Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 30, 2025

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

RE: CCN: 245119
Cycle Start Date: March 19, 2025

Dear Administrator:

On April 23, 2025, 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,

Sarah Lane

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

April 30, 2025

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

Re: Reinspection Results
Event ID: PIC912

Dear Administrator:

On April 23, 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 March 19, 2025. 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
Email: sarah.lane@state.mn.us

Electronically delivered
April 1, 2025

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

RE: CCN: 245119
Cycle Start Date: March 19, 2025

Dear Administrator:

On March 19, 2025, 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:

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 June 19, 2025 (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 September 19, 2025 (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)

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,

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 **03/19/2025**

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 3/18/25 through 3/19/25, 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 H51199586C (MN00111059) H51191060C (MN00111433) As a result of the survey a deficiency was cited 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=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:	F 689		4/18/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/10/2025

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 689	Continued From page 1 Based on observation, interview and document review the facility failed to reduce the risk of falls for 1 of 3 residents (R3) reviewed for accidents and supervisor. R3 had a high risk for falls and was observed attempting to self-transfer from a wheelchair to bed. Findings include: During continuous observation on 3/19/25, R3 was seated in the dining room with his eyes closed at 6:45 a.m., where he remained until 7:47 a.m., when he propelled himself down the hall toward his room. Staff spoke with R3 on his way down the hall. At 7:51 a.m. R3 was observed propelling from his room. At 7:47 a.m. R3 told NA-B, " I want to go to sleep but they keep kicking me out." NA-B said, "they kicked you out, huh." then walked away. At 8:02 a.m. a staff member moved R3 to a table in the common area where he sat with a book. At 8:25 a.m. R3 remained seated in his wheelchair with his eyes closed. At 9:12 a.m. R3 again propelled himself toward his room. At 9:18 a.m., R3 got the door to his room open, and a housekeeper moved him back into the hallway. At 9:30 a.m., the housekeeper told R3 he had to wait for the NA's and said they could not take him to the bathroom because they were a little busy. At 9:32 a.m., R3 again entered his room. Surveyor alerted trained medication aide (TMA)-A that R3 was attempting to self-transfer to his bed. TMA-A intervened and told R3 he needed to wait for a NA to come off break and one to finish charting before they could help him into bed. At 9:40 a.m. NA-B was observed in the common area. TMA-A did not report that R3 had requested help. At 9:49 a.m. NA-A returned to the unit. At 9:51 a.m. R3 was talking to TMA-A who did not acknowledge him.	F 689	Plan to correct for resident identified with the deficient practice: To reduce the risk of falls for R3, all fall interventions have been reviewed and updated as needed to R3 care plan and added to the Fall Interventions section in the PCC Kardex. Plan to identify other residents at risk from deficient practice: All residents with a high fall risk have the potential to be affected by this deficient practice. Plan to ensure other residents are not impacted by deficient practice: All residents who are at a high risk of falling, identified with a score of 10 or greater on our falls risk assessment, were reviewed for appropriate fall prevention interventions. All residents identified, had their care plans and Kardex Fall Interventions section updated to reflect current appropriate interventions. NAR-A received 1:1 education on the resident Kardex and the resident information found there. All nursing staff signed off for education of the new Falls Intervention section added to the Kardex and that the Kardex will be reviewed at the start of each scheduled shift to identify any newly added fall updates and interventions. Fall prevention and Management policy was reviewed by DON and no changes were necessary.	

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	245119	A. BUILDING ______ B. WING ______	C 03/19/2025

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 2 R3 propelled himself toward his room. TMA-A then asked NA-A and NA-B to assist R3 to lay down. NA-B stated, "We aren't supposed to, are we?" and NA-A said, "they want him up until after dinner." At 9:56 a.m., NA-A and NA-B assisted R3 to his room. NA-A said R3 had been up since she arrived at 6:00 a.m. NA-A and NA-B assisted R3 in the mechanical stand and transferred him to his bed and covered him with blankets. When asked about toileting, NA-A said R3 would tell them if he needed to go and said, sometimes they offer. NA-A and NA-B checked R3's brief and changed it after they determined he was wet. While charting R3's brief, NA-A stated R3 did not like to roll and said, "believe it or not, he is terrified of falling out of bed." NA-B stated R3's wife wanted staff to keep him up during the day because of falls. NA-B said if laid down, R3 would try to crawl out of bed. R3's Admission Record indicated he admitted to the facility on 1/23/25. Diagnosis included hemiplegia (severe or complete unilateral loss of strength or paralysis) and hemiparesis (weakness in one leg, arm, or side of the face) and vascular dementia. R3's Fall Risk Assessment dated 1/30/25, indicated he had a fall on 1/27/25. Continence and mobility indicated R3 required assistance with elimination, was confined to a chair and was only able to steady himself with assistance. R3's admission Minimum Data Set (MDS) dated 1/30/25, identified severe cognitive impairment. The MDS indicated R3 displayed no behaviors, was frequently incontinent of bladder and always continent of bowel. R3's MDS indicated he was dependent on staff for transfers and toileting.	F 689	Plan for monitoring: Audits will be completed by DON or designee to check that the resident fall interventions and changes are added to the resident Kardex when identified by falls IDT review after each fall x2 weeks, 2x/wk x1 week, 1x/wk x1week, monthly x1. Audits will be completed by DON or designee to check that new resident fall interventions and changes that were added to the Fall Interventions section of the resident Kardex are being followed by nursing staff daily x1 week, 2x/wk x1week, 1x/wk x1week, monthly x1. Findings will be brought to the facilities Quality Assurance Committee for review and further auditing recommendations.	

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F 689	Continued From page 3	F 689		

R3's care area assessment (CAA), dated 2/4/25, indicated he was continent of bowel, frequently incontinence of bladder and needed assistance with cares. R3 had a diagnosis of vascular dementia, peripheral vascular disease, benign prostatic hyperplasia, and hemiplegia/hemiparesis of left side. The fall CAA indicated R3 needed extensive assistance with activities of daily living, scored 16 on the fall risk assessment indicating a high risk for falls and had one fall since admission to the facility.

R3's care plan dated 2/28/25, identified bladder incontinence related to confusion and impaired mobility. The care plan directed staff to change R3 as needed. The care plan identified a risk for falls related to confusion and poor communication. The care plan directed staff to assist as needed with mobility and transfers, ensure call light was within reach, appropriate footwear, and bed in lowest position with a fall mat beside the bed. The care plan indicated R3 liked to get out of bed and crawl.

R3's Kardex Report dated 3/18/25, indicated Bladder/Bowel, "change and PRN" (as needed). Safety, ensure call light in reach, bed in low position with fall mats. "I prefer to get out of bed and crawl."

Facility Resident Incident Log dated 1/20/25 through 2/26/25, indicated R3 had one fall on 1/27/25.

R3's Progress Notes identified the following:

1/26/25, Nursing assistant (NA) entered the tub room and found R3 had transferred himself onto

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AITKIN HEALTH SERVICES	**301 MINNESOTA AVENUE SOUTH AITKIN, MN 56431**

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F 689	Continued From page 4	F 689		

the toilet. Staff assisted R3 and reminded him to call for help as he required assistance to transfer.

1/27/25, Staff heard a banging noise and found R3 on the floor in his room. R3 was laying with his feet toward the bathroom door. A correlating Incident Form dated 1/27/25, indicated interdisciplinary team (IDT) reviewed the incident and recommended R3 be placed on every two-hour toileting plan.

1/31/25, R3 self-transferred into bed from his wheelchair. R3 had two episodes of putting himself on the floor and told staff "I just roll over and this is where I end up." The note indicated "was a purposeful act."

2/18/25, R3 was found attempting to crawl out of bed. R3 had his body scooted down with his knees on the fall mat.

2/25/25, R3 attempted to crawl out of bed this shift.

2/26/25, R3 was found attempting to self-transfer out of bed. NA found R3 with both legs on the fall mat and the top half of his body on the bed. R3 was reminded to use the call light.

2/28/25, R3 attempted to crawl out of bed. Upper body on bed with legs on fall mat.

3/7/25 at 3:00 p.m., NA reported when passing by R3's room he was crawling out of bed a kneeling on the floor mat in front of his bed. R3's hands were on the bed when she found him. Root cause indicated, it appeared R3 was crawling out of bed. A correlating Incident Audit Report dated 3/11/25, indicated R3 stated he wanted to get out of bed.

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F 689	Continued From page 5	F 689		

The IDT review determined R3 was care planned to be able to get out of bed to his mat and indicated the incident was intentional and not a fall.

3/7/25 at 9:00 p.m., R3 was heard yelling from his room. R3 was found sitting on his fall mat. R3 was unable to describe what he was doing at the time and had been incontinent of bladder.

3/8/25, R3 found seated on his fall mat with his back against the bed around midnight. R3 had stool on his hands, urinal, and mat. Root cause indicated, possibly needed to use the bathroom.

During interview on 3/18/25 at 4:04 p.m. NA-A stated R3 liked to "sneak" into his room and transfer himself in and out of bed. NA-A stated R3 transferred with staff using a mechanical stand. NA-A said she had not seen R3 try to self-transfer but said she had found him on the ground. When asked about fall interventions, NA-A stated, "I wouldn't know." NA-A said staff used the Kardex for a care guide.

During interview on 3/19/25 at 10:06 a.m., registered nurse (RN)-A stated R3 should be checked every two hours and said it should have been in his care plan. RN-B stated she thought R3 could verbalize the need to use the toilet, but not consistently. RN-A stated they had R3 on a two-hour toileting plan to try to "catch" him but said on the off hours staff would find him on the mat. RN-A said R3 could not be left alone in his room because he did not use the call light. RN-A stated when R3 had been at home he would crawl to the bathroom when he needed to go. RN-A stated initially when R3 rolled out of bed they were calling it a fall and said there had been

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F 689	Continued From page 6	F 689		

no instances of rolling out of bed in the medical record, just crawling out of bed and kneeling on the mat. RN- A was unable to explain how staff assessed whether R3 rolled out of bed or was intentionally crawling out of bed.

On 3/19/25 at 11:57 a.m. R3 was interviewed with family member (FM)-A. FM-A stated R3 had fallen and broke his hip and went to a different facility for rehab. FM-A stated R3 returned home after rehab but only lasted two days because she could not care for him. FM-A stated prior to the fall with fracture, R3 did not really have falls at home. FM-A said, "I guess he crawled on the floor" at the previous facility and was told he did that here at the facility. FM-A said R3 did not do that at home. FM-A said she felt a big part of R3's falls was when he needed to go to the bathroom. FM-A said the staff had not really implemented a plan. FM-A said they had discussed toileting R3 at 10:30 a.m. since he always wanted to go when staff were trying to bring others to lunch but said it had not happened.

During interview on 3/19/25 at 12:50 p.m., the director of nursing (DON) stated after a fall, the IDT reviewed and said they had a list of suggestions they used for fall interventions. The DON said she thought R3 was on a two-hour toileting plan and said the previous day, RN-A had discussed it with staff. At 1:07 p.m. the DON stated when R3 was seen on the floor it was not considered a fall and said it had been the nurse practitioners idea. The DON stated she was unable to provide evidence of assessment to indicate R3 was on the floor intentionally versus falling out of bed.

Facility Policy Fall Prevention and Management

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F 689	Continued From page 7 dated 6/5/23, indicated the care center will assess each resident for risk of falls and identify interventions to assist in preventing falls and/or injuries. A falls analysis will be completed when a resident had two or more falls, to review fall trends, identify individual and systemic causes of falls, evaluate current interventions for effectiveness and if needed to determine additional interventions. All interventions that are identified through the assessment/review process will be documented in the resident's care plan using person centered language.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 1, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: PIC911

Dear Administrator:

The above facility was surveyed on March 18, 2025 through March 19, 2025 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:

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

Minnesota Department of Health

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 ______	03/19/2025

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 *****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 3/18/25 through 3/19/25, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/10/25

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H51199586C (MN00111059) H51191060C (MN00111433) As a result of the survey a licensing order was issued at 0830. 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 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 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 observation, interview and document review the facility failed to reduce the risk of falls for 1 of 3 residents (R3) reviewed for accidents and supervisor. R3 had a high risk for falls and was observed attempting to self-transfer from a wheelchair to bed. Findings include: During continuous observation on 3/19/25, R3	2 830	Corrected	4/18/25

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2 830	Continued From page 3 was seated in the dining room with his eyes closed at 6:45 a.m., where he remained until 7:47 a.m., when he propelled himself down the hall toward his room. Staff spoke with R3 on his way down the hall. At 7:51 a.m. R3 was observed propelling from his room. At 7:47 a.m. R3 told NA-B, " I want to go to sleep but they keep kicking me out." NA-B said, "they kicked you out, huh." then walked away. At 8:02 a.m. a staff member moved R3 to a table in the common area where he sat with a book. At 8:25 a.m. R3 remained seated in his wheelchair with his eyes closed. At 9:12 a.m. R3 again propelled himself toward his room. At 9:18 a.m., R3 got the door to his room open, and a housekeeper moved him back into the hallway. At 9:30 a.m., the housekeeper told R3 he had to wait for the NA's and said they could not take him to the bathroom because they were a little busy. At 9:32 a.m., R3 again entered his room. Surveyor alerted trained medication aide (TMA)-A that R3 was attempting to self-transfer to his bed. TMA-A intervened and told R3 he needed to wait for a NA to come off break and one to finish charting before they could help him into bed. At 9:40 a.m. NA-B was observed in the common area. TMA-A did not report that R3 had requested help. At 9:49 a.m. NA-A returned to the unit. At 9:51 a.m. R3 was talking to TMA-A who did not acknowledge him. R3 propelled himself toward his room. TMA-A then asked NA-A and NA-B to assist R3 to lay down. NA-B stated, "We aren't supposed to, are we?" and NA-A said, "they want him up until after dinner." At 9:56 a.m., NA-A and NA-B assisted R3 to his room. NA-A said R3 had been up since she arrived at 6:00 a.m. NA-A and NA-B assisted R3 in the mechanical stand and transferred him to his bed and covered him with blankets. When asked about toileting, NA-A said R3 would tell them if he needed to go and said, sometimes	2 830		

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2 830	Continued From page 4	2 830		

they offer. NA-A and NA-B checked R3's brief and changed it after they determined he was wet. While charting R3's brief, NA-A stated R3 did not like to roll and said, "believe it or not, he is terrified of falling out of bed." NA-B stated R3's wife wanted staff to keep him up during the day because of falls. NA-B said if laid down, R3 would try to crawl out of bed.

R3's Admission Record indicated he admitted to the facility on 1/23/25. Diagnosis included hemiplegia (severe or complete unilateral loss of strength or paralysis) and hemiparesis (weakness in one leg, arm, or side of the face) and vascular dementia.

R3's Fall Risk Assessment dated 1/30/25, indicated he had a fall on 1/27/25. Continence and mobility indicated R3 required assistance with elimination, was confined to a chair and was only able to steady himself with assistance.

R3's admission Minimum Data Set (MDS) dated 1/30/25, identified severe cognitive impairment. The MDS indicated R3 displayed no behaviors, was frequently incontinent of bladder and always continent of bowel. R3's MDS indicated he was dependent on staff for transfers and toileting.

R3's care area assessment (CAA), dated 2/4/25, indicated he was continent of bowel, frequently incontinence of bladder and needed assistance with cares. R3 had a diagnosis of vascular dementia, peripheral vascular disease, benign prostatic hyperplasia, and hemiplegia/hemiparesis of left side. The fall CAA indicated R3 needed extensive assistance with activities of daily living, scored 16 on the fall risk assessment indicating a high risk for falls and had one fall since admission to the facility.

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2 830	Continued From page 5	2 830		

R3's care plan dated 2/28/25, identified bladder incontinence related to confusion and impaired mobility. The care plan directed staff to change R3 as needed. The care plan identified a risk for falls related to confusion and poor communication. The care plan directed staff to assist as needed with mobility and transfers, ensure call light was within reach, appropriate footwear, and bed in lowest position with a fall mat beside the bed. The care plan indicated R3 liked to get out of bed and crawl.

R3's Kardex Report dated 3/18/25, indicated Bladder/Bowel, "change and PRN" (as needed). Safety, ensure call light in reach, bed in low position with fall mats. "I prefer to get out of bed and crawl."

Facility Resident Incident Log dated 1/20/25 through 2/26/25, indicated R3 had one fall on 1/27/25.

R3's Progress Notes identified the following:

1/26/25, Nursing assistant (NA) entered the tub room and found R3 had transferred himself onto the toilet. Staff assisted R3 and reminded him to call for help as he required assistance to transfer.

1/27/25, Staff heard a banging noise and found R3 on the floor in his room. R3 was laying with his feet toward the bathroom door. A correlating Incident Form dated 1/27/25, indicated interdisciplinary team (IDT) reviewed the incident and recommended R3 be placed on every two-hour toileting plan.

1/31/25, R3 self-transferred into bed from his wheelchair. R3 had two episodes of putting

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2 830	Continued From page 6 himself on the floor and told staff "I just roll over and this is where I end up." The note indicated "was a purposeful act." 2/18/25, R3 was found attempting to crawl out of bed. R3 had his body scooted down with his knees on the fall mat. 2/25/25, R3 attempted to crawl out of bed this shift. 2/26/25, R3 was found attempting to self-transfer out of bed. NA found R3 with both legs on the fall mat and the top half of his body on the bed. R3 was reminded to use the call light. 2/28/25, R3 attempted to crawl out of bed. Upper body on bed with legs on fall mat. 3/7/25 at 3:00 p.m., NA reported when passing by R3's room he was crawling out of bed a kneeling on the floor mat in front of his bed. R3's hands were on the bed when she found him. Root cause indicated, it appeared R3 was crawling out of bed. A correlating Incident Audit Report dated 3/11/25, indicated R3 stated he wanted to get out of bed. The IDT review determined R3 was care planned to be able to get out of bed to his mat and indicated the incident was intentional and not a fall. 3/7/25 at 9:00 p.m., R3 was heard yelling from his room. R3 was found sitting on his fall mat. R3 was unable to describe what he was doing at the time and had been incontinent of bladder. 3/8/25, R3 found seated on his fall mat with his back against the bed around midnight. R3 had stool on his hands, urinal, and mat. Root cause indicated, possibly needed to use the bathroom.	2 830		

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2 830	Continued From page 7 During interview on 3/18/25 at 4:04 p.m. NA-A stated R3 liked to "sneak" into his room and transfer himself in and out of bed. NA-A stated R3 transferred with staff using a mechanical stand. NA-A said she had not seen R3 try to self-transfer but said she had found him on the ground. When asked about fall interventions, NA-A stated, "I wouldn't know." NA-A said staff used the Kardex for a care guide. During interview on 3/19/25 at 10:06 a.m., registered nurse (RN)-A stated R3 should be checked every two hours and said it should have been in his care plan. RN-B stated she thought R3 could verbalize the need to use the toilet, but not consistently. RN-A stated they had R3 on a two-hour toileting plan to try to "catch" him but said on the off hours staff would find him on the mat. RN-A said R3 could not be left alone in his room because he did not use the call light. RN-A stated when R3 had been at home he would crawl to the bathroom when he needed to go. RN-A stated initially when R3 rolled out of bed they were calling it a fall and said there had been no instances of rolling out of bed in the medical record, just crawling out of bed and kneeling on the mat. RN- A was unable to explain how staff assessed whether R3 rolled out of bed or was intentionally crawling out of bed. On 3/19/25 at 11:57 a.m. R3 was interviewed with family member (FM)-A. FM-A stated R3 had fallen and broke his hip and went to a different facility for rehab. FM-A stated R3 returned home after rehab but only lasted two days because she could not care for him. FM-A stated prior to the fall with fracture, R3 did not really have falls at home. FM-A said, "I guess he crawled on the floor" at the previous facility and was told he did	2 830		

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2 830	Continued From page 8	2 830		

that here at the facility. FM-A said R3 did not do that at home. FM-A said she felt a big part of R3's falls was when he needed to go to the bathroom. FM-A said the staff had not really implemented a plan. FM-A said they had discussed toileting R3 at 10:30 a.m. since he always wanted to go when staff were trying to bring others to lunch but said it had not happened.

During interview on 3/19/25 at 12:50 p.m., the director of nursing (DON) stated after a fall, the IDT reviewed and said they had a list of suggestions they used for fall interventions. The DON said she thought R3 was on a two-hour toileting plan and said the previous day, RN-A had discussed it with staff. At 1:07 p.m. the DON stated when R3 was seen on the floor it was not considered a fall and said it had been the nurse practitioners idea. The DON stated she was unable to provide evidence of assessment to indicate R3 was on the floor intentionally versus falling out of bed.

Facility Policy Fall Prevention and Management dated 6/5/23, indicated the care center will assess each resident for risk of falls and identify interventions to assist in preventing falls and/or injuries. A falls analysis will be completed when a resident had two or more falls, to review fall trends, identify individual and systemic causes of falls, evaluate current interventions for effectiveness and if needed to determine additional interventions. All interventions that are identified through the assessment/review process will be documented in the resident's care plan using person centered language.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could review/revise policies and procedures related to

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2 830	Continued From page 9 falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		