DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 13, 2023

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

RE: CCN: 245119
Cycle Start Date: December 6, 2022

Dear Administrator:

On December 15, 2022, we informed you that we may impose enforcement remedies.

On December 29, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On December 19, 2022, the situation of immediate jeopardy to potential health and safety cited at F0700 was removed.

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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 6, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 6, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 6, 2023.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Aitkin Health Services is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 29, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

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 - 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

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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 June 6, 2023 (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 § 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) 565-9462

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) / 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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@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 12/29/2022

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 12/27/22 through 12/29/22, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F700 when the facility failed to assess and review for risks and benefits of the use of assistive devices including bed rails . The IJ began on 10/12/22, and the immediacy was removed on 12/19/22. The following complaint: H51197000C (MN89511), was SUBSTANTIATED at F700 for PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents. In addition the following complaint was substantiated: H51197099C (MN85118). As a result of the investigation, additional deficiencies were cited at F656. 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/17/2023

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 000	Continued From page 1 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		1/27/23

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F 656	Continued From page 2 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions were implemented for 2 of 4 residents (R1, R2) reviewed who required staff assistance with activities of daily living (ADLs) including repositioning and toileting. Findings include: R1's admission Minimal Data Set dated 9/28/22, indicated R1 had a diagnosis of multiple sclerosis and had cognitive impairments. Further review of MDS, revealed R1 required extensive assist from two staff members for ADLs such as bed mobility, dressing, and toileting. R1 was totally dependent on staff for transfers. R1's care plan as of 12/27/22, indicated R1 required assistance with bed mobility and directed staff to assist R1 into bed after breakfast and lunch for a minimum of 20 minutes as well as assist with turning and repositioning every two hours.	F 656	It is the policy of Aitkin Health Services to ensure that residents admitted to Aitkin Health Services will have a plan of care. The care plan is accessible by Nursing through care stream or care plan. Social Services, Activities staff, and Register Nursing Assistants are able to access a view resident□s plan of cares through care stream on EMAR. The facility policy on Care Plans was reviewed and remains appropriate. This policy will continue to remain in effect for all residents in the building. All RN, LPN□s, TMA□s, NAR□s, activity aids, and social services staff will be reeducated on the Care Plan policy. The Director of Nursing (DON) or designee will perform on the floor Audits to ensure care plans are being followed. Audits will be conducted a minimum of twice weekly for four weeks then weekly for three months. Results of all audits will be reviewed by the facility Quality Assurance Performance Improvement Committee.	

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F 656	Continued From page 3 R2's quarterly MDS dated 10/26/22, indicated R2 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, revealed R2 required extensive assistance from one staff member for ADLs such as transfers, dressing and toileting. R2's care plan as of 12/27/22, indicated R2 required assist of one staff for toileting every four hours and directed staff R2 could not be left alone while toileting. On 12/27/22, at 9:37 a.m. R1 was observed in her high back wheelchair at a table near the nursing station. Through continuous observation, R1 remained in her wheelchair at the nursing station until 11:14 a.m. when trained medication assistant (TMA)-A assisted R1 into the dining room for noon meal. Through continuous observation, at 12:17 p.m. R1 was assisted from the dining room, back to the table at the nursing station by TMA-A. At 12:34 p.m. nursing assistant (NA)-A sits at the table at the nursing station, in front of R1, and began to chart on a tablet. At 12:45 p.m. NA-B approached nursing station and stated to NA-A R1 "needs to be checked and changed". Both NA-A and NA-B assist R1 to her room and use a full body mechanical lift to transfer R1 from wheelchair to bed. NA-A indicated R1's skin on bottom had no redness or open sores. During constant observation, R1 lacked repositioning for more than 3 hours. On 12/27/22, at 2:17 p.m. NA-B indicated each resident had a care plan to identify level of care needed for ADLS, which included toileting and repositioning schedule. NA-B stated R1 required	F 656	Physician address Dr. David Goodwin 301 MN Ave SW Aitkin, MN 56431	

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F 656	Continued From page 4 staff assistance for all ADLs and required to be repositioned while in her wheelchair and bed every two hours due to bowel incontinence and risk for skin breakdown. NA-B confirmed she was R1's nursing assistant for the day but was unable to provide a time R1 had last been repositioned prior to 12:45 p.m. and stated, "probably more than three hours ago". On 12/28/22, at 10:15 a.m. TMA-B indicated R2 required a mechanical standing lift for all transfers. Further, TMA-B stated R2 did not utilize the call light system and staff anticipated her needs. TMA-B indicated R2 had a toileting program and staff would leave R2 on the toilet hooked up to the mechanical lift and staff turned on R2's bathroom call light and then staff left the bathroom and came back. On 12/28/22, at 10:47 a.m. NA-C indicated staff had access to each resident's care plan which identified resident specific interventions related to care assistance and staff were expected to check for care plan updates daily and throughout their shift. NA-C indicated R2 required assistance by one staff member for transferring using a mechanical standing lift and was on a toileting program. Further, NA-C indicated R2 was not able to utilize the call light system and staff would place R2 on the toilet in the bathroom, turn on R2's bathroom call light to "remember to go back" and staff would leave R2 alone in the bathroom. NA-C confirmed she was not aware of the intervention in R2's care plan directing staff R2 wasn't to be left alone in bathroom and stated, "I have not seen that before". On 12/28/22, at 11:31 a.m. NA-D indicated R2	F 656		

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F 656	Continued From page 5 required assistance with ADLS with one staff member and was on a toileting schedule of every 3-4 hours. Further, NA-D indicated she would assist R2 to the toilet, lock the brakes on the mechanical stand lift, leave R2 in the bathroom alone, close the bathroom door then set a timer on her phone and/or watch to go back and assist R2 off the toilet. NA-D confirmed she was not aware of the intervention in R2's care plan indicating R2 was not supposed to be left alone in bathroom. On 12/28/22, at 1:19 p.m. licensed practical nurse (LPN)-A indicated R2 required staff assistance with all ADLS and does not utilize the call light system, staff were expected to anticipate needs. LPN-A indicated staff would assist R2 onto the toilet, leave R2 in the bathroom alone, and then set a timer to return to R2 on the toilet. Further, LPN-A confirmed she was not aware of R2's care plan intervention directied staff not to leave R2 in the bathroom alone. On 12/28/22, 2:27 p.m. nurse manager (NM)-B indicated staff were expected to follow each resident's care plan for ADL assistance. NM-B confirmed R2's care plan directed staff to not leave R2 alone in the bathroom and was not aware staff weren't following R2's care plan. On 12/28/22, at 2:50 p.m. NM-A indicated R1 required to be checked and repositioned every two hours while in her wheelchair or bed. Further, NM-A indicated staff were expected to follow R1's care plan for repositioning and toileting due to risk of skin breakdown. On 12/28/22, at 4:02 p.m. director of nursing (DON) confirmed R2's care plan directed staff to	F 656		

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F 656	Continued From page 6 not leave R2 in the bathroom alone and stated staff were expected to follow each resident's care plan. Further, DON stated nursing assistants had access to each resident's care plan and the nurse manager on the unit was expected to oversee nursing assistants to ensure staff were following care plans. Review of facility policy titled Care Plans dated 12/29/22, indicated care plans were updated on an ongoing basis as needed and were available to staff using the YARDI (facility's electronic medical record) system.	F 656		
F 700 SS=J	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.	F 700		

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F 700	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assess and/or re-assess and review for risks and benefits of the use of assistive devices including bed rails resulting in risk of potential serious harm, injury, impairment, or death for 1 of 4 (R1) residents who had a bed rail in place despite being at risk and was found with head between the mattress and bed rail. This resulted in an Immediate Jeopardy for R1. Additionally, the facility failed to assess and/or re-assess and review for risks and benefits of the use of assistive devices including bed rails for 3 of 4 residents (R2, R3, R4) reviewed for safety. The immediate jeopardy began on 10/12/22, when bed rails were placed on R1's bed prior to an assessment being completed to determine safe for use. On 12/18/22, R1 was found on the floor after sliding from her bed, which resulted in R1's head being entrapped between the bed rail and mattress. The administrator, director of quality, nurse manager, and health unit coordinator were notified of the immediate jeopardy at 1:30 p.m. on 12/29/22. The immediate jeopardy was removed and the deficient practice corrected on 12/19/22, prior to the start of the survey and was therefore was issued at Past Noncompliance. Findings include: R1 was admitted to the facility on 9/20/22. R1's admission Minimal Data Set (MDS) dated 9/28/22, indicated R1 had a diagnosis of multiple sclerosis and had severely impaired cognition. R1 was dependent on staff for all activities of daily	F 700	Past noncompliance: no plan of correction required.	

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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 700	Continued From page 8 living (ADLS). Job Work Order dated 10/12/22, indicated attach bed rails to R1's bed. Review of Fall Scene Investigation dated 12/18/22, at approximately 6:50 p.m. indicated R1 was found by nursing staff on the floor on the left side of her bed. R1's body was observed to be laying on the fall mat next to bed, which was in the lowest position, and R1's head was on the bed in between the bed rail and mattress. R1 was assessed with no injury noted. R1's Mobility Rail Results dated 12/19/22, following the incident, revealed R1 was not appropriate for bed rails due to risk of strangulation, suffocation, bodily injury, or death if the resident or body parts were caught between the bed rail and mattress. Further, assessment determined R1 was at risk for serious injury if attempted to climb over or around the bed rails, and bed rails were determined dangerous due to R1 being considered a fall risk from bed. R1's bed rails were removed from bed on 12/19/22. In addition, R1's initial Mobility Rail Result assessment was requested but was not completed by the facility prior to installing bed rails on R1's bed on 10/12/22. On 12/27/22, at 1:49 a.m. trained medication assistant (TMA)-A indicated R1 had bed rails on her bed prior to incident on 12/18/22. TMA-A stated they had not witnessed R1 utilize the bed rails for mobility purposes and stated R1 wouldn't grab onto anything as she was fully dependent on staff for all ADLs. TMA-A indicated she found R1 on the floor beside her bed on the evening of 12/18/22. TMA-A indicated she observed R1's	F 700		

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F 700	Continued From page 9 head "stuck" between the mattress and bed rail. On 12/27/22, at 2:08 p.m. family member (FM)-A indicated R1 was determined to be a high risk for falls and had fallen out of bed a "few times". Further, FM-A indicated prior to R1's incident on 12/18/22, the facility had not notified them of the risks of utilizing the bed rails and no consent was obtained prior to installing R1's bed rails on 10/12/22. FM-A stated R1 would not be able to grab onto the bed rails to utilize them for mobility as R1 did not have the strength in her arms. On 12/27/22, at 2:17 p.m. nursing assistant (NA)-B indicated she observed R1 to have bed rails on her bed prior to the incident on 12/18/22. NA-B stated she had not witnessed R1 utilizing the bed rails for mobility or aiding in turning or repositioning while in bed as R1 was dependent on staff for all ADLs including bed mobility. In addition, NA-B indicated she had heard about R1's incident regarding being "stuck" in between the bed rails and mattress, and NA-B stated, "I could see that happening as she can move around a lot" while in bed. On 12/28/22, at 11:19 a.m. licensed practical nurse (LPN)-B stated on the evening of 12/18/22, LPN-B was working on the other unit and was notified to assist staff with R1. LPN-B entered R1's room and R1 was already back onto her bed. In addition, LPN-B stated R1 was assessed for injuries with no concerns identified however, R1 did report pain in her forehead and LPN-B stated, "I guess if you were stuck the way she was, that would be a normal spot for pain". On 12/28/22, at 11:31 NA-D stated on the evening of 12/18/22, NA-D and another staff	F 700		

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F 700	Continued From page 10 assisted R1 with p.m. cares and placed R1 in her bed at approximately 6:00 p.m. NA-D stated at approximately 7:00 p.m. she was notified by another staff member she needed assistance due to R1 being found lying on the floor. Further, NA-D stated when she walked into R1's room, R1 was observed with her body on the floor mat next to bed and R1's head was "face down between the bed rail and mattress" and R1 was heard "moaning". NA-D stated she assisted R1 back onto her bed and observed R1's face to be red from "her breathe being taken away", but no injuries were noted. On 12/28/22, at 2:50 p.m. nurse manager (NM)-A indicated R1 rolled out of bed on 12/18/22, and had got "stuck" between the bed rail and the mattress. NM-A indicated a bed rail assessment had not been completed prior to incident due to therapy staff initiating a work order for the bed rails and had not notified the nursing department prior to the bed rail being installed. On 12/28/22, at 12:37 a.m. physical therapy assistant (PTA) had been seen by therapy for bed mobility, seated balance, and core strengthening for a few months and then discharged off therapy services due to no further progression. PTA confirmed she filled out the work order for R1's bed rails on 10/12/22 to aid in therapy services working on reaching and bed mobility. Further, PTA confirmed she did not complete a bed rail assessment prior to R1's bed rails being installed and was not aware of the facility policy on bed rail assessments at that time. In addition, PTA stated she had received education on policies and procedures of requesting bed rails following R1's incident on 12/18/22.	F 700		

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F 700	Continued From page 11 On 12/28/22, at 4:00 p.m. interim Director of Nursing (DON) indicated therapy staff initiated a work order for bed rails for R1 prior to notifying the nursing staff. Since the nursing staff were unaware R1 had bed rails, an assessment was not completed prior to bed rails being installed. DON stated a consent form with the risks and benefits related to the use of bedrails was not obtained and completed by resident's representative until after the incident. DON indicated licensed nursing staff were expected to complete a bed rail assessment and obtain a consent form acknowledging the risks and benefits of bed rails prior to installing the bed rails on a resident's bed. Further, DON indicated education was provided following the incident to the nurse managers to ensure bed rail policy and procedure were being followed and the expectation to complete bed rail assessments prior to installing the bed rails and re-assessed quarterly, "as this was not being completed" per facility policy. On 12/29/22, at 12:30 p.m. Interview with maintenance director confirmed bed rails were installed on R1's bed on 10/12/22, when the work order was received. The past noncompliance immediate jeopardy began on 10/12/22. The immediate jeopardy was removed and the deficient practice corrected by 12/19/22, after the facility implemented a systemic plan that included the following actions: R1's bed rails were removed, R1's care plan was updated to include two-hour safety checks, all residents currently residing in facility, who had bed rails, were re-assessed for appropriateness and safety, and education provided to nursing staff and therapy department on bed rail policy	F 700		

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F 700	Continued From page 12 and procedures. R2 was admitted to the facility on 9/17/18. R2's quarterly MDS dated 10/26/22, indicated R2 had a diagnosis of dementia and had severely impaired cognition. R2 required extensive assist by staff for ADLs such as bed mobility and transfers. R2 General Nurse's Observation dated 9/17/19, indicated R2 utilized ¼ side rail on right side of bed to assist in transfers and R2 was able to utilize the bed rail appropriately. On 12/18/22, following R1's incident, R2 was re-assessed, and her bed rails were removed due to determining R2 was not appropriate for bed rails. In addition, quarterly bed rail assessments (to be completed per facility policy), for R2 were requested but facility was unable to provide. R3 was admitted to the facility on 5/6/20. R3's quarterly MDS dated 10/12/22, indicated R3 had a diagnosis of hemiparesis to left side and had moderate cognitive impairments. R3 required extensive staff assist for ADLs such as bed mobility and transfers. R3's Admissions Observation dated 5/11/20, indicated a mobility rail assessment was completed and determined R3 was appropriate for ¼ bed rails to aid in bed mobility. Further, Mobility Rail Results assessment dated 12/19/22, indicated bed rails were appropriate for R3 to utilize for mobility and transfers. In addition, quarterly bed rail assessments (to be completed per facility policy), prior to 12/19/22, were requested for R3 but facility was unable to	F 700		

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F 700	Continued From page 13 provide. R4 was admitted to the facility on 10/28/20. R4's annual MDS dated 10/4/22, indicated R4 had a diagnosis of hyperlipidemia and was cognitively intact. R4 required extensive staff assist for ADLs such as bed mobility and transfers. R4's Mobility Rail Results assessment dated 12/21/22, indicated bed rails were appropriate for R4 to utilize to promote independence and aid in turning and repositioning in bed. In addition, initial and quarterly bed rail assessments (to be completed per facility policy), prior to 12/21/22, were requested but facility was unable to provide. On 12/28/22, at 2:08 p.m. Administrator confirmed quarterly bed rail assessments for R3 and R4 could not be located. On 1/3/22, at 12:12 p.m. administrator confirmed staff had not completed any mobility rail assessments for R4 prior to 12/21/22, as the nursing department was not aware of implementation and could not verify when the bed rails were installed. Review of facility policy titled Mobility Rail Policy dated 9/21/16, indicated facility will ensure each resident with bed side rail placement has an individual assessment to determine safety based upon the resident needs as consistent with state and federal rules and regulations. Further, policy indicated the procedure to ensure safe environment of each resident included the interdisciplinary team will reassess a resident for necessity of mobility rails quarterly, annually or	F 700		

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F 700	Continued From page 14 with a significant change in condition.	F 700		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 13, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: ZM0T11

Dear Administrator:

The above facility was surveyed on December 27, 2022 through December 29, 2022 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:

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

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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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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 12/27/22 through 12/29/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000		

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2 000	Continued From page 1 when they will be completed. The following complaints were found to be SUBSTANTIATED: H51197000C (MN89511) H51197099C (MN85118) As a result of the investigation, a licensing order issued at 0565. 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 corrected prior to electronically submitting to	2 000		

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2 000	Continued From page 2 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		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to assess and/or re-assess and review for risks and benefits of the use of assistive devices including bed rails resulting in risk of potential serious harm, injury, impairment, or death for 1 of 4 (R1) residents who had a bed rail in place despite being at risk and was found with head between the mattress and bed rail. Additionally, the facility failed to assess and/or re-assess and review for risks and benefits of the use of assistive devices including bed rails for 3 of 4 residents (R2, R3, R4) reviewed for safety. Findings include: R1 was admitted to the facility on 9/20/22.	2 565	Corrected	1/17/23

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2 565	Continued From page 3 R1's admission Minimal Data Set (MDS) dated 9/28/22, indicated R1 had a diagnosis of multiple sclerosis and had severely impaired cognition. R1 was dependent on staff for all activities of daily living (ADLS). Job Work Order dated 10/12/22, indicated attach bed rails to R1's bed. Review of Fall Scene Investigation dated 12/18/22, at approximately 6:50 p.m. indicated R1 was found by nursing staff on the floor on the left side of her bed. R1's body was observed to be laying on the fall mat next to bed, which was in the lowest position, and R1's head was on the bed in between the bed rail and mattress. R1 was assessed with no injury noted. R1's Mobility Rail Results dated 12/19/22, following the incident, revealed R1 was not appropriate for bed rails due to risk of strangulation, suffocation, bodily injury, or death if the resident or body parts were caught between the bed rail and mattress. Further, assessment determined R1 was at risk for serious injury if attempted to climb over or around the bed rails, and bed rails were determined dangerous due to R1 being considered a fall risk from bed. R1's bed rails were removed from bed on 12/19/22. In addition, R1's initial Mobility Rail Result assessment was requested but was not completed by the facility prior to installing bed rails on R1's bed on 10/12/22. On 12/27/22, at 1:49 a.m. trained medication assistant (TMA)-A indicated R1 had bed rails on her bed prior to incident on 12/18/22. TMA-A stated they had not witnessed R1 utilize the bed rails for mobility purposes and stated R1 wouldn't	2 565		

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2 565	Continued From page 4 grab onto anything as she was fully dependent on staff for all ADLs. TMA-A indicated she found R1 on the floor beside her bed on the evening of 12/18/22. TMA-A indicated she observed R1's head "stuck" between the mattress and bed rail. On 12/27/22, at 2:08 p.m. family member (FM)-A indicated R1 was determined to be a high risk for falls and had fallen out of bed a "few times". Further, FM-A indicated prior to R1's incident on 12/18/22, the facility had not notified them of the risks of utilizing the bed rails and no consent was obtained prior to installing R1's bed rails on 10/12/22. FM-A stated R1 would not be able to grab onto the bed rails to utilize them for mobility as R1 did not have the strength in her arms. On 12/27/22, at 2:17 p.m. nursing assistant (NA)-B indicated she observed R1 to have bed rails on her bed prior to the incident on 12/18/22. NA-B stated she had not witnessed R1 utilizing the bed rails for mobility or aiding in turning or repositioning while in bed as R1 was dependent on staff for all ADLs including bed mobility. In addition, NA-B indicated she had heard about R1's incident regarding being "stuck" in between the bed rails and mattress, and NA-B stated, "I could see that happening as she can move around a lot" while in bed. On 12/28/22, at 11:19 a.m. licensed practical nurse (LPN)-B stated on the evening of 12/18/22, LPN-B was working on the other unit and was notified to assist staff with R1. LPN-B entered R1's room and R1 was already back onto her bed. In addition, LPN-B stated R1 was assessed for injuries with no concerns identified however, R1 did report pain in her forehead and LPN-B stated, "I guess if you were stuck the way she was, that would be a normal spot for pain".	2 565		

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	00002	A. BUILDING: _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 565	Continued From page 5 On 12/28/22, at 11:31 NA-D stated on the evening of 12/18/22, NA-D and another staff assisted R1 with p.m. cares and placed R1 in her bed at approximately 6:00 p.m. NA-D stated at approximately 7:00 p.m. she was notified by another staff member she needed assistance due to R1 being found lying on the floor. Further, NA-D stated when she walked into R1's room, R1 was observed with her body on the floor mat next to bed and R1's head was "face down between the bed rail and mattress" and R1 was heard "moaning". NA-D stated she assisted R1 back onto her bed and observed R1's face to be red from "her breathe being taken away", but no injuries were noted. On 12/28/22, at 2:50 p.m. nurse manager (NM)-A indicated R1 rolled out of bed on 12/18/22, and had got "stuck" between the bed rail and the mattress. NM-A indicated a bed rail assessment had not been completed prior to incident due to therapy staff initiating a work order for the bed rails and had not notified the nursing department prior to the bed rail being installed. On 12/28/22, at 12:37 a.m. physical therapy assistant (PTA) had been seen by therapy for bed mobility, seated balance, and core strengthening for a few months and then discharged off therapy services due to no further progression. PTA confirmed she filled out the work order for R1's bed rails on 10/12/22 to aid in therapy services working on reaching and bed mobility. Further, PTA confirmed she did not complete a bed rail assessment prior to R1's bed rails being installed and was not aware of the facility policy on bed rail assessments at that time. In addition, PTA stated she had received education on policies and procedures of requesting bed rails following R1's	2 565		

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2 565	Continued From page 6 incident on 12/18/22. On 12/28/22, at 4:00 p.m. interim Director of Nursing (DON) indicated therapy staff initiated a work order for bed rails for R1 prior to notifying the nursing staff. Since the nursing staff were unaware R1 had bed rails, an assessment was not completed prior to bed rails being installed. DON stated a consent form with the risks and benefits related to the use of bedrails was not obtained and completed by resident's representative until after the incident. DON indicated licensed nursing staff were expected to complete a bed rail assessment and obtain a consent form acknowledging the risks and benefits of bed rails prior to installing the bed rails on a resident's bed. Further, DON indicated education was provided following the incident to the nurse managers to ensure bed rail policy and procedure were being followed and the expectation to complete bed rail assessments prior to installing the bed rails and re-assessed quarterly, "as this was not being completed" per facility policy. On 12/29/22, at 12:30 p.m. Interview with maintenance director confirmed bed rails were installed on R1's bed on 10/12/22, when the work order was received. R2 was admitted to the facility on 9/17/18. R2's quarterly MDS dated 10/26/22, indicated R2 had a diagnosis of dementia and had severely impaired cognition. R2 required extensive assist by staff for ADLs such as bed mobility and transfers. R2 General Nurse's Observation dated 9/17/19, indicated R2 utilized ¼ side rail on right side of	2 565		

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2 565	Continued From page 7 bed to assist in transfers and R2 was able to utilize the bed rail appropriately. On 12/18/22, following R1's incident, R2 was re-assessed, and her bed rails were removed due to determining R2 was not appropriate for bed rails. In addition, quarterly bed rail assessments (to be completed per facility policy), for R2 were requested but facility was unable to provide. R3 was admitted to the facility on 5/6/20. R3's quarterly MDS dated 10/12/22, indicated R3 had a diagnosis of hemiparesis to left side and had moderate cognitive impairments. R3 required extensive staff assist for ADLs such as bed mobility and transfers. R3's Admissions Observation dated 5/11/20, indicated a mobility rail assessment was completed and determined R3 was appropriate for ¼ bed rails to aid in bed mobility. Further, Mobility Rail Results assessment dated 12/19/22, indicated bed rails were appropriate for R3 to utilize for mobility and transfers. In addition, quarterly bed rail assessments (to be completed per facility policy), prior to 12/19/22, were requested for R3 but facility was unable to provide. R4 was admitted to the facility on 10/28/20. R4's annual MDS dated 10/4/22, indicated R4 had a diagnosis of hyperlipidemia and was cognitively intact. R4 required extensive staff assist for ADLs such as bed mobility and transfers. R4's Mobility Rail Results assessment dated 12/21/22, indicated bed rails were appropriate for R4 to utilize to promote independence and aid in	2 565		

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2 565	Continued From page 8 turning and repositioning in bed. In addition, initial and quarterly bed rail assessments (to be completed per facility policy), prior to 12/21/22, were requested but facility was unable to provide. On 12/28/22, at 2:08 p.m. Administrator confirmed quarterly bed rail assessments for R3 and R4 could not be located. On 1/3/22, at 12:12 p.m. administrator confirmed staff had not completed any mobility rail assessments for R4 prior to 12/21/22, as the nursing department was not aware of implementation and could not verify when the bed rails were installed. Review of facility policy titled Mobility Rail Policy dated 9/21/16, indicated facility will ensure each resident with bed side rail placement has an individual assessment to determine safety based upon the resident needs as consistent with state and federal rules and regulations. Further, policy indicated the procedure to ensure safe environment of each resident included the interdisciplinary team will reassess a resident for necessity of mobility rails quarterly, annually or with a significant change in condition. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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