	B. WING		07/29/2015
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
AITKIN H	EALTH SERVICES			01 MINNESOTA AVENUE SOUTH AITKIN, MN 56431	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETI TE DATE
K 044	properly close and Section 19.2.2.2.6. would not close wh hold open.	or horizontal doors would not latch as required by SC(00) One leaf of the double doors en released from the magnetic ice was confirmed by the ance (MC) and the	K 044	Repeated opening and closing reveal the set of double doors now self-close properly. Other areas in the facility were inspect and found those areas to positively la Staff will be made aware of this requirement and to monitor during first drills and other times of non-latching double doors and report this to the Environmental Services Director immediately. The Environmental Services Director responsible for ongoing monitoring of 044 Correction Date: 8/30/15	e cted tch. e
K 050 SS=F	Fire drills are held a varying conditions, The staff is familiar that drills are part o Responsibility for p assigned only to co qualified to exercise conducted between	FETY CODE STANDARD at unexpected times under at least quarterly on each shift. with procedures and is aware f established routine. lanning and conducting drills is mpetent persons who are e leadership. Where drills are o 9 PM and 6 AM a coded y be used instead of audible	K 050		8/30/15
	Based on review o facility has not been required by LSC(00 deficient practice of	s not met as evidenced by: f available fire drill records the n conducting fire drills as) section 18.7.1.2. This ould effect all building g patients, visitors and staff in		K 050 Aitkin Health Services will conduct fir drills at varying times in compliance v NFPA 101, 2000 edition, section 19.7 A yearly fire drill schedule was develo by the Environmental Services Direct conduct fire drills at various times wit	vith .1.2. oped or to

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Event ID: RWDR21

Facility ID: 00002

If continuation sheet Page 2 of 3

		AND HUMAN SERVICES				FORM /	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - AITKIN HEALTH SERVICES	(X3) DATE COMF	SURVEY PLETED
		245119	B. WING			07/2	9/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	IEALTH SERVICES				01 MINNESOTA AVENUE SOUTH ITKIN, MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 050	Findings include: At the conclusion o 10:00AM, documer are not being condu- shifts. All drills are of each other within This deficient pract	f the inspection tour 7-29-15 at nation reveled the the fire drills ucted at varied times within the being conducted with 2 hours in the shifts. tice was confirmed by the Maintenance (MC) and the	K	050	the shifts. This schedule is known the Environmental Services Directo drill times will continue to be docum in the fire drill log. The Environmental Services Director responsible for compliance with conducting fire drills at varying time required by K 050. Correction Date: 8/30/15	or. Fire nented or is	

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and the second second

Facility ID: 00002

If continuation sheet Page 3 of 3

PRINTED: 08/27/2015



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 13, 2015

Ms. Jolynn Kullhem, Administrator Aitkin Health Services 301 Minnesota Avenue South Aitkin, Minnesota 56431

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5119023

Dear Ms. Kullhem:

The above facility was surveyed on July 27, 2015 through July 30, 2015 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 contact Chris Campbell at (218) 302-6151 or email: chris.campbell@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 Meeth

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

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY
A. BUILDING: 000002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STA AITKIN HEALTH SERVICES AITKIN, MN SECT ADVENUE AITKIN, MN SUMMARY STATEMENT OF DEFICIENCIES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG 2 000 Initial Comments 2 000 ******ATTENTION******* NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STA AITKIN HEALTH SERVICES (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 000 Initial Comments 2 000 *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section		COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STA AITKIN HEALTH SERVICES (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 000 Initial Comments 2 000 *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section		
301 MINNESOTA AVENU 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 2 000 Initial Comments 2 000 ******ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section		07/30/2015
AITKIN HEALTH SERVICES 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 2 000 Initial Comments 2 000 *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section	ATE, ZIP CODE	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG 2 000 Initial Comments 2 000 *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section Initial Comments	E SOUTH	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG 2 000 Initial Comments 2 000 ******ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section Initial Comments		
*****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section		
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: divs="" fpc="" in<br="" profinfo="" www.health.state.mn.us="">fobul.htm> The State licensing orders are delineated on the attached Minnesota</http:>		
Minnesota Department of Health	TITLE	(X6) DATE
Electronically Signed	IIILE	08/21/15

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			B. WING			
		00002			07	7/30/2015
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
AITKIN HI	EALTH SERVICES		MN 56431			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From page	e 1	2 000			
	you electronically. A is necessary for State enter the word "correc- text. You must then in State licensure proce- completion date, the corrected prior to ele Minnesota Departmen On 07/27/2015 throu this Department's sta and the following cor Please indicate in yo correction that you ha and identify the date Minnesota Department the State Licensing O federal software. Tag	gh 07/30/2015 surveyors of aff, visited the above provider rection orders are issued.				
	column entitled "ID F statute/rule out of cod "Summary Statemen and replaces the "To correction order. This findings which are in after the statement, " evidence by." Follow are the Suggested M Time period for Correct PLEASE DISREGAR FOURTH COLUMN	RD THE HEADING OF THE WHICH STATES,				
	evidence by." Follow are the Suggested M Time period for Corre PLEASE DISREGAR FOURTH COLUMN "PROVIDER'S PLAN	ing the surveyors findings lethod of Correction and ection. RD THE HEADING OF THE WHICH STATES, I OF CORRECTION." THIS RAL DEFICIENCIES ONLY.				

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00002	B. WING		07/30/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	TE, ZIP CODE	
	EALTH SERVICES		NESOTA AVENUE	E SOUTH	
			MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 000	Continued From page	2	2 000		
		IREMENT TO SUBMIT A ION FOR VIOLATIONS OF STATUTES/RULES.			
2 900	MN Rule 4658.0525 S Ulcers	Subp. 3 Rehab - Pressure	2 900		9/1/15
	Subp. 3. Pressure so comprehensive reside of nursing services m development of a nur provides that:	ent assessment, the director ust coordinate the			
	without pressure sore pressure sores unless condition demonstrate	s the individual's clinical			
	receives necessary t	 has pressure sores reatment and services to vent infection, and prevent oping. 			
	by:	t is not met as evidenced			
	review, the facility fail comprehensive reass determine if appropria place when a new pre of 3 residents (R48) id	essment was conducted to ate interventions were in essure ulcer developed for 1		F: 314 AHS ensures a comprehensive skin assessment is conducted (with root cau analysis) for any new skin ulcer to ensu appropriate intervention are in place to promote healing, prevent infection, and	
	pressure ulcers. Findings include:			prevent new sores from developing. R48 had a comprehensive reassessme of the new skin area on 7/29/15 by the certified wound nurse and it was	nt
	R48's admission Mini	mum Data Set (MDS)		determined to be MASD in the crease	

STATE FORM

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00002	B. WING		07/30/2015
IAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE	01/30/2013
		301 MIN	NESOTA AVENU	ESOUTH	
	EALTH SERVICES	AITKIN,	MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE
2 900	Continued From page	e 3	2 900		
	severe cognitive impa assist of two staff for dressing, and toilet us of one staff for person frequently incontinent MDS further indicated pressure ulcer which and was at risk for de ulcers. R48's hospital discha identified R48 had dia history of a cerebrova congestive heart failu disease. Review of R48's hosp dated 6/26/15, indica pressure ulcer (partia shallow ulcer without white tissue that adhe	8/15, indicated R48 had airment, required extensive bed mobility, transfers, se, and extensive assistance nal hygiene, and was t of bowel and bladder. The d R48 had one stage 2 was present on admission evelopment of pressure arge summary, dated 7/1/15, agnoses which included ascular accident (stroke), ire, and degenerative joint bital wound documentation ted R48 had a Stage 2 al thickness of skin loss, slough, which is yellow or eres to the ulcer bed) on the and a Stage 2 pressure al buttock.		below the coccyx. Skin training, including facility skin protocol, Braden Scale, and tissue tolerance will be provided to all RN¿ LPN¿s by 8/28/15. A comprehensive reassessment (RC will be conducted on all current resid with open areas by 8/28/15. A comprehensive assessment (RCA) of conducted on any new residents add with an open area as well as any cu residents identified with a new open DON/Designee will conduct audits of weekly basis for any residents with of areas to date, to assess for complet comprehensive assessment and appropriate interventions. Audit residents will be brought to QAPI for further re- and recommendations. Completion Date: 9/1/15	CA) dent will be mitted rrent area. n a open ion of
d ic w re cl F tc s fc d re w re	documentation form f identified R48 had be with stage 2 pressure region, which was mo changes and skin ins Further, the form iden to help determine the score was 13, indicat for development of pr decreased mobility and repositioned using a were floated off the m reducing cushion on	nd functional ability, was draw sheet in bed, heels nattress, and had a pressure			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED	
			B. WING				
		00002			07	/30/2015	
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
ITKIN HE	EALTH SERVICES		NESOTA AVENUE \$ MN 56431	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 900	Continued From pag	je 4	2 900				
	mattress had been p with reduction of pre entry note corrected clarification that the	ery 2 hours and an air placed on the bed to assist ssure. On 7/29/15, a late the documentation with a stage 2 pressure ulcers were buttocks and not on the					
	revealed the followir - on 7/1/15 identified lower buttocks which (cm) x 2.5 cm with th 10% yellow colored the wound, and an c	om 7/1/15 to 7/29/15 Ig: an open lesion on the left measured 2.5 centimeters he wound bed 90% pink and material in different spots of open lesion on the right lower 0.5 cm x 0.5 cm with dry skin					
	and right lower butto right buttocks wound	g change done at both left ocks open areas. Both left and d beds were noted to be white d reported slight discomfort e open areas.					
	scant clear drainage a dressing was char area (tail bone/base	er buttocks open area had a, and no apparent odor, and aged to the coccyx/sacral of the spine). The note ed slight pain with dressing					
	buttocks open area of wound beds had app 10% or less of yellow drainage present on skin surrounding wo	ver buttocks and left lower dressing changes done. Both proximately 90% pink with v slough present. Clear gauze when changed and und was slightly red. R48 had mfort when open areas					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY
			B. WING			
	ROVIDER OR SUPPLIER	00002	DDRESS, CITY, STATE		07	/30/2015
	COMPER OR SOLT ELER		NESOTA AVENUE §			
AITKIN HE	EALTH SERVICES		MN 56431			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLE DATE
2 900	Continued From pag	je 5	2 900			
	cleansed.					
	lower buttocks open note on 7/21/15, iden identified R48 had a which measured 2.5 no drainage or odor. was closed, fragile a -on 7/29/15, area on	ht lower buttocks and left areas were healed. Also, a ntified as a first recording open area on the coccyx cm long by 0.4 cm wide with The note indicated the area and pink in color. the coccyx identified as skin damage (MASD).				
	area on the coccyx w determined to not be evidenced by the he pressure ulcers on the which healed on 7/2 preventative interver indicated R48 had a incontinence. The w cm, and on 7/21/15, The documentation to bed had a whitish-co	tional noted identified the was a MASD and was a pressure-related as aling of two previous ne left and right buttocks, 1/15 with the use of current ntions. The documentation MASD related to yound measured 2.4 cm x 1.0 it measured 2.5 cm x 0.4 cm. further indicated the wound blored film present on wound er of the wound noted to be				
	R48 at the facility an Stage 2 verses wors coccyx and describe lesion 20% granulat with a shiny, moist, g slough." and "small History of buttock les	a.m., the physician visited ad documented R48 had a sening shear/friction on the d it as an "elliptical midline tion (pink or beefy red tissue granular appearance)/80% left lateral of midline lesion. sions healed." The physician ent orders for the pressure				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00002	B. WING		07	7/30/2015
NAME OF PI	ROVIDER OR SUPPLIER		 DDRESS, CITY, STATE			130/2013
AITKIN HE	EALTH SERVICES		NESOTA AVENUE	SOUTH		
			MN 56431	PROVIDER'S PLAN O		(175)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page	e 6	2 900			
	7/2/15, indicated R48 area and tolerated th hours without redness prominence's. An un observation indicated and tolerated 3 hours for 3 hours with rednes for 3 hours with redness form did not identify the stage 2 pressure ulce would be repositione sitting and lying positi developed a new pre- facilty had not completion	adated tissue tolerance d R48 had no skin concerns s of lying in the same position ess over bony prominence's. e Reposition Observation the presence of the two ers. The form indicated R48 d every 3 hours for both tions. Even though R48 essure ulcer on 7/21/15, the ete a new tissue tolerance n to determine if the current				
	identified R48's cocc	n Ulcer Healing Chart yx ulcer had worsened from vith an increase in size and gh.				
	impaired skin integrit ulcer will be resolved plan listed various int assess pressure ulce after each incontinen infection, pressure re	and turn and reposition				
	Assignment Sheet di every 2 hours, use as	's NAR (nursing assistant) rected staff to reposition R48 ssist of 2 staff for bed to use the toilet before and t at 1:00 p.m.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00002	B. WING		07	/30/2015
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
ITKIN HE	EALTH SERVICES		MN 56431	500TH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page	97	2 900			
	director of nursing (D R48's dressing from the had a small amount of through the 4x4 gauz pressure ulcer measu another small pressur lower edge of the larg 0.4 cm. The bed of the covered with yellow s covered with a thicke DON stated it was just edges were regular a skin surrounding the blanchable. No mace immediately surround DON stated she felt it area and indicated she physician had identifit a stage 2 pressure ul two stage 2 pressure healed in the ischeal buttocks. During an interview o LPN-A stated R48's o 2.4 cm x 1 cm with ar	lough with the lower half r, darker yellow slough. The rker than the previous day. a film yesterday. The nd deep red and the red pressure area was ration was observed ling the pressure area. The t was a maceration-related				
	be a newer area or a	stated the smaller area may n extension of the old area. area had been closed in the				
	DON stated a compre					

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		00002	B. WING		07	//30/2015
NAME OF PF	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
AITKIN HE	ALTH SERVICES		NESOTA AVENUE S MN 56431	SOUTH		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	O THE APPROPRIATE	COMPLETE
2 900	Continued From page	e 8	2 900			
	assess it immediately current facility policy developed a new pre 7/21/15. The DON sta had indicated R48 has repositioning during to though was not sure tested at 3 hours with pressure ulcers were that would have put h stated she would exp ulcers and the nurse risk factors and deter The facility policy and Protocol updated 2/1 care and services wo treat, and monitor pro The policy and proce pressure ulcers as th resident's clinical con risk factors were not not implemented, and interventions were not wound documentatio monitoring and week and procedure indica moderate to high risk have a comprehensiva assessment complete interventions for prev pressure ulcers. Risl evaluated for each sta and modified, stabiliz Conditions contributin	ed to determine appropriate ention and treatment of				
	dehydration, edema,	emaciation. The DON or be notified of new areas and				
		e analysis in addition to a				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 000002 00002 NAME OF PROVIDER OR SUPPLIER STREET A			(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00003	B. WING		07/30/2015	
		ADDRESS, CITY, STATE	ZIP CODE	0/	(130/2015	
	EALTH SERVICES		NESOTA AVENUE S	OUTH		
			MN 56431			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page 9		2 900			
	anytime a new area or round documentation wound, staging, mea presence of pain, wo of wound edges and The policy indicated or individualized interve Review of the Tissu Observation Procedur assessment form rev	ealed a new tissue tolerance in both lying and sitting with				
	Director of Nursing (I develop policies and development/or wors The DON or her desi appropriate staff on ti procedures. The DOI develop monitoring s compliance.	N or her designee could ystems to ensure ongoing				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			9/1/15
	control program must procedures which pro	d procedures. The infection t include policies and ovide for the following: ased on systematic data				

STATE FORM

6899

RWDR11

If continuation sheet 10 of 13

Minnesota Department of Healt STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	00002		B. WING		07/30/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
AITKIN HE	ALTH SERVICES		NESOTA AVENU MN 56431	ESOUTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET
21390	Continued From page	e 10	21390		
	collection to identify r residents;	nosocomial infections in			
		letection, investigation, and of infectious diseases;			
	C. isolation and	precautions systems to			
	reduce risk of transmission of infectious agents; D. in-service education in infection				
	prevention and control;				
	E. a resident health program including an				
	immunization program, a tuberculosis program as				
	defined in part 4658	.0810, and policies and			
	procedures of resident care practices to assist in				
	the prevention and treatment of infections;				
		ent and implementation of			
		cies and infection control tuberculosis program as			
	defined in part 4658.	0815;			
	G. a system for reviewing antibiotic use;H. a system for review and evaluation of				
	•	t infection control, such as			
	disinfectants, antisep				
	incontinence product				
	-	aintaining awareness of			
	current standards of	practice in infection control.			
	This MN Requiremer by:	nt is not met as evidenced			
		n, interview, and document		F: 441	
	· · · · · · · · · · · · · · · · · · ·	led to have separate areas		AHS will handle, store, process and	
		ersonal laundry and hand		transport linens so as to prevent the	
	-	laundry room. This had the of 36 residents residing in		spread of infection. The facility Linen Handling Policy was	
	the facility.			reviewed and revised on 8/14/15 to	,
	· · · · · · · · · · · · · · · · · · ·			indicate all soiled linen and clothing w	ill be
	Findings include:			rinsed in the hopper in the soiled utilit room on the unit prior to being brough	y
		n of the Clean Laundry		laundry.	
		9:40 a.m., a clean double		The clean laundry room sink has been	ר
	wash sink was obser	ved. On the right of sink an		designated for handwashing only.	

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED 07/30/2015	
		00002	B. WING		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE	
	EALTH SERVICES	301 MINN	NESOTA AVENU	E SOUTH	
	ALIH SERVICES	AITKIN, I	MN 56431		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLET
21390	Continued From page	e 11	21390		
21390	eye wash station was dirty personal linens the left of the sink was Above the sink was a In an interview on 7/3 Housekeeper (H)-A e next to the washing r Laundry Room was w clothing. H-A stated station and that no he laundry area. H-A st of "mess" every day. bowel movements in occasionally vomit. In addition, in the inte a.m., H-A stated that available in the laund a face mask was ava use a face mask to s During an observatio H-A pointed out three resident care areas. linens, gloves, face m available in all three In a follow-up intervie H-A stated she used	s located and bins of sorted (clothing and blankets). To ere two washing machines. a hand soap dispenser. 30/15, at 9:40 a.m., explained that the double sink machines in the Clean where she rinsed soiled she used that sink as a wash opper was available in the ated that there is some kind H-A stated that she rinses to the sink daily, and erview on 7/30/15, at 9:40 there were no gowns dry area. H-A showed where ailable, but stated she did not ort laundry. In on 7/30/15, at 9:57 a.m., e soiled utility rooms in Hoppers for rinsing soiled masks and gowns were	21390	All Nursing, Housekeeping, and Laun staff will be re-educated on Linen Har Policy by 8/28/15. Laundry will log any instance of receir un-rinsed soiled linen and notify nursi staff when soiled linen is brought bac the unit. DON/Designee will audit Lau logs on a weekly basis and follow up ensure compliance with updated Line Handling Procedures. Audit results w brought to QAPI for further review and recommendation. Completion Date 9/1/15	ndling ving ng k to undry to n <i>r</i> ill be
	handwashing. H-A s with bleach at the en soiled and clean use	-			
	laundry is supposed	30/15, at 12:54 p.m., tated that rinsing of all soiled to be done upstairs in the utility rooms, not in the			

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00002 NAME OF PROVIDER OR SUPPLIER STREET			(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED 07/30/2015		
			A. BUILDING:				
				07			
			.DDRESS, CITY, STATE, NESOTA AVENUE S				
AITKIN HI	EALTH SERVICES	AITKIN,	MN 56431				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
21390	Continued From page 12		21390				
	soiled laundry rinsed Clean Laundry Room cross-contamination. A Linen Handling poli directed to not pre-rin clothing in resident ca	airs. M-A stated having the into the multi-use sink in the could be a source of cy provided by the policy ise or wash out any linens or are areas. However, the s where soiled linen or sed.					
	Director of Nursing (E develop policies and laundry rinsing and ha ares are completed. T could educate all app policies and procedur designee could devel ensure ongoing comp	op monitoring systems to					