Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 7, 2025

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

RE: CCN: 245119
Cycle Start Date: December 12, 2024

Dear Administrator:

On December 24, 2024, we notified you a remedy was imposed. On January 2, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 30, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 8, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 24, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 8, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 30, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 7, 2025

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

Re: Reinspection Results
Event ID: B68612

Dear Administrator:

On January 2, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 12, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 24, 2024

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

RE: CCN: 245119
Cycle Start Date: December 12, 2024

Dear Administrator:

On December 12, 2024, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 8, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 8, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 8, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 8, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Aitkin Health Services will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 8, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 12, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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 ______	C 12/12/2024

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 On 12/11/24 through 12/12/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H51192161C (MN00108421) with a deficiency issued at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 689	How to correct for R1 - R1 is no longer a	12/30/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/30/2024

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 ______	C 12/12/2024

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F 689	Continued From page 1 facility failed to supervise, implement, and assess fall interventions to reduce the risk of falls for 1 of 3 residents (R1) reviewed for falls. This resulted in actual harm when R1 fell and sustained a laceration to the middle of her forehead which required an emergency department (ED) visit and sutures. Findings include: R1's Face Sheet dated 4/29/24, indicated R1 had arthritis in both hips, spinal stenosis (abnormal narrowing of the spinal canal), and mild cognitive impairment. R1's quarterly Minimum Data Set (MDS) dated 9/24/24, identified R1 had mild impaired cognition, had two or more falls without injury and one fall with minor injury, and needed extensive assistance with transfers, toileting and bed mobility. R1's Fall Risk Assessment dated 9/24/24 indicated R1 had three or more falls in the last 90 days, was confined to her chair, needed assistance with elimination, and not steady on her feet without assistance. R1's score was 20 (a score of 10 or higher put the resident at risk for falls). R1's care plan dated 10/2/24, identified R1 was at risk for falls due to cognitive impairment. An intervention directed staff would not leave R1 in her wheelchair in her room alone. R1 would stay in a common area if she did not want to sit in her recliner after meals or activities. Additional interventions identified encouraging R1 to wear	F 689	resident at Aitkin Health Services. This deficient practice has the potential to impact all residents at Aitkin Health Services. Actions to prevent future occurrences: Resident specific fall interventions will be added to EMR/Care Stream for staff to reference when caring for individual residents. New incident interventions, changes in status and therapy recommendations related to falls will be added in BOLD in the EMR/Care Stream Information header for two weeks. After two weeks, the interventions will continue to show in EMR/Care Stream as a daily task. The Communication Book has been eliminated. All direct care staff will demonstrate individually, the ability to sign in to Yardi/EMR, navigate to Care Stream and identify fall interventions. Ongoing monitoring: DON or designee will audit direct care staffs' ability to log in and chart in the electronic medical record 2x/week x 2 weeks, 1x/week x 2 weeks, and then monthly for 2 months. Results will be reported to QAPI Committee for additional direction. DON or designee will audit direct call	

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 ______	C 12/12/2024

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 689	Continued From page 2 glasses, wear good footwear, and to use a reacher when grabbing items out of reach. R1's Emergency Department (ED) Provider Encounter note dated 11/18/24, indicated R1 had a large laceration in the middle of her forehead that needed 15 sutures to close. On 11/19/24 at 12:51 a.m., a progress note written by registered nurse (RN)-A indicated on 11/18/24 at around 6:14 p.m., R1 was found in her room on the floor in front of her closet, yelling for help. R1's wheelchair was behind her. R1 was bleeding from her forehead, she was assessed and sent to the ED. A facility communication book was located on each unit (Garden Terrace and Town Square) and in the administration office. The front of the book indicated staff were to review the book at the start of the shift, and staff were to sign after reading the new information. The Garden Terrace communication book had eleven updates from 11/4/24 to 12/11/24, with three staff signatures total. The Garden Terrace communication book lacked updates pertaining to R1 and her fall on 11/18/24. The Town Square communication book had eleven updates from 11/4/24 to 12/11/24, with two staff signatures on several pages. The Town Square communication book lacked updates pertaining to R1 and her fall on 11/18/24. The administration office communication book had ten updates from 11/4/24 to 12/11/24 with three staff signatures on one page. An update to the administration office communication book dated 11/19/24 indicated R1 could not be left alone in her room in her wheelchair. There were no other	F 689	implementation of falls interventions 2x/week x 2 weeks, 1x/week x 2 weeks, and then monthly for 2 months. Results will be reported to QAPI Committee. DON or designee will audit EMR/Care Stream to ensure fall interventions are present for direct care staff reference 2x/week x 2 weeks, 1x/week x 2 weeks, and then monthly for 2 months. Results will be reported to QAPI Committee for additional direction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431

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F 689	Continued From page 3	F 689		

changes to R1's fall risk interventions in the administration office communication book.

On 12/11/24 at 12:19 p.m., nursing assistant (NA)-A stated she was an agency staff member on 11/18/24. After dinner, she went into R1's room and asked if she wanted to go to bed and R1 declined. She left R1 in her wheelchair in her room alone. She was not aware R1 was not supposed to be left alone in her room while she was in her wheelchair until after she fell the evening of 11/18/24. She has been directed to look in the communication book for any changes in interventions for residents, but she could not recall the last time she looked in the communication book. She had access to document in R1's electronic medical record (EMR), but was not given access to review R1's care plan and interventions.

On 12/12/24 at 10:54 a.m., RN-B stated the facility did not have a good way to communicate with agency staff. The facility had relied on word of mouth, but this was not working. The facility had a communication book for any changes in interventions or other updates on residents. Staff were to read and sign when they come into work. RN-B stated she was not sure who was responsible for ensuring the communication book had been read by staff, and she was not sure why the communication book was not being signed by staff. There was a hole in the process that had not been fixed.

On 12/12/24 at 11:01 a.m., RN-A stated on 11/18/24 at around 6:14 p.m., she was getting

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 ______	C 12/12/2024

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 689	Continued From page 4 report from another staff member when she heard someone yelling. She went into R1's room and saw R1 on the floor in front of her closet. R1's wheelchair was behind her, and she was bleeding from her head. R1 had been left alone in her room in her wheelchair, and shouldn't have been. She assessed R1 and sent her into the ED due to R1's forehead laceration. On 12/12/24 at 11:19 a.m., the director of nursing (DON) stated agency staff had access to document in the resident's EMRs, but were not able to review resident care plans or interventions. The EMR had a care stream section that showed activity of daily living (ADL) needs, but it would have been a hit or miss if fall interventions were in the care stream for staff to see. Staff should look in the communication book for any interventions or changes to resident care. The nurse managers were responsible for making sure staff were looking at the communication books and signing them. She was not sure why staff were not looking at the communication book. On 12/12/24 at 11:57 a.m., physician's assistant (PA)-A stated she was aware R1 had a fall, but was not aware staff were not following the care plan. It was possible if the care plan had been followed, R1 would not have fallen. R1 had been was declining prior to the fall, but after the fall on 11/18/24, R1 had a more rapid decline, and was more confused and agitated. The facility Fall Prevention and Management policy dated 2/15/24, directed there will be interventions implemented to minimize future falls.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 24, 2024

Administrator
Aitkin Health Services
301 Minnesota Avenue South
Aitkin, MN 56431

Re: State Nursing Home Licensing Orders
Event ID: B68611

Dear Administrator:

The above facility was surveyed on December 11, 2024 through December 12, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 12/12/2024

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) COMPLETE DATE
2 000	Initial Comments	2 000		

Initial Comments

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

NH LICENSING CORRECTION ORDER

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

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

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

INITIAL COMMENTS:
On 12/11/24 through 12/12/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was

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 ___	C 12/12/2024

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) COMPLETE DATE
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issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.

The following complaint was reviewed: H51192161C (MN00108421) with a licensing order issued at 4658.0520 Subp 1.

Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be

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2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to supervise, implement, and assess fall interventions to reduce the risk of falls for 1 of 3 residents (R1) reviewed for falls. This resulted in actual harm when R1 fell and sustained a	2 830	Completed	12/30/24

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laceration to the middle of her forehead which required an emergency department (ED) visit and sutures.

Findings include:

R1's Face Sheet dated 4/29/24, indicated R1 had arthritis in both hips, spinal stenosis (abnormal narrowing of the spinal canal), and mild cognitive impairment.

R1's quarterly Minimum Data Set (MDS) dated 9/24/24, identified R1 had mild impaired cognition, had two or more falls without injury and one fall with minor injury, and needed extensive assistance with transfers, toileting and bed mobility.

R1's Fall Risk Assessment dated 9/24/24 indicated R1 had three or more falls in the last 90 days, was confined to her chair, needed assistance with elimination, and not steady on her feet without assistance. R1's score was 20 (a score of 10 or higher put the resident at risk for falls).

R1's care plan dated 10/2/24, identified R1 was at risk for falls due to cognitive impairment. An intervention directed staff would not leave R1 in her wheelchair in her room alone. R1 would stay in a common area if she did not want to sit in her recliner after meals or activities. Additional interventions identified encouraging R1 to wear glasses, wear good footwear, and to use a reacher when grabbing items out of reach.

R1's Emergency Department (ED) Provider Encounter note dated 11/18/24, indicated R1 had a

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large laceration in the middle of her forehead that needed 15 sutures to close.

On 11/19/24 at 12:51 a.m., a progress note written by registered nurse (RN)-A indicated on 11/18/24 at around 6:14 p.m., R1 was found in her room on the floor in front of her closet, yelling for help. R1's wheelchair was behind her. R1 was bleeding from her forehead, she was assessed and sent to the ED.

A facility communication book was located on each unit (Garden Terrace and Town Square) and in the administration office. The front of the book indicated staff were to review the book at the start of the shift, and staff were to sign after reading the new information. The Garden Terrace communication book had eleven updates from 11/4/24 to 12/11/24, with three staff signatures total. The Garden Terrace communication book lacked updates pertaining to R1 and her fall on 11/18/24. The Town Square communication book had eleven updates from 11/4/24 to 12/11/24, with two staff signatures on several pages. The Town Square communication book lacked updates pertaining to R1 and her fall on 11/18/24. The administration office communication book had ten updates from 11/4/24 to 12/11/24 with three staff signatures on one page. An update to the administration office communication book dated 11/19/24 indicated R1 could not be left alone in her room in her wheelchair. There were no other changes to R1's fall risk interventions in the administration office communication book.

On 12/11/24 at 12:19 p.m., nursing assistant (NA)-A stated she was an agency staff member on

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2 830	Continued From page 5 11/18/24. After dinner, she went into R1's room and asked if she wanted to go to bed and R1 declined. She left R1 in her wheelchair in her room alone. She was not aware R1 was not supposed to be left alone in her room while she was in her wheelchair until after she fell the evening of 11/18/24. She has been directed to look in the communication book for any changes in interventions for residents, but she could not recall the last time she looked in the communication book. She had access to document in R1's electronic medical record (EMR), but was not given access to review R1's care plan and interventions. On 12/12/24 at 10:54 a.m., RN-B stated the facility did not have a good way to communicate with agency staff. The facility had relied on word of mouth, but this was not working. The facility had a communication book for any changes in interventions or other updates on residents. Staff were to read and sign when they come into work. RN-B stated she was not sure who was responsible for ensuring the communication book had been read by staff, and she was not sure why the communication book was not being signed by staff. There was a hole in the process that had not been fixed. On 12/12/14 at 11:01 a.m., RN-A stated on 11/18/24 at around 6:14 p.m., she was getting report from another staff member when she heard someone yelling. She went into R1's room and saw R1 on the floor in front of her closet. R1's wheelchair was behind her, and she was bleeding from her head. R1 had been left alone in her room in her wheelchair, and shouldn't have been. She assessed R1 and sent her into the ED due to R1's	2 830		

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2 830	Continued From page 6 forehead laceration. On 12/12/24 at 11:19 a.m., the director of nursing (DON) stated agency staff had access to document in the resident's EMRs, but were not able to review resident care plans or interventions. The EMR had a care stream section that showed activity of daily living (ADL) needs, but it would have been a hit or miss if fall interventions were in the care stream for staff to see. Staff should look in the communication book for any interventions or changes to resident care. The nurse managers were responsible for making sure staff were looking at the communication books and signing them. She was not sure why staff were not looking at the communication book. On 12/12/24 at 11:57 a.m., physician's assistant (PA)-A stated she was aware R1 had a fall, but was not aware staff were not following the care plan. It was possible if the care plan had been followed, R1 would not have fallen. R1 had been was declining prior to the fall, but after the fall on 11/18/24, R1 had a more rapid decline, and was more confused and agitated. The facility Fall Prevention and Management policy dated 2/15/24, directed there will be interventions implemented to minimize future falls. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and re-educate all staff on the policies and procedures to ensure staff follow resident care plans and are able to locate interventions. The DON or designee could develop monitoring systems and audit to ensure ongoing compliance. The DON oor designee could bring the results of	2 830		

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	these audits to the QAPI committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			