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: VWX6

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 **08/01/2014** (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: * Code: **A*** (L12)

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

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 :
Patricia Halverson, Unit Supervisor 08/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/18/2014 (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
09/19/2014 (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245119

September 25, 2014

Mr. Scot Allen, Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, Minnesota 56431

Dear Mr. Allen:

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 15, 2014 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
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

September 25, 2014

Mr. Scot Allen, Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, Minnesota 56431

RE: Project Number S5119022

Dear Mr. Allen:

On August 12, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 1, 2014. 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 19, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 1, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 15, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 1, 2014, effective September 15, 2014 and therefore remedies outlined in our letter to you dated August 12, 2014, 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
Division of Compliance Monitoring
Minnesota Department of Health
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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245119	A. Building B. Wing	9/19/2014

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **09/15/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/15/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/15/2014**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **09/15/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **09/15/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/15/2014**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/15/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PLH/mm	09/25/2014	12835	09/19/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/1/2014

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 — ID: VWX6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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 **08/01/2014** (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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Teresa Ament, HFE NEII — 08/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 09/18/2014 (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)

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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
Posted 09/19/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 12, 2014

Mr. Scot Allen, Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, Minnesota 56431

RE: Project Number S5119022

Dear Mr. Allen:

On August 1, 2014, 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;

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

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

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

DEPARTMENT CONTACT

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

Patricia Halverson, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Patricia.halverson@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 10, 2014, 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 10, 2014 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 November 1, 2014 (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 February 1, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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

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

Telephone: (651) 201-4118
Fax: (651) 215-969

5119s14

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 _____	08/01/2014

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 PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. CENSUS - 41	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor resident choices regarding bathing type or frequency for 2 of 3 residents (R3, R56) reviewed for choices. Findings include:	F 242	F242 Both R3 and R56 were re-interviewed in regards to bathing preferences and frequency. R3 and R56 bathing choices are indicated on the bathing schedule. All residents have the potential to be	9/15/14

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

Electronically Signed | 08/22/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. BUILDING _____ B. WING _____	08/01/2014

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 242	Continued From page 1 R3, interviewed on 7/29/14, at 4:30 p.m., stated she was unable to choose how many times a week she took a bath. R3 stated she receives a bath once a week, but would like a bath twice a week. R3 said she had not told anyone, because the subject has never come up. R3's quarterly Minimum Data Set (MDS) dated 6/19/14, identified diagnoses that included diabetes, hypertension, cerebral vascular accident (CVA), depression, and a Stage IV pressure ulcer. The MDS further identified R3 as cognitively intact, and had exhibited no rejection of care. The MDS also identified R3 as requiring extensive assistance of two staff for bed mobility, and total assistance of two staff for transfers and bathing. On 8/1/14, at 9:30 a.m. registered nurse (RN)- A was interviewed and stated the bath aide should be asking resident's about their preferences for bathing frequency. R56 was admitted to the facility on 7/14/14. R56's face sheet dated 7/17/14, identified diagnoses that included diabetes, hypertension and chronic pain. A progress note dated 7/22/14, identified a diagnosis of metastatic prostate cancer. R56's General Nurse's Observation dated 7/24/14, indicated R56 required total assistance of two staff for transfers, and total assistance of one staff for bathing. The care plan dated 7/28/14, indicated R56 was alert and oriented with confusion at times. On 7/29/14, at 4:54 p.m. R56 stated he was unable to choose whether he took a bath or a shower. R56 stated he thought he could only have bed baths, but would prefer a shower. R56	F 242	affected by this deficient practice. Aitkin Health Services (AHS) will ensure that all residents bathing preferences and frequency will be determined upon admission and as needed. The facility has implemented a Resident Preference Form to ensure resident bathing preferences are obtained upon admission and as needed. Mandatory training on resident choice to be/provided to all staff on 8/13/14, 8/20/14, 8/27/14, and 8/28/14. The Director of Nursing Services (DNS) or designee will audit that all new admissions bathing choices are reflected accurately on the bathing schedule. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. Audit results will be brought forward to the QAPI committee for further recommendations.	

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F 242	Continued From page 2 stated he hasn't had a shower since he was admitted. On 8/1/14, at 9:30 a.m. RN-A was interviewed and stated residents should be asked their choice of a bath or a shower by the bath aide. RN-A stated she was unaware if R56 had had a bath or a shower since admission. On 8/1/14, at 9:08 the director of social services SS-D was interviewed and stated nursing staff addressed resident preferences for frequency and type of bathing. SS-D stated preference for bathing was not discussed at resident's care conferences. The facility was unable to provide a policy and procedure on resident choices.	F 242		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		9/15/14

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F 279	Continued From page 3 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan for use of Coumadin (a blood thinner with side effect of potential increased bleeding) for 2 of 5 residents (R14, R44) reviewed for unnecessary medications. Findings include: R14's physician progress notes dated 4/8/14, included diagnoses of atrial fibrillation (an irregular heart rate) with Coumadin for long term anticoagulation, Alzheimer's dementia, congestive heart failure, and chronic obstructive pulmonary disease. R14's physician orders dated 7/31/14, included Coumadin 2.5 milligrams (mg) one time daily every Sunday, Wednesday, and Friday, and Coumadin 5 mg one time daily the rest of the week. R14's care plan did not address monitoring for side effects of Coumadin, such as signs and symptoms of bleeding. During an interview on 8/1/14, at 1:01 p.m., registered nurse (RN)-D stated they chart by exception, meaning only when they see something abnormal is noticed, it is charted. RN-D verified Coumadin and monitoring for side effects had not been addressed on the care plan.	F 279	F279 R14 and R44 care plans were changed to reflect monitoring of Coumadin side effects. All residents receiving Coumadin have the potential to be affected by this deficient practice. All residents receiving Coumadin will have side effect monitoring placed on their care plans. AHS reviewed and updated the care plan policy to reflect side effects of medications (anticoagulants) as a focus area. The facility anticoagulation policy and procedure was reviewed and revised. Facility licensed staff have been re-educated on Coumadin care planning, side effect monitoring, and anticoagulant therapy policy and procedure on 8/13/14, 8/20/14, and 8/27/14. The DNS or designee will audit a minimum of three records of resident□s receiving Coumadin weekly x4 weeks, then monthly thereafter to ensure residents receiving Coumadin are being monitored for side effects. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. Audit results will be brought forward to the	

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F 279	Continued From page 4 Requested, but facility was unable to provide a policy and procedure for anticoagulation therapy. The policy and procedure for care planning dated 6/11, lacks direction for care planning of essential focus areas, including side effects of anticoagulants. R44's Face Sheet dated 8/6/13, identified a diagnosis of atrial fibrillation. R44's physician's orders dated 7/30/14, directed Coumadin 7.5 mg on Saturdays, and 9 mg the rest of the week. The order included to check lab work on 8/20/14. R44's care plan dated 8/19/13, lacked indication of monitoring for side effects of Coumadin. On 8/1/14, at 9:30 a.m. RN-A was interviewed and verified monitoring for side effects of Coumadin is not on the care plan. RN-A stated the licensed staff monitored for side effects of Coumadin weekly on Wednesday afternoon shift.	F 279	QAPI committee for further recommendations.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		9/15/14

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F 329	Continued From page 5 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure parameters for the use of as needed (PRN) pain medication for 1 of 5 residents (R16) reviewed for unnecessary medications. Findings include: R16's Physician Orders dated 6/10/14, included Ibuprofen (a mild pain relieving medication) 200 mg, two tablets by mouth as needed two times per day for other chronic pain; and Oxycodone HCL (narcotic pain medication) 5 mg, one tablet by mouth as needed every four hours for other chronic pain. The Care Planning Report effective 4/25/14, indicated R16 had pain from degenerative arthritis of the knees and spine. R16 was reluctant to take extra medications. R16's activities of daily living (ADL) varied with pain. The care plan further indicated R16's goal for pain management was to enjoy life as a result of effective pain control.	F 329	F329 R16□s as needed (PRN) pain medications were reassessed by the Physician (MD) on 08/01/2014 and changed to reflect the MD orders. (PRN Ibuprofen was discontinued and the PRN Oxycodone was put on a routine schedule). All residents receiving PRN pain medications have the potential to be impacted by this deficient practice. All residents with PRN pain medications will be reviewed to ensure parameters for use are clearly indicated. Facility licensed staff to be/have been re-educated on unnecessary drug protocols, including pain PRN parameters on 8/13/14, 8/20/14, and 8/27/14. The facility pain policy and procedures have reviewed and revised as appropriate. The Pharmacist Consultant will review PRN medications on his monthly visits and make recommendations regarding PRN pain medication parameters as needed.	

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F 329	Continued From page 6 R16's Medication Administration Record (MAR) for 7/14, indicated Ibuprofen once on 7/2/14 and once on 7/11/14. The MAR further indicated R16 received Oxycontin 13 times during the month on 7/6/14, 7/10/14, 7/11/14, 7/13/14, 7/14/14, 7/15/14, 7/18/14, 7/19/14, 7/23/14, 7/28/14, 7/29/14, 7/30/14 and 7/31/14. During numerous intermittent observations from 7/29/14 through 8/1/14, R16 was observed up and about in the wheelchair in activities and in the unit dining room with no signs or symptoms of pain or discomfort. On 8/1/14, at 8:55 a.m. licensed practical nurse (LPN)-A, verified the order lacked parameters regarding when to give Ibuprofen versus Oxycontin. LPN-A stated the decision was, "At our discretion". On 8/1/14, at 9:05 a.m. the director of nursing (DON) verified the PRN pain medication orders lacked parameters for determination of using Ibuprofen versus Oxycodone. The facility's Pain Management policy dated 9/1/09, indicated residents receiving pain management interventions would be monitored for pain levels on a scheduled basis and/or as needed using the appropriate scale on the residents pain monitoring form and documented accordingly.	F 329	The DNS or designee will monitor a minimum of three records of residents receiving PRN analgesics for parameters per week x4 weeks, then monthly thereafter to ensure residents receiving PRN pain medications have parameters. Staff will be re-educated on an ongoing basis based on results of audits. Audit results will be brought to QAPI Committee for further recommendations.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization,	F 334		9/15/14

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F 334	Continued From page 7 each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and	F 334		

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F 334	Continued From page 8 (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide pneumococcal vaccination education and offer pneumococcal immunization for 1 of 5 residents (R27) reviewed for immunizations. Findings include: R27's computer-generated Face Sheet dated 8/1/14, indicated R27 was over 65 years old, had diagnosis of chronic airway obstruction, and was admitted to the facility in early July, 2014. The Immunization Information Connection form in R27's medical record dated 7/1/14, lacked	F 334	F334 R27 was educated on receiving the Pneumococcal immunization and refused to be immunized. The resident□s MD was updated on the resident□s choice to not receive the pneumococcal vaccine. All new admissions who have not previously received the Pneumococcal vaccine have the potential to be affected by this deficient practice. The facility pneumococcal policy and procedure has been reviewed and revised as appropriate. All new admissions will be assessed for the necessity of the	

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F 334	Continued From page 9 evidence to indicate R27 had received a pneumococcal vaccination prior to admission to the facility or had been offered or educated on the benefits of pneumococcal vaccine. On 8/1/14, at 10:00 a.m. the director of nursing (DON) stated she usually completed a resident's immunization history within 21 days of admission to the facility. The DON further stated she had attempted to contact R27's clinic/medical provider for past immunizations, however the clinic did not return the information on R27's immunization history. The DON confirmed R27's medical record lacked documentation of a prior pneumococcal vaccination. The DON stated R27 was not provided education or offered the pneumococcal immunization on admission. A Pneumococcal Immunization Policy reviewed/amended 7/2013, directed upon admission all residents would be asked if they have had the PPV [pneumococcal polysaccharide vaccine] and would be offered a copy of the educational information about the PPV. The Policy further directed if a resident's vaccination history reveals no record of receiving the PPV, the resident's primary physician would be informed at the time of their next visit to the facility.	F 334	pneumococcal vaccine and/or education and have the MD and Nurse Practitioner (NP) updated with the information obtained as needed. Facility licensed staff have been re-educated on pneumococcal immunization and education on 8/13/14, 8/20/14, and 8/27/14. The Director of Nursing Services (DNS) or designee will audit all new admissions pneumococcal vaccine history and need for immunization and education. Staff will be re-educated on an ongoing basis as needed based on the results of the audits Audit results will be brought forward to the QAPI committee for further recommendations.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and	F 356		9/15/14

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F 356	Continued From page 10 unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post the nurse staffing posting to include the actual hours worked for both licensed and unlicensed staff. This had the potential to affect all of the 41 residents residing in the facility, family members, and any visitors who may have chosen to view the information. Findings include: During the initial tour of the facility on 7/29/14, at approximately 2:30 p.m. the facility's nurse staff	F 356	F356 The Posted Nurse Staffing Data was modified to reflect actual hours worked by nursing staff. All residents, family members, and visitors have the potential to be affected by this deficit practice. AHS will continue to follow the federal regulation on the nurse staff posting. Staff education to be/provided on 8/13/14, 8/20/14, 8/27/14, and 8/28/14 on actual nursing hours worked. Random	

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F 356	Continued From page 11 posting was observed to be located in a clear, plastic holder mounted on the wall in the hallway near the main entrance to the facility. The Report of Nursing Staff Directly Responsible for Resident Care form was observed to contain no actual hours worked for the RN's (registered nurses), LPN's (licensed practical nurses), TMA's (trained medication assistants), or NAR's (nursing assistants - registered). On 8/1/14, at 8:30 a.m. the administrator stated the director of nursing (DON) was responsible for creating the nurse staff posting each day, and the information would be posted on the night shift. The administrator further stated the facility utilizes 12 hours shifts for the NAR's and several other nursing staff work split shifts so the actual hours worked would be difficult to place on a posting of nurse staffing The administrator stated she was not aware the nurse staff posting needed to include the actual hours worked by licensed and unlicensed staff. The administrator also stated the facility did not have a nurse staff posting policy and facility followed the federal regulation for contents of the nurse staff posting.	F 356	observational audits of posted nurse staffing data will be completed 2x weekly x2 weeks, then 1x weekly x2 weeks, then monthly thereafter, to ensure the posting data reflects actual hours worked. Audit results will be brought to the QAPI Committee for further recommendations	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		9/15/14

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F 428	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consultant pharmacist failed to address the lack of parameters for the use of as needed (PRN) pain medication for 1 of 5 residents (R16) reviewed for unnecessary medications. Findings include: R16's Physician Orders dated 6/10/14, included Ibuprofen (a mild pain relieving medication) 200 mg, two tablets by mouth as needed two times per day for other chronic pain; and Oxycodone HCL (narcotic pain medication) 5 mg, one tablet by mouth as needed every four hours for other chronic pain. The pharmacist monthly Medication Regimen Review documentation from 12/21/13 through June 2014, lacked recommendations to develop parameters for use of PRN Ibuprofen and Oxycodone. R16's Medication Administration Record (MAR) for 7/14, indicated R16 received Tylenol three times a day on each day of the month. Ibuprofen once on 7/2/14 and once on 7/11/14. The MAR further indicated R16 received Oxycontin 13 times during the month on 7/6/14, 7/10/14, 7/11/14, 7/13/14, 7/14/14, 7/15/14, 7/18/14, 7/19/14, 7/23/14, 7/28/14, 7/29/14, 7/30/14 and 7/31/14. During numerous intermittent observations from 7/29/14 through 8/1/14, R16 was observed up and about in the wheelchair in activities and in the	F 428	F428 R16□s as needed (PRN) pain medications were reassessed by the Physician (MD) on 08/01/2014 and changed to reflect the MD orders. (PRN Ibuprofen was discontinued and the PRN Oxycodone was put on a routine schedule). All residents receiving PRN pain medications have the potential to be impacted by this deficient practice. The Pharmacist Consultant was advised of the deficient practice and will review PRN medications on his monthly visits and make recommendations regarding PRN pain medication parameters as needed. The DNS or designee will monitor a minimum of three records of residents receiving PRN analgesics for parameters x4 weeks, then monthly thereafter to ensure residents receiving PRN pain medications have parameters. All new PRN pain medication orders will be audited x1 month to ensure they contain parameters for use. Through the auditing process any PRN pain medication without parameters will be brought to the attention of the pharmacist and MD/NP for clarification. Audit results will be brought to QAPI Committee for further recommendations.	

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(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 428	Continued From page 13 unit dining room. R16 showed no signs or symptoms of pain or discomfort. The consultant pharmacist, interviewed on 8/1/14, at 1:40 p.m., verified the lack of parameters for use of PRN Ibuprofen and Oxycontin. On 8/1/14, at 9:05 a.m. the director of nursing (DON) verified PRN pain medication did not include parameters for use of Ibuprofen or Oxycodone. The facility's Pain Management policy dated 9/1/09, indicated residents receiving pain management interventions would be monitored for pain levels on a scheduled basis and/or as needed using the appropriate scale on the residents pain monitoring form and documented accordingly. The consultant pharmacist would review the residents medication regimen and make recommendations as they saw appropriate.	F 428		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure walls, doors, resident equipment and/or ceilings were maintained and repaired for 11 of 41 residents (residing in rooms 102, 103, 104, 107, 109, 110, 113, 115, 133, 135, 142). In addition, the carpet	F 465	F465 Rooms 102, 103, 104, 107, 109, 110, 113, 115, 133, 135, 142 walls, doors, equipment, and ceilings were repaired and painted and ceiling tile and commode were replaced.	9/15/14

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 _____	08/01/2014

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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F 465	Continued From page 14 in the common hallways of the secured unit was soiled and stained. This had the potential to affect 19 of 19 residents who resided in the secured unit. On 8/1/14, at 10:12 a.m. an environmental tour with the environmental services director (ESD) and the following issues were observed: The floor had a large crack that was almost the full length of the room in rooms 102 and 104. The ESD verified they are cracked and harder to clean. A new floor would have to be placed over the existing floor to repair the crack. The backing from a previous soap dispenser remained on the wall in the bathrooms in rooms 102, 103, 107, and 110. The ESD verified new soap dispensers were put up and the old ones removed a couple of weeks ago. The wallpaper and wall were scraped behind the bed in rooms 102 and 103. The wall was gouged behind the headboard for room 104. The bathroom floor in room 104 was badly worn and discolored. The commode over the toilet had brakes that did not lock and the backing was worn. The ESD verified it needed to be replaced immediately. In room 103, the register and closet doors were scraped and the right upper siderail on the bed was wiggly. The ESD verified the scraped areas and the loose siderail. In room 109, the wall outside the bathroom door was dirty, the inside of the bathroom door was dirty, and the doorframe was chipped with sharp	F 465	The secured unit carpeted hallways will be replaced with new flooring beginning on August 25th, 2014. (Letter enclosed). Room 104 and 110 bathroom floors will be replaced with new flooring (Letter enclosed). The cracks in bedrooms 102 and 104 are filled and sealed with no noted transition and are cleanable surfaces. Policies and procedures for cleaning, maintaining resident rooms, and identifying housekeeping and maintenance issue have been reviewed and updated. A routine maintenance and housekeeping checklist/schedule was implemented as of 8/18/2014. The ESD or designee will audit the utilization of the maintenance and housekeeping schedules and checklists weekly x4 weeks, then monthly thereafter. Audit results will be brought forward to QAPI for further recommendations.	

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	245119	A. BUILDING _____ B. WING _____	08/01/2014

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F 465	Continued From page 15 edges. In room 110, the baseboard on the bathroom wall behind and to the left of the toilet was cracked, the base of the toilet had brownish yellow stain around the caulking. The ESD stated the bathrooms are cleaned daily and verified the cracked baseboard. In room 113, the bathroom door frame was chipped, the wall and door to the bathroom were dirty, and the wall by the bottom of the bed was dirty. The ESD verified the findings. In room 115, the bathroom vent was dusty. In room 133, the bedroom and bathroom floors were marred with black marks, the walls in the bathroom were nicked and scratched. The ESD verified the findings. In room 135, the bathroom had several stained ceiling tiles. The door jamb going into the room 142 was badly gouged. The carpet in the hallways in the secured unit were very stained. The ESD verified the carpeting was stained. The stains came back from underneath the carpet within days of cleaning. He stated the long range goal is to replace the carpet with flooring but there was no timeline for replacement. The policies and procedures for cleaning and maintaining resident rooms, identifying housekeeping and maintenance issues, and maintenance and housekeeping schedules were	F 465		

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	245119	A. BUILDING _____ B. WING _____	08/01/2014

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F 465	Continued From page 16 requested. No policies and procedures were provided. A routine maintenance schedule was not provided. An undated monthly resident room rotation checklist was provided which addressed the weekly "team clean" tasks that included bed inspection of electrical cords, mattresses, cleaning of entire frame and making the bed. The checklist also included deep clean tasks, such as dusting vents and fans monthly.	F 465		

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

F5119022

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 _____	**07/31/2014**

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 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Aitkin Health Services was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Aitkin Health Services is a one story building with a full basement. The original building was constructed in 1955 with additions in 1962, and a dining room main entry was added in 2002. Both the existing building and the addition are type II(111) construction. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of44 beds and had a census of 41 at the time of the survey. At this time, the conditions of 42 CFR, Subpart 483.70(a) is met.	K 000		

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

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

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 _____	**07/31/2014**

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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 41 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000		

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

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