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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RWDR
Facility ID: 00002

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245119**
2. STATE VENDOR OR MEDICAID NO. (L2) **231247600**

3. NAME AND ADDRESS OF FACILITY
(L3) **AITKIN HEALTH SERVICES**
(L4) **301 MINNESOTA AVENUE SOUTH**
(L5) **AITKIN, MN** (L6) **56431**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2006**
6. DATE OF SURVEY **09/09/2015** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12.Total Facility Beds **44** (L18)

13.Total Certified Beds **44** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Chris Campbell, Unit Supervisor 10/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/08/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/09/1967** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **09/23/2015** (L33)

DETERMINATION APPROVAL

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, 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

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245119	A. Building B. Wing	9/9/2015

Name of Facility	Street Address, City, State, Zip Code
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0314 Reg. # 483.25(c) LSC	09/01/2015	ID Prefix F0441 Reg. # 483.65 LSC	09/01/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 7/30/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245119	01 - MAIN BUILDING 01	9/18/2015

Name of Facility	Street Address, City, State, Zip Code
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0044	08/30/2015	ID Prefix Reg. # NFPA 101 LSC K0050	08/30/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
7/29/2015	

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245119	02 - AITKIN HEALTH SERVICES	9/18/2015

Name of Facility	Street Address, City, State, Zip Code
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0044	08/30/2015	ID Prefix Reg. # NFPA 101 LSC K0050	08/30/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/29/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RWDR
Facility ID: 00002

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245119**

2. STATE VENDOR OR MEDICAID NO. (L2) **231247600**

3. NAME AND ADDRESS OF FACILITY
(L3) **AITKIN HEALTH SERVICES**
(L4) **301 MINNESOTA AVENUE SOUTH**
(L5) **AITKIN, MN** (L6) **56431**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2006**

6. DATE OF SURVEY **07/30/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12. Total Facility Beds **44** (L18)

13. Total Certified Beds **44** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	44			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, HFE NEII 08/28/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/16/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/09/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

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

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

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

<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.

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING ______ B. WING ______	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehensive reassessment was conducted to determine if appropriate interventions were in place when a new pressure ulcer developed for 1 of 3 residents (R48) identified with current pressure ulcers.	F 314	F: 314 AHS ensures a comprehensive skin assessment is conducted (with root cause analysis) for any new skin ulcer to ensure appropriate intervention are in place to promote healing, prevent infection, and prevent new sores from developing. R48 had a comprehensive reassessment	9/1/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/21/2015

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.

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

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F 314	Continued From page 1 Findings include: R48's admission Minimum Data Set (MDS) assessment dated 7/8/15, indicated R48 had severe cognitive impairment, required extensive assist of two staff for bed mobility, transfers, dressing, and toilet use, and extensive assistance of one staff for personal hygiene, and was frequently incontinent of bowel and bladder. The MDS further indicated R48 had one stage 2 pressure ulcer which was present on admission and was at risk for development of pressure ulcers. R48's hospital discharge summary, dated 7/1/15, identified R48 had diagnoses which included history of a cerebrovascular accident (stroke), congestive heart failure, and degenerative joint disease. Review of R48's hospital wound documentation dated 6/26/15, indicated R48 had a Stage 2 pressure ulcer (partial thickness of skin loss, shallow ulcer without slough, which is yellow or white tissue that adheres to the ulcer bed) on the right medial buttock. and a Stage 2 pressure ulcer on the left medial buttock. Review of the facility Admissions Observation documentation form from 7/1/15 through 7/10/15 identified R48 had been admitted to the facility with stage 2 pressure ulcers on the coccyx region, which was monitored with dressing changes and skin inspections were done weekly. Further, the form identified R48's Braden (a tool to help determine the risk for pressure ulcers) score was 13, indicating R48 was a moderate risk for development of pressure ulcers, had decreased mobility and functional ability, was	F 314	of the new skin area on 7/29/15 by the certified wound nurse and it was determined to be MASD in the crease below the coccyx. Skin training, including facility skin protocol, Braden Scale, and tissue tolerance will be provided to all RN¿s and LPN¿s by 8/28/15. A comprehensive reassessment (RCA) will be conducted on all current resident with open areas by 8/28/15. A comprehensive assessment (RCA) will be conducted on any new residents admitted with an open area as well as any current residents identified with a new open area. DON/Designee will conduct audits on a weekly basis for any residents with open areas to date, to assess for completion of comprehensive assessment and appropriate interventions. Audit results will be brought to QAPI for further review and recommendations. Completion Date: 9/1/15	

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F 314	Continued From page 2	F 314		

repositioned using a draw sheet in bed, heels were floated off the mattress, and had a pressure reducing cushion on the wheelchair. The documentation further indicated R48 was turned and repositioned every 2 hours and an air mattress had been placed on the bed to assist with reduction of pressure. On 7/29/15, a late entry note corrected the documentation with a clarification that the stage 2 pressure ulcers were located on the lower buttocks and not on the coccyx.

Review of R48's Skin Condition/Wound Progression notes from 7/1/15 to 7/29/15 revealed the following:
- on 7/1/15 identified an open lesion on the left lower buttocks which measured 2.5 centimeters (cm) x 2.5 cm with the wound bed 90% pink and 10% yellow colored material in different spots of the wound, and an open lesion on the right lower buttocks measuring 0.5 cm x 0.5 cm with dry skin on the edges of the open area.

-on 7/10/15, dressing change done at both left and right lower buttocks open areas. Both left and right buttocks wound beds were noted to be white in color and R48 had reported slight discomfort with cleansing of the open areas.

-on 7/12/15, left lower buttocks open area had scant clear drainage, and no apparent odor, and a dressing was changed to the coccyx/sacral area (tail bone/base of the spine). The note identified R48 reported slight pain with dressing change.

-on 7/15/15, right lower buttocks and left lower buttocks open area dressing changes done. Both

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F 314	Continued From page 3 wound beds had approximately 90% pink with 10% or less of yellow slough present. Clear drainage present on gauze when changed and skin surrounding wound was slightly red. R48 had reported slight discomfort when open areas cleansed. -on 7/21/15, both right lower buttocks and left lower buttocks open areas were healed. Also, a note on 7/21/15, identified as a first recording identified R48 had a open area on the coccyx which measured 2.5 cm long by 0.4 cm wide with no drainage or odor. The note indicated the area was closed, fragile and pink in color. -on 7/29/15, area on the coccyx identified as moisture associated skin damage (MASD). -on 7/29/15, an additional noted identified the area on the coccyx was a MASD and was determined to not be a pressure-related as evidenced by the healing of two previous pressure ulcers on the left and right buttocks, which healed on 7/21/15 with the use of current preventative interventions. The documentation indicated R48 had a MASD related to incontinence. The wound measured 2.4 cm x 1.0 cm, and on 7/21/15, it measured 2.5 cm x 0.4 cm. The documentation further indicated the wound bed had a whitish-colored film present on wound edges with the center of the wound noted to be pinkish-red in color. On 7/29/15 at 10:15 a.m., the physician visited R48 at the facility and documented R48 had a Stage 2 verses worsening shear/friction on the coccyx and described it as an "elliptical midline lesion 20% granulation (pink or beefy red tissue with a shiny, moist, granular appearance)/80%	F 314		

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F 314	Continued From page 4	F 314		

slough." and "small left lateral of midline lesion. History of buttock lesions healed." The physician changed the treatment orders for the pressure ulcer.

A Tissue Tolerance Reposition Observation dated 7/2/15, indicated R48 had a reddened perineal area and tolerated the same sitting position for 3 hours without redness over the bony prominence's. An undated tissue tolerance observation indicated R48 had no skin concerns and tolerated 3 hours of lying in the same position for 3 hours with redness over bony prominence's. The Tissue Tolerance Reposition Observation form did not identify the presence of the two stage 2 pressure ulcers. The form indicated R48 would be repositioned every 3 hours for both sitting and lying positions. Even though R48 developed a new pressure ulcer on 7/21/15, the facilty had not complete a new tissue tolerance reposition observation to determine if the current assessment was adequate for R48.

Review of R48's Skin Ulcer Healing Chart identified R48's coccyx ulcer had worsened from 7/20/15 to 7/29/15, with an increase in size and the presence of slough.

R48's care plan dated 7/27/15, indicated R48 had impaired skin integrity with the goal of : Pressure ulcer will be resolved by 10/31/15. R48's care plan listed various interventions which included: assess pressure ulcer, provide good pericare after each incontinent episode, monitor for infection, pressure reducing cushion on wheelchair and bed, and turn and reposition

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F 314	Continued From page 5 every 2 hours and as needed for comfort. Review of the facility's NAR (nursing assistant) Assignment Sheet directed staff to reposition R48 every 2 hours, use assist of 2 staff for bed mobility, and prompt to use the toilet before and after meals, and toilet at 1:00 p.m. During observation on 7/30/15, at 9:47 a.m. the director of nursing (DON) and LPN-A removed R48's dressing from the coccyx. The dressing had a small amount of serosanguineous drainage through the 4x4 gauze dressing. The primary pressure ulcer measured 2.5 cm x 1.0 cm with another small pressure area on the side of the lower edge of the larger area measuring 0.5 cm x 0.4 cm. The bed of the wound was 100% covered with yellow slough with the lower half covered with a thicker, darker yellow slough. The DON stated it was darker than the previous day. She stated it was just a film yesterday. The edges were regular and deep red and the red skin surrounding the pressure area was blanchable. No maceration was observed immediately surrounding the pressure area. The DON stated she felt it was a maceration-related area and indicated she was not aware the physician had identified the area on the coccyx as a stage 2 pressure ulcer. She confirmed R48 had two stage 2 pressure ulcers, which had just healed in the ischeal tuberosity areas of the buttocks. During an interview on 7/29/15, at 11:54 a.m. LPN-A stated R48's coccyx open area measured 2.4 cm x 1 cm with an open area on the side of it measuring 0.5 cm x 0.2 cm with 20% red and 80% slough. LPN-A stated the smaller area may be a newer area or an extension of the old area.	F 314		

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F 314	Continued From page 6 LPN-A indicated the area had been closed in the last week During an interview on 7/30/15, at 12:29 p.m. the DON stated a comprehensive assessment which includes skin, bowel and bladder, fall risk, and pain is completed by the eighth day after admission. The DON verified if a resident is admitted with pressure ulcers, the RN should assess it immediately. The DON confirmed the current facility policy and confirmed R48 had developed a new pressure ulcer on the coccyx on 7/21/15. The DON stated the tissue testing form had indicated R48 had tolerated 3 hours without repositioning during the tissue tolerance testing, though was not sure why R48 would have been tested at 3 hours without repositioning when pressure ulcers were already present and verified that would have put him more at risk. The DON stated she would expect nurses to measure skin ulcers and the nurse manager would consider the risk factors and determine initial interventions. The facility policy and procedure for Skin Ulcer Protocol updated 2/1/15, indicated appropriate care and services would be provided to prevent, treat, and monitor progress of all healing ulcers. The policy and procedure identified avoidable pressure ulcers as those that developed when a resident's clinical condition was not evaluated, risk factors were not identified, interventions were not implemented, and the effectiveness of interventions were not monitored or revised. The wound documentation was to include daily monitoring and weekly assessment. The policy and procedure indicated residents identified at moderate to high risk by the Braden scale would have a comprehensive pressure ulcer risk assessment completed to determine appropriate	F 314		

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F 314	Continued From page 7 interventions for prevention and treatment of pressure ulcers. Risk factors were to be evaluated for each skin assessment, identified and modified, stabilized, or removed if possible. Conditions contributing to the development of pressure ulcers included prolonged illness, dehydration, edema, emaciation. The DON or wound nurse was to be notified of new areas and complete a root cause analysis in addition to a Braden and tissue tolerance test to be done anytime a new area develops. Weekly wound round documentation was to include the type of wound, staging, measurements, exudates, presence of pain, wound base tissue, description of wound edges and surrounding tissue, odor. The policy indicated consistent, routine, of individualized interventions must be in place. Review of the Tissue Tolerance/Repositioning Observation Procedure on the back of the assessment form revealed a new tissue tolerance would be completed in both lying and sitting with the development of a new skin ulcer.	F 314		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		9/1/15

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F 441	Continued From page 8 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have separate areas for rinsing of soiled personal laundry and hand washing in the clean laundry room. This had the potential to affect 32 of 36 residents residing in the facility. Findings include: During an observation of the Clean Laundry Room on 7/30/15, at 9:40 a.m., a clean double	F 441	F: 441 AHS will handle, store, process and transport linens so as to prevent the spread of infection. The facility Linen Handling Policy was reviewed and revised on 8/14/15 to indicate all soiled linen and clothing will be rinsed in the hopper in the soiled utility room on the unit prior to being brought to laundry. A separate area has been designated in	

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F 441	Continued From page 9 wash sink was observed. On the right of sink an eye wash station was located and bins of sorted dirty personal linens (clothing and blankets). To the left of the sink were two washing machines. Above the sink was a hand soap dispenser. In an interview on 7/30/15, at 9:40 a.m., Housekeeper (H)-A explained that the double sink next to the washing machines in the Clean Laundry Room was where she rinsed soiled clothing. H-A stated she used the sink as a wash station and that no hopper was available in the laundry area. H-A stated that there is some kind of "mess" every day. H-A stated that she rinses bowel movements into the sink daily, and occasionally vomit. In addition, in the interview on 7/30/15, at 9:40 a.m., H-A stated that there were no gowns available in the laundry area. H-A showed where a face mask was available, but stated she did not use a face mask to sort laundry. During an observation on 7/30/15, at 9:57 a.m., H-A pointed out three soiled utility rooms in resident care areas. Hoppers for rinsing soiled linens, gloves, face masks and gowns were available in all three rooms. In a follow-up interview on 7/30/15, at 12:07 p.m., H-A stated she used both sides of the sink in the Clean Laundry Room to rinse "messes" down the drain. H-A stated the sink is also used for handwashing. H-A stated the sink was washed with bleach at the end of the day, but not between soiled and clean uses. In an interview on 7/30/15, at 12:54 p.m., Maintenance (M)-A stated that rinsing of all soiled	F 441	the laundry room with a dirty sink and PPE is available in this area. A clean sink for hand washing has also been designated in the clean area of the laundry room. All Nursing, Housekeeping, and Laundry staff will be re-educated on Linen Handling Policy by 8/28/15. Laundry will log any instance of receiving un-rinsed soiled linen and includes instructions to notify nursing staff when soiled linen is brought back to the unit to be rinsed in the hopper by nursing staff with appropriate PPE. DON/Designee will audit Laundry logs on a weekly basis and follow up to ensure compliance with updated Linen Handling Procedures. Audit results will be brought to QAPI for further review and recommendation. Completion Date 9/1/15	

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F 441	Continued From page 10 laundry is supposed to be done upstairs in the hoppers in the soiled utility rooms, not in the laundry room downstairs. M-A stated having the soiled laundry rinsed into the multi-use sink in the Clean Laundry Room could be a source of cross-contamination. A Linen Handling policy provided by the policy directed to not pre-rinse or wash out any linens or clothing in resident care areas. However, the policy did not address where soiled linen or clothing was to be rinsed.	F 441		

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F5119023

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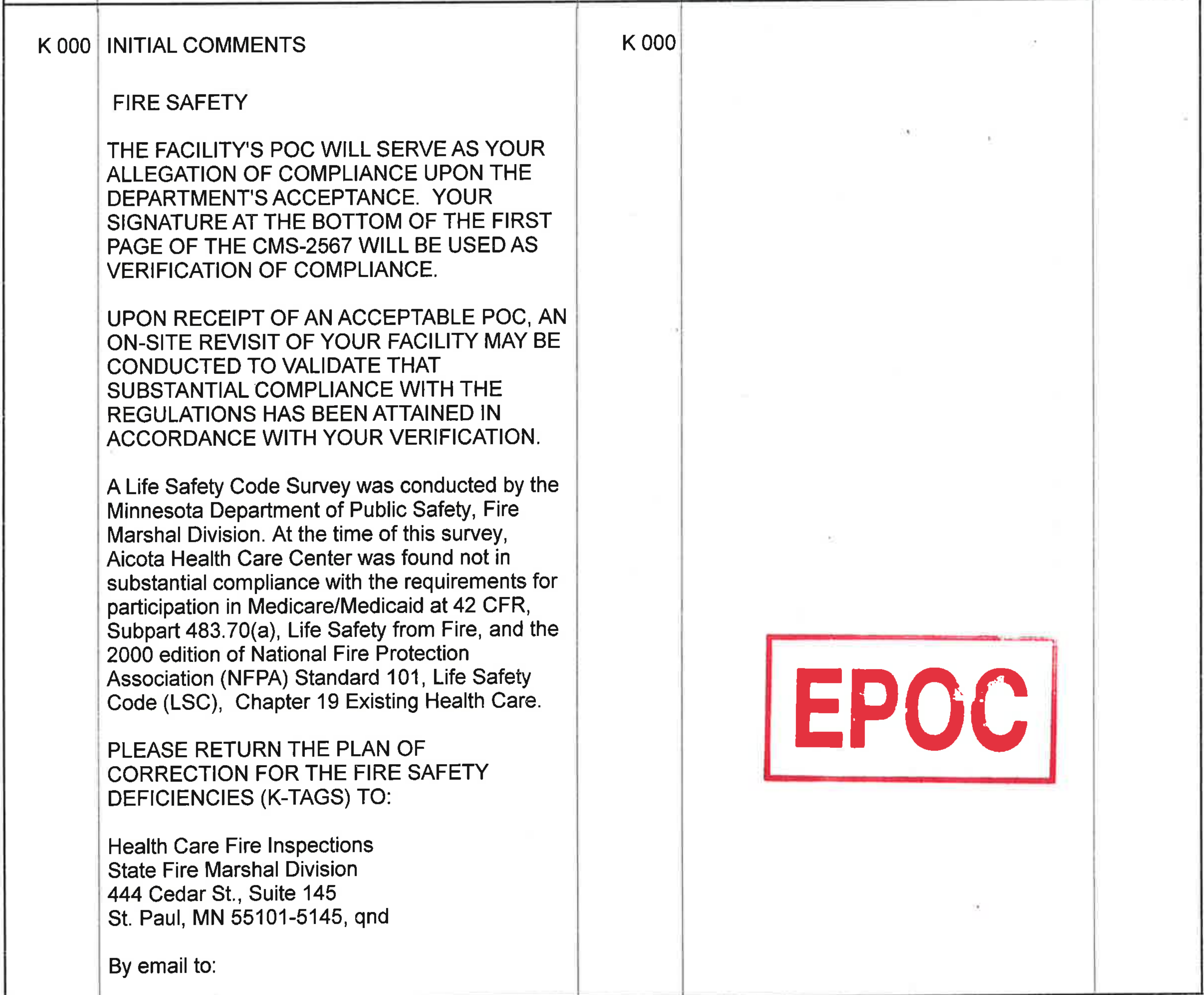
K 000	INITIAL COMMENTS	K 000		



FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Aicota Health Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
444 Cedar St., Suite 145
St. Paul, MN 55101-5145, qnd

By email to:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/21/2015

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	245119	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**07/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	**301 MINNESOTA AVENUE SOUTH** **AITKIN, MN 56431**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Aitkin Health Services was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Aitkin Health Services is a one story building with a full basement. The original building was constructed in 1955 with additions in 1962, and a dining room main entry was added in 2002. Both the existing building and the addition are type II(111) construction. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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K 000	Continued From page 2 open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of44 beds and had a census of 36 at the time of the survey. At this time, the conditions of 42 CFR, Subpart 483.70(a) is NOT met.	K 000		
K 044 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 This STANDARD is not met as evidenced by: Based on observation and testing the horizontal exit doors going into the "new" skilled nursing area would not properly close and latch. This deficient practice could affect all building occupants in the event of a fire. Findings include: During the facility tour on 7-29-15 at 9:00 AM, the double cross corridor horizontal exit doors would not properly close and latch as required by LSC(00) Section 19.2.2.2.6. One leaf of the double doors would not close when released from the magnetic hold open. This deficient practice was confirmed by the Director of Maintenance (MC) and the Administrator (JK) at the time of exit.	K 044	K 044 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	8/30/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/29/2015

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AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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K 044	Continued From page 3	K 044	Correction Date: 8/30/15	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on a review of fire drill records, it was determined that the facility staff have not conducted fire exit drills in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code" (LSC) 2000 edition section 19.7.1.2. Conducting fire drills at approximately the same time during the shift gives a false sense of security which would negatively impact all occupants of the building in a fire emergency. Findings include: At the conclusion of the facility tour on 7-29-15 at 10:00AM, documentation revealed that fire exit drills are not being conducted at varying times within the shifts. All drills are being conducted within 2 hours of each other during the shfts. This deficient practice was confirmed by the Director of Facility Maintenance (MC) and the	K 050	K 050 Aitkin Health Services will conduct fire drills at varying times in compliance with NFPA 101, 2000 edition, section 19.7.1.2. A yearly fire drill schedule was developed by the Environmental Services Director to conduct fire drills at various times within the shifts. This schedule is known only to the Environmental Services Director. Fire drill times will continue to be documented in the fire drill log. The Environmental Services Director is responsible for compliance with conducting fire drills at varying times as required by K 050. Correction Date: 8/30/15	8/30/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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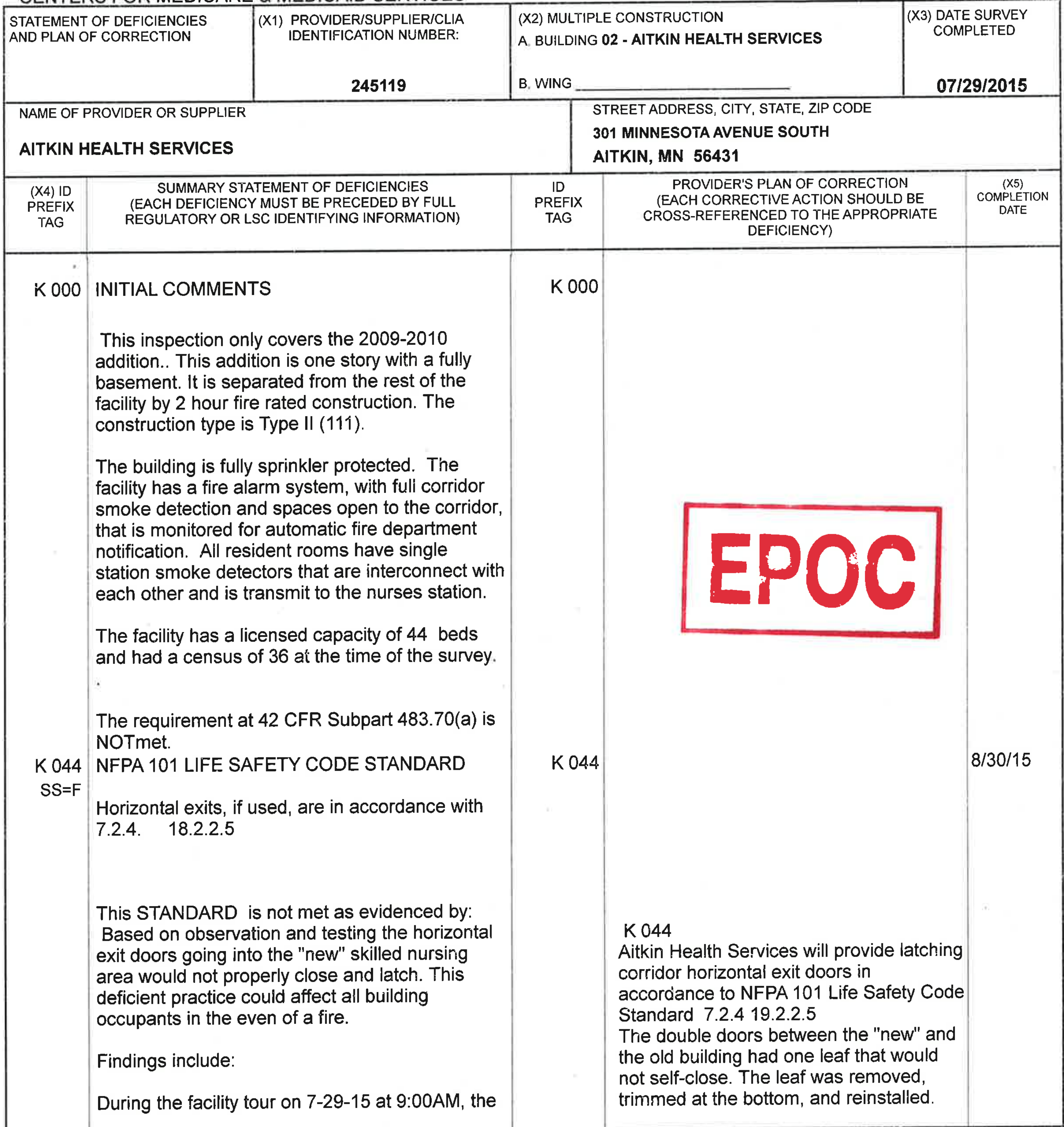
K 050	Continued From page 4 Administrator (JK)) at the time of exit.	K 050		

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

F5119023

PRINTED: 08/27/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING **02 - AITKIN HEALTH SERVICES** B. WING ______	**07/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	**301 MINNESOTA AVENUE SOUTH** **AITKIN, MN 56431**

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K 000	INITIAL COMMENTS This inspection only covers the 2009-2010 addition.. This addition is one story with a fully basement. It is separated from the rest of the facility by 2 hour fire rated construction. The construction type is Type II (111). The building is fully sprinkler protected. The facility has a fire alarm system, with full corridor smoke detection and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that are interconnect with each other and is transmit to the nurses station. The facility has a licensed capacity of 44 beds and had a census of 36 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOTmet.	K 000	EPOC	
K 044 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5 This STANDARD is not met as evidenced by: Based on observation and testing the horizontal exit doors going into the "new" skilled nursing area would not properly close and latch. This deficient practice could affect all building occupants in the even of a fire. Findings include: During the facility tour on 7-29-15 at 9:00AM, the	K 044	K 044 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.	8/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/21/2015

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.

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

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	245119	A. BUILDING 02 - AITKIN HEALTH SERVICES B. WING	07/29/2015

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K 044	Continued From page 1 double cross corridor horizontal doors would not properly close and latch as required by SC(00) Section 19.2.2.2.6. One leaf of the double doors would not close when released from the magnetic hold open. This deficient practice was confirmed by the Director of Maintenance (MC) and the Administrator (JK) at the time of exit.	K 044	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 Correction Date: 8/30/15	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of available fire drill records the facility has not been conducting fire drills as required by LSC(00) section 18.7.1.2. This deficient practice could effect all building occupants, including patients, visitors and staff in the event of a fire.	K 050	K 050 Aitkin Health Services will conduct fire drills at varying times in compliance with NFPA 101, 2000 edition, section 19.7.1.2. A yearly fire drill schedule was developed by the Environmental Services Director to conduct fire drills at various times within	8/30/15

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

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	245119	A. BUILDING **02 - AITKIN HEALTH SERVICES** B. WING	**07/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 050	Continued From page 2 Findings include: At the conclusion of the inspection tour 7-29-15 at 10:00AM, documentation reveled the the fire drills are not being conducted at varied times within the shifts. All drills are being conducted with 2 hours of each other within the shifts. This deficient practice was confirmed by the Director of Facility Maintenance (MC) and the Administrator (JK) at the time of exit.	K 050	the shifts. This schedule is known only to the Environmental Services Director. Fire drill times will continue to be documented in the fire drill log. The Environmental Services Director is responsible for compliance with conducting fire drills at varying times as required by K 050. Correction Date: 8/30/15	

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately 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 Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00002	A. BUILDING: ____ B. WING ____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

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

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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On 07/27/2015 through 07/30/2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehensive reassessment was conducted to determine if appropriate interventions were in place when a new pressure ulcer developed for 1 of 3 residents (R48) identified with current pressure ulcers. Findings include: R48's admission Minimum Data Set (MDS)	2 900	F: 314 AHS ensures a comprehensive skin assessment is conducted (with root cause analysis) for any new skin ulcer to ensure appropriate intervention are in place to promote healing, prevent infection, and prevent new sores from developing. R48 had a comprehensive reassessment of the new skin area on 7/29/15 by the certified wound nurse and it was determined to be MASD in the crease	9/1/15

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2 900	Continued From page 3 assessment dated 7/8/15, indicated R48 had severe cognitive impairment, required extensive assist of two staff for bed mobility, transfers, dressing, and toilet use, and extensive assistance of one staff for personal hygiene, and was frequently incontinent of bowel and bladder. The MDS further indicated R48 had one stage 2 pressure ulcer which was present on admission and was at risk for development of pressure ulcers. R48's hospital discharge summary, dated 7/1/15, identified R48 had diagnoses which included history of a cerebrovascular accident (stroke), congestive heart failure, and degenerative joint disease. Review of R48's hospital wound documentation dated 6/26/15, indicated R48 had a Stage 2 pressure ulcer (partial thickness of skin loss, shallow ulcer without slough, which is yellow or white tissue that adheres to the ulcer bed) on the right medial buttock. and a Stage 2 pressure ulcer on the left medial buttock. Review of the facility Admissions Observation documentation form from 7/1/15 through 7/10/15 identified R48 had been admitted to the facility with stage 2 pressure ulcers on the coccyx region, which was monitored with dressing changes and skin inspections were done weekly. Further, the form identified R48's Braden (a tool to help determine the risk for pressure ulcers) score was 13, indicating R48 was a moderate risk for development of pressure ulcers, had decreased mobility and functional ability, was repositioned using a draw sheet in bed, heels were floated off the mattress, and had a pressure reducing cushion on the wheelchair. The documentation further indicated R48 was turned	2 900	below the coccyx. Skin training, including facility skin protocol, Braden Scale, and tissue tolerance will be provided to all RN¿s and LPN¿s by 8/28/15. A comprehensive reassessment (RCA) will be conducted on all current resident with open areas by 8/28/15. A comprehensive assessment (RCA) will be conducted on any new residents admitted with an open area as well as any current residents identified with a new open area. DON/Designee will conduct audits on a weekly basis for any residents with open areas to date, to assess for completion of comprehensive assessment and appropriate interventions. Audit results will be brought to QAPI for further review and recommendations. Completion Date: 9/1/15	

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2 900	Continued From page 4	2 900		

and repositioned every 2 hours and an air mattress had been placed on the bed to assist with reduction of pressure. On 7/29/15, a late entry note corrected the documentation with a clarification that the stage 2 pressure ulcers were located on the lower buttocks and not on the coccyx.

Review of R48's Skin Condition/Wound Progression notes from 7/1/15 to 7/29/15 revealed the following:
- on 7/1/15 identified an open lesion on the left lower buttocks which measured 2.5 centimeters (cm) x 2.5 cm with the wound bed 90% pink and 10% yellow colored material in different spots of the wound, and an open lesion on the right lower buttocks measuring 0.5 cm x 0.5 cm with dry skin on the edges of the open area.

-on 7/10/15, dressing change done at both left and right lower buttocks open areas. Both left and right buttocks wound beds were noted to be white in color and R48 had reported slight discomfort with cleansing of the open areas.

-on 7/12/15, left lower buttocks open area had scant clear drainage, and no apparent odor, and a dressing was changed to the coccyx/sacral area (tail bone/base of the spine). The note identified R48 reported slight pain with dressing change.

-on 7/15/15, right lower buttocks and left lower buttocks open area dressing changes done. Both wound beds had approximately 90% pink with 10% or less of yellow slough present. Clear drainage present on gauze when changed and skin surrounding wound was slightly red. R48 had reported slight discomfort when open areas

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cleansed.

-on 7/21/15, both right lower buttocks and left lower buttocks open areas were healed. Also, a note on 7/21/15, identified as a first recording identified R48 had a open area on the coccyx which measured 2.5 cm long by 0.4 cm wide with no drainage or odor. The note indicated the area was closed, fragile and pink in color.

-on 7/29/15, area on the coccyx identified as moisture associated skin damage (MASD).

-on 7/29/15, an additional noted identified the area on the coccyx was a MASD and was determined to not be a pressure-related as evidenced by the healing of two previous pressure ulcers on the left and right buttocks, which healed on 7/21/15 with the use of current preventative interventions. The documentation indicated R48 had a MASD related to incontinence. The wound measured 2.4 cm x 1.0 cm, and on 7/21/15, it measured 2.5 cm x 0.4 cm. The documentation further indicated the wound bed had a whitish-colored film present on wound edges with the center of the wound noted to be pinkish-red in color.

On 7/29/15 at 10:15 a.m., the physician visited R48 at the facility and documented R48 had a Stage 2 verses worsening shear/friction on the coccyx and described it as an "elliptical midline lesion 20% granulation (pink or beefy red tissue with a shiny, moist, granular appearance)/80% slough." and "small left lateral of midline lesion. History of buttock lesions healed." The physician changed the treatment orders for the pressure ulcer.

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A Tissue Tolerance Reposition Observation dated 7/2/15, indicated R48 had a reddened perineal area and tolerated the same sitting position for 3 hours without redness over the bony prominence's. An undated tissue tolerance observation indicated R48 had no skin concerns and tolerated 3 hours of lying in the same position for 3 hours with redness over bony prominence's. The Tissue Tolerance Reposition Observation form did not identify the presence of the two stage 2 pressure ulcers. The form indicated R48 would be repositioned every 3 hours for both sitting and lying positions. Even though R48 developed a new pressure ulcer on 7/21/15, the facilty had not complete a new tissue tolerance reposition observation to determine if the current assessment was adequate for R48.

Review of R48's Skin Ulcer Healing Chart identified R48's coccyx ulcer had worsened from 7/20/15 to 7/29/15, with an increase in size and the presence of slough.

R48's care plan dated 7/27/15, indicated R48 had impaired skin integrity with the goal of : Pressure ulcer will be resolved by 10/31/15. R48's care plan listed various interventions which included: assess pressure ulcer, provide good pericare after each incontinent episode, monitor for infection, pressure reducing cushion on wheelchair and bed, and turn and reposition every 2 hours and as needed for comfort.

Review of the facility's NAR (nursing assistant) Assignment Sheet directed staff to reposition R48 every 2 hours, use assist of 2 staff for bed mobility, and prompt to use the toilet before and after meals, and toilet at 1:00 p.m.

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During observation on 7/30/15, at 9:47 a.m. the director of nursing (DON) and LPN-A removed R48's dressing from the coccyx. The dressing had a small amount of serosanguineous drainage through the 4x4 gauze dressing. The primary pressure ulcer measured 2.5 cm x 1.0 cm with another small pressure area on the side of the lower edge of the larger area measuring 0.5 cm x 0.4 cm. The bed of the wound was 100% covered with yellow slough with the lower half covered with a thicker, darker yellow slough. The DON stated it was darker than the previous day. She stated it was just a film yesterday. The edges were regular and deep red and the red skin surrounding the pressure area was blanchable. No maceration was observed immediately surrounding the pressure area. The DON stated she felt it was a maceration-related area and indicated she was not aware the physician had identified the area on the coccyx as a stage 2 pressure ulcer. She confirmed R48 had two stage 2 pressure ulcers, which had just healed in the isccheal tuberosity areas of the buttocks.

During an interview on 7/29/15, at 11:54 a.m. LPN-A stated R48's coccyx open area measured 2.4 cm x 1 cm with an open area on the side of it measuring 0.5 cm x 0.2 cm with 20% red and 80% slough. LPN-A stated the smaller area may be a newer area or an extension of the old area. LPN-A indicated the area had been closed in the last week

During an interview on 7/30/15, at 12:29 p.m. the DON stated a comprehensive assessment which includes skin, bowel and bladder, fall risk, and pain is completed by the eighth day after admission. The DON verified if a resident is

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admitted with pressure ulcers, the RN should assess it immediately. The DON confirmed the current facility policy and confirmed R48 had developed a new pressure ulcer on the coccyx on 7/21/15. The DON stated the tissue testing form had indicated R48 had tolerated 3 hours without repositioning during the tissue tolerance testing, though was not sure why R48 would have been tested at 3 hours without repositioning when pressure ulcers were already present and verified that would have put him more at risk. The DON stated she would expect nurses to measure skin ulcers and the nurse manager would consider the risk factors and determine initial interventions.

The facility policy and procedure for Skin Ulcer Protocol updated 2/1/15, indicated appropriate care and services would be provided to prevent, treat, and monitor progress of all healing ulcers. The policy and procedure identified avoidable pressure ulcers as those that developed when a resident's clinical condition was not evaluated, risk factors were not identified, interventions were not implemented, and the effectiveness of interventions were not monitored or revised. The wound documentation was to include daily monitoring and weekly assessment. The policy and procedure indicated residents identified at moderate to high risk by the Braden scale would have a comprehensive pressure ulcer risk assessment completed to determine appropriate interventions for prevention and treatment of pressure ulcers. Risk factors were to be evaluated for each skin assessment, identified and modified, stabilized, or removed if possible. Conditions contributing to the development of pressure ulcers included prolonged illness, dehydration, edema, emaciation. The DON or wound nurse was to be notified of new areas and complete a root cause analysis in addition to a

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2 900	Continued From page 9 Braden and tissue tolerance test to be done anytime a new area develops. Weekly wound round documentation was to include the type of wound, staging, measurements, exudates, presence of pain, wound base tissue, description of wound edges and surrounding tissue, odor. The policy indicated consistent, routine, of individualized interventions must be in place. Review of the Tissue Tolerance/Repositioning Observation Procedure on the back of the assessment form revealed a new tissue tolerance would be completed in both lying and sitting with the development of a new skin ulcer. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or her designee could develop policies and procedures to prevent the development/or worsening of pressure ulcers. The DON or her designee could educate all appropriate staff on these policies and procedures. The DON or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data	21390		9/1/15

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21390	Continued From page 10 collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks 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; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have separate areas for rinsing of soiled personal laundry and hand washing in the clean laundry room. This had the potential to affect 32 of 36 residents residing in the facility. Findings include: During an observation of the Clean Laundry Room on 7/30/15, at 9:40 a.m., a clean double wash sink was observed. On the right of sink an	21390	F: 441 AHS will handle, store, process and transport linens so as to prevent the spread of infection. The facility Linen Handling Policy was reviewed and revised on 8/14/15 to indicate all soiled linen and clothing will be rinsed in the hopper in the soiled utility room on the unit prior to being brought to laundry. The clean laundry room sink has been designated for handwashing only.	

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21390	Continued From page 11 eye wash station was located and bins of sorted dirty personal linens (clothing and blankets). To the left of the sink were two washing machines. Above the sink was a hand soap dispenser. In an interview on 7/30/15, at 9:40 a.m., Housekeeper (H)-A explained that the double sink next to the washing machines in the Clean Laundry Room was where she rinsed soiled clothing. H-A stated she used the sink as a wash station and that no hopper was available in the laundry area. H-A stated that there is some kind of "mess" every day. H-A stated that she rinses bowel movements into the sink daily, and occasionally vomit. In addition, in the interview on 7/30/15, at 9:40 a.m., H-A stated that there were no gowns available in the laundry area. H-A showed where a face mask was available, but stated she did not use a face mask to sort laundry. During an observation on 7/30/15, at 9:57 a.m., H-A pointed out three soiled utility rooms in resident care areas. Hoppers for rinsing soiled linens, gloves, face masks and gowns were available in all three rooms. In a follow-up interview on 7/30/15, at 12:07 p.m., H-A stated she used both sides of the sink in the Clean Laundry Room to rinse "messes" down the drain. H-A stated the sink is also used for handwashing. H-A stated the sink was washed with bleach at the end of the day, but not between soiled and clean uses. In an interview on 7/30/15, at 12:54 p.m., Maintenance (M)-A stated that rinsing of all soiled laundry is supposed to be done upstairs in the hoppers in the soiled utility rooms, not in the	21390	All Nursing, Housekeeping, and Laundry staff will be re-educated on Linen Handling Policy by 8/28/15. Laundry will log any instance of receiving un-rinsed soiled linen and notify nursing staff when soiled linen is brought back to the unit. DON/Designee will audit Laundry logs on a weekly basis and follow up to ensure compliance with updated Linen Handling Procedures. Audit results will be brought to QAPI for further review and recommendation. Completion Date 9/1/15	

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21390	Continued From page 12 laundry room downstairs. M-A stated having the soiled laundry rinsed into the multi-use sink in the Clean Laundry Room could be a source of cross-contamination. A Linen Handling policy provided by the policy directed to not pre-rinse or wash out any linens or clothing in resident care areas. However, the policy did not address where soiled linen or clothing was to be rinsed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or her designee could develop policies and procedures to ensure dirty laundry rinsing and handwashing are in separate ares are completed. The DON or her designee could educate all appropriate staff on these policies and procedures. The DON or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		