DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 14, 2023

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

RE: CCN: 245119
Cycle Start Date: September 8, 2023

Dear Administrator:

On October 31, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 20, 2023

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

RE: CCN: 245119
Cycle Start Date: September 8, 2023

Dear Administrator:

On September 8, 2023, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 8, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 8, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 09/08/2023

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 9/6/23 through 9/8/23, 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 complaints were reviewed during the survey: H51195088C (MN96426); H51195324C (MN95709); H51195295C (MN96553). As a result of the investigation, deficiencies were cited at F689 and F609. 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		

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

Electronically Signed | 09/29/2023

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

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report a serious bodily injury within two hours, as required, to the State Agency (SA) for 1 of 3 residents (R2), who sustained fractured ribs following a fall. Findings include:	F 609	It is the policy of Aitkin Health Services to report any allegations of maltreatment of a vulnerable adult (VA) residing in our care center to the appropriate authorities and when abuse or injury is identified, file a report within two hours with SA. The Abuse policies were reviewed and the	10/20/23

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F 609	Continued From page 2 R2's annual Minimal Data Set (MDS) dated 8/23/23, identified R2 had diagnosis of Alzheimer's disease and severely impaired cognition. R2's MDS identified R2 required extensive assistance of one staff for activities of daily living such as bed mobility, transfers, dressing and toileting. MDS revealed R2 has had two or more falls with no injury since prior MDS assessment. R2's Fall Scene Investigation dated 4/20/23, indicated R2 had an unwitnessed fall in her room and was found on the floor in a sitting position and at the time of the fall R2 was assessed by licensed practical nurse (LPN)-A, who determined there were no injuries or concerns at that time. Further, Fall Scene Investigation revealed on 4/21/23, R2 was brought to Urgent Care to be evaluated and x-rays revealed that R2 had a minimally displaced fractures of the right ribs 7 and 8 and non-displaced fractures of right ribs 9 and 10. R2 returned to the facility with no new orders. On 9/7/23 at 2:29 p.m., LPN-A indicated facility policy for reporting serious bodily injuries was to immediately notify the physician, nurse manager and director of nursing (DON). Further, LPN-A indicated she could not recall R2's incident on 4/20/22, and was unaware if R2's fractures were reported to the SA. On 9/7/23 at 4:42 p.m., DON indicated facility policy for reporting serious bodily injury was to immediately report to the SA the same day staff were made aware of the injury. Further, DON indicated she was aware of R2's rib fractures, however, could not recall if R2's injury was	F 609	reporting process meets the required compliance with no revisions required. All residents have the potential to be impacted by the deficient practice. All staff will be re-educated on the reporting process and the Abuse policy before their next shift. any potential abuse situation is reviewed by the Administrator (NHA) and Director of Nursing (DON). Any abuse situation will be audited by NHA an DON to ensure each step of the process is being followed. Audits of all alleged violations involving abuse, neglect, exploitation or maltreatment including injuries of unknown origin, serious bodily injury and misappropriation of resident property will be completed by the Administrator and/or his delegate 3x/week for 2 weeks, 2x/week for 2 weeks and then weekly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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F 609	Continued From page 3 reported to the SA. DON indicated during the time of R2's incident there was a lot of management changes and could have missed reporting injury to the SA. Review of facility policy titled Maltreatment Reporting Guidelines dated 10/18/21, revealed care center staff were expected to report to the SA any suspected maltreatment (all alleged violations involving abuse, neglect, exploitation, or maltreatment including injuries of unknown origin and misappropriation of resident property) immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury.	F 609		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, the facility failed analysis root cause for falls for 1 of 3 (R3), implement interventions determined by the interdisciplinary team (IDT) to prevent future falls for 2 of 3 residents (R1, R2) and revise care plans with updated fall interventions for 3 of 3 residents (R1,R2, R3) reviewed for falls.	F 689	It is the policy of Aitkin Health Services to ensure resident safety through IDT (interdisciplinary team) review and implementation of interventions to prevent falls. The Fall Prevention & Management Policies were reviewed and the processes meet the required compliance with no	10/20/23

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F 689	Continued From page 4 Findings include: R1's admission Minimal Data Set (MDS) dated 8/15/23, identified R1 had diagnosis of dementia and severely impaired cognition. R1's MDS identified R1 required extensive assistance by two staff members for activities of daily living (ADLs) such as bed mobility, transfers, dressing and toileting. MDS revealed R1 had two or more falls with no injury since admission. R1's Fall Scene Investigation dated 8/12/23, revealed IDT reviewed R1's fall and new intervention was added to have staff turn on favorite radio station when R3 was in bed due to R3 enjoying country music and finds music soothing. However, R3's care plan lacked evidence of being revised to include this new intervention for staff to implement. R2's annual MDS dated 8/23/23, identified R2 had diagnosis of Alzheimer's disease and severely impaired cognition. R2's MDS identified R2 required extensive assistance of one staff for ADLs such as bed mobility, transfers, dressing and toileting. MDS revealed R2 had two or more falls with no injury since prior MDS assessment. R2's Service Plan as of 9/6/23, identified R2 was at risk for falls or injury related to cognitive deficits and interventions included: anti roll-back feature on wheelchair, assist as needed with mobility and transfers, encourage call light use for assistance, anticipate needs, appropriate footwear, involve in activities to occupy R2's time when attempting to stand or walk and needs have been met, call light within reach, room free of clutter, reorient to room, when awake keep in common area for direct supervision and responsive interactions.	F 689	required revisions. Residents R1 & R2 have have been reassessed, interventions evaluated and their care plans updated. This deficient practice has the potential to impact all residents. All nursing staff will be educated on the Root Cause Analysis and implementing interventions for falls. All falls will be reviewed by the IDT to monitor root cause analysis and that proper interventions were initiated. Resident care plans will be revised with updated fall interventions at the time of implementation. Interventions will be reviewed by Nurse Managers in one week for appropriateness an then weekly and as needed, progress notes will be entered and care plans revised with ay cahges. Interventions and changes will be audited by the Administrator, DON and/or their delegate to ensure each step of the process is being followed. Audits of IDT interventions, needed updates and care plan revisions will audited weekly by the DON and/or her delegate 3x/week for 2 weeks, 2x/week for 2 weeks, and then weekly until results are reported at QAPI Committee for additional auditing recommendations.	

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F 689	Continued From page 5 R2's Fall Scene Investigation dated 6/2/23, revealed IDT had reviewed R2's fall and determined the root cause of R2's fall was restlessness before R2 went to bed and implemented staff were to walk R2 to her room from the nurses' station when getting R3 ready for bed. However, R2's care plan lacked evidence of being revised to include this intervention. R3's quarterly MDS dated 7/21/23, identified R3 had diagnoses which included stroke, dementia and hemiplegia or hemiparesis. R3's MDS identified R3 required extensive assistance of one staff for ADLs such as bed mobility, transfers, dressing and toileting. MDS revealed R3 had two or more falls with no injury since prior MDS assessment. R3's Service Plan as of 9/6/23, identified R3 was at risk for falls or injury related to cognitive deficits, and interventions included: assist as needed with mobility and transfers, do not leave in room unattended while agitated, gripper socks on at all times when not wearing shoes, do not put into bed when agitated, do not leave alone in bathroom, and check my positioning in wheelchair after visitors leave. R3's care plan lacked evidence of staff utilizing falls mats while in bed or a weight blanket when agitated. R3's Fall Scene Investigation dated 3/1/23, revealed IDT reviewed R3's fall and new fall intervention included placing fall mats on both sides of R3's bed. However, R3's care plan lacked evidence of being revised to include this intervention. R3's Fall Scene Investigation dated 3/26/23,	F 689		

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F 689	Continued From page 6 revealed IDT reviewed R3's fall and new fall intervention included utilizing a weighted blanket when R3 appeared anxious. However, R3's care plan lacked evidence of being revised to include this intervention. On 9/6/23 at 12:44 p.m., R3 was observed in his wheelchair in the commons area on Town Square unit with his wife, R3 was positioned well in custom wheelchair and had on appropriate footwear, and R3 was not exhibiting any behaviors. On 9/6/23 at 12:44 p.m., R1 was observed in the commons area on Town Square unit near the nurses' station, R1 was positioned well in standard wheelchair, wearing glasses, shoes, and appeared comfortable with eyes closed and was not exhibiting any behaviors. On 9/6/23 at 12:49 p.m., R2 was observed in the commons area on Garden Terrace unit near the nurses' station, R2 was positioned well in standard wheelchair at a table with fidget activities. R2 was not exhibiting any behaviors. On 9/7/23 at 2:58 p.m., registered nurse (RN)-A indicated following a fall the IDT would meet and review each resident's Fall Scene Investigation form to determine a cause of the fall and determine an intervention to prevent future falls. RN-A stated the resident's care plan was then updated with the new intervention and communicated verbally to floor staff following the IDT meeting. RN-A confirmed R2's care plan was not revised to include staff walking R2 prior to assisting her into bed. RN-A confirmed R3's care plan was not revised to include floor mats on both sides of bed or providing R3 with a weighted	F 689		

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F 689	Continued From page 7 blanket if R3 was exhibiting anxious behaviors. Further, RN-A stated since interventions were not placed into each resident's care plan, "how would staff know? They wouldn't know because it's not in there". On 9/7/23 at 4:03 p.m., licensed practical nurse (LPN)-B indicated following a fall the IDT would review the Fall Scene Investigation and identify any trends, and would discuss ways to prevent or reduce the fall risk by implementing a intervention. Following IDT review, the resident's care plan would be updated with the new intervention to ensure staff were aware and staff are verbally updated as well. LPN-B confirmed R1's care plan was not revised to include turning on radio station while R1 was in bed. On 9/7/23 at 4:42 p.m., director of nursing (DON) stated staff were expected to complete the Fall Scene Investigation form following a fall, the IDT would then review the form to determine a root cause and determine appropriate intervention to prevent repeated falls. During the IDT meeting, staff who were present would share responsibility for revising the resident's care plan with the updated intervention as well as verbally communicating the intervention to the floor staff following the IDT meeting. Further, DON stated the facility's electronic medical record system has had some errors with deleting interventions from the resident's care plans and facility was in process of fixing this error. R3's Progress Note dated 3/16/23, at 6:50 a.m. R3 was found on the floor, lying prone between the fall matts in resident's room. R3's bed was noted to be in the lowest position, and R3 was wearing socks, shirt, and a brief. R3 stated he	F 689		

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F 689	Continued From page 8 was attempting to get up out of bed and "get moving". There were no injuries noted. However, resident record lacked evidence a Fall Scene Investigation was completed, IDT meeting for root cause analysis or intervention implemented following this fall. On 9/7/23 at 2:58 p.m., RN-A indicated staff were expected to complete a Fall Scene Investigation form following each resident's fall, and this form would then be reviewed by the IDT to determine next steps. RN-A confirmed R3's fall that occurred on 3/16/23, was not reviewed by the IDT due to staff not completing the form. R1's Fall Scene Investigation dated 8/25/23, revealed IDT reviewed R1's fall and determined an appropriate intervention was to have pharmacy review R3 medications based on IDT's root cause analysis. However, R1's medical record lacked evidence the facility staff had initiated the pharmacy review process at the time of survey. R2's Fall Scene Investigation dated 2/22/23, revealed IDT reviewed R2's fall and determined R2 would complete a genetic test and results would be sent to pharmacy for review and recommendations. However, R2's medical record lacked evidence a genetic test was completed, or a pharmacy review was completed following this fall. On 9/7/23 at 2:58 p.m., RN-A was unaware if R2 had a genetic test and pharmacy completed following her fall on 2/22/23. On 9/7/23 at 4:03 p.m., LPN-B confirmed he had not initiated the pharmacy review process yet and	F 689		

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F 689	Continued From page 9 the review had not been completed. On 9/7/23 at 4:42 p.m., director of nursing (DON) confirmed R2's medical record lacked evidence a genetic test or pharmacy review was competed. Review of facility policy titled Fall Prevention and Management dated 6/5/23, identified if a resident were to fall, staff would perform the incident fall tracking assessment and determine a potential root cause. Further, IDT would evaluate the fall by reviewing the fall incident report to determine a root cause analysis (RCA) of the fall and further interventions may be put into place according to the determined root cause of the fall, to help prevent further falls. All interventions that are identified through the assessment/review process will be documented in the resident's care plan.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 20, 2023

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

Re: Event ID: HNE911

Dear Administrator:

The above facility survey was completed on September 8, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	09/08/2023

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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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/6/23 through 9/8/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/29/23

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 _____	09/08/2023

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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2 000	Continued From page 1 The following complaints were reviewed during the survey: H51195088C (MN96426); H51195324C (MN95709); H51195295C (MN96553). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		