



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email
December 18, 2020

Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

RE: CCN: 245363
Cycle Start Date: October 21, 2020

Dear Administrator:

On December 17, 2020, 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,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 8, 2020

Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

RE: CCN: 245363
Cycle Start Date: October 21, 2020

Dear Administrator:

On October 21, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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.

Aicota Health Care Center

November 8, 2020

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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" tag) i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

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 January 21, 2021 (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 April 21, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

Aicota Health Care Center

November 8, 2020

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a long horizontal line extending to the right.

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

PRINTED: 11/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245363	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/21/2020
NAME OF PROVIDER OR SUPPLIER AICOTA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 850 SECOND STREET NORTHWEST 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 10/20/20, through 10/21/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint(s) were found to be substantiated: H5363012C with no deficiency cited. However, related deficiencies were issued. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		11/27/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
11/13/2020

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

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F 609	<p>Continued From page 1</p> <p>serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately, but no later than two hours, to the State Agency (SA) for 1 of 3 residents (R1) reviewed for staff to resident abuse.</p> <p>Findings include:</p> <p>R1's Admission Record printed 10/21/20, indicated R1's diagnoses included dementia with behavioral disturbances, and Parkinson's.</p> <p>R1's care plan initiated 10/13/20, indicated R1 required behavioral management, and interventions included staff to allow resident to vent, explain procedures before initiating, and reproach with different staff. R1's care plan directed staff to assist with all activities of daily living (ADLs) including toileting and personal cares.</p>	F 609	<p>Facility will ensure all alleged violations are reported in a timely manner according to facility policy. Facility completed audit for last 3 months of reporting and found 3 of 3 were reported correctly.</p> <p>DON/designee will provide education to all staff regarding timely reporting. Education will also be provided to all staff with the ability to report in the facility. Education will be completed by 11/27/2020.</p> <p>DON/designee will audit state reported violations for next 3 month on timely reporting and report findings at next quality council meeting.</p>		

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F 609	Continued From page 2 A facility employee warning for registered nurse (RN)-A dated 10/16/20, indicated on 10/16/20, registered nurse (RN)-A was reported to the director of nursing (DON) regarding an incident on 10/16/20, involving potential verbal abuse towards R1. According to the report, on 10/16/20, during morning cares nursing assistant (NA)-A had observed RN-A threaten to harm R1 while providing toileting assistance. The report further indicated RN-A performed an act which was inappropriate towards R1. Review of the facility's working schedule indicated RN-A worked the nightshift on 10/16/20, the night of the alleged incident. Facility records indicated on 10/16/20, RN-A was suspended on 10/16/20, and ultimately terminated per the facilities own investigation of the allegation of abuse. On 10/21/20, at 8:33 a.m. an interview was conducted with the DON. The DON confirmed the incident involving R1 was not reported to the SA timely, and should have been. The DON verified the incident occurred on 10/16/20, at approximately 2:30 a.m., however, it was not reported to the SA until 12:30 p.m. that day. The DON stated RN-A had not provided additional cares for R1 after the incident. The DON stated she arrived to the facility at approximately 5:45 a.m. and immediately suspended RN-A. The DON stated RN-A was ultimately terminated on 10/16/20. The facility policy Vulnerable Adult Abuse Prevention Plan last reviewed 7/18/19, directed staff that any suspicion of abuse must be reported to the administrator or designated representative who then would notify the state	F 609			

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F 609	Continued From page 3	F 609			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 3 residents (R1) reviewed for allegation of verbal abuse. Findings include: R1's Admission Record printed 10/21/20, indicated R1's diagnoses included dementia with behavioral disturbances, and Parkinson's. R1's care plan initiated 10/13/20, indicated R1 required behavioral management, and interventions included staff to allow resident to	F 610	Facility will ensure proper investigation of alleged violations are conducted according to policies and procedures of facility. Policy will be updated to add follow-up investigation to be used following an alleged violation within the investigation period. Facility completed audit for last 3 months of reporting and found 3 of 3 were reported correctly. Education will be provided to staff who complete follow up investigations. Education and policy update will be completed by 11/27/2020. DON/designee will audit state reported violations for next	11/27/20	

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F 610	<p>Continued From page 4</p> <p>vent, explain procedures before initiating, and reproach with different staff. R1's care plan directed staff to assist with all activities of daily living (ADLs) including toileting and personal cares.</p> <p>A facility employee warning for registered nurse (RN)-A dated 10/16/20, indicated on 10/16/20, registered nurse (RN)-A was reported to the director of nursing (DON) regarding an incident on 10/16/20, involving potential verbal abuse towards R1. According to the report, on 10/16/20, during morning cares nursing assistant (NA)-A had observed RN-A threaten to harm R1 while providing toileting assistance. The report further indicated RN-A performed an act which was inappropriate towards R1.</p> <p>Review of the facility's working schedule indicated NA-B worked the nightshift on 10/16/20 (the night of the alleged incident). Facility records indicated on 10/16/20, NA-B was suspended and ultimately terminated per the facilities own investigation of the allegation of abuse.</p> <p>On 10/21/20, at 8:33 a.m. an interview was conducted with the DON. The DON stated she had only interviewed the staff members that reported the incident. The DON stated she felt this was an isolated event, so no other staff or residents were interviewed regarding RN-A's interaction with residents while providing cares. The DON stated any allegation of abuse should be thoroughly investigated.</p> <p>On 10/21/20, at 2:33 p.m. an interview was conducted with the administrator. The administrator stated no other residents were interviewed regarding cares provided by RN-A</p>	F 610	3 month on proper investigation follow up and report findings at quality council meeting.		

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F 610	Continued From page 5 because he felt it was a specific incident, and no further investigation was needed.	F 610			
F 943 SS=D	<p>The facility Resident Abuse/ Neglect/ Exploitation and Reporting Requirements policy revised date 1/21/19, indicated all allegations are to be thoroughly investigated to prevent further potential abuse</p> <p>Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3)</p> <p>§483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-</p> <p>§483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>§483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>§483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide facility specific abuse prevention training to 1 of 1 employees (RN-A) whose files were reviewed. The lack of training had the potential to affect all 56 residents residing in the facility.</p> <p>On 10/21/20, at 11:55 a.m. review of employee records revealed the following:</p>	F 943		11/27/20	
			DON/designee will ensure all staff have received Abuse and Neglect training in accordance with the policies of the facility on or before 11/27/2020. DON/designee will audit that education has been completed on new staff over the next 3 months and report findings to the quality council meeting.		

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F 943	Continued From page 6 Registered nurse (RN)-A's (who had been terminated for an allegation of verbal abuse on 10/16/20), learning transcript indicated RA-A had not completed the Abuse and Vulnerable Adult (VA) training course since 5/23/19. On 10/21/20, at 1:04 p.m. the director of nursing (DON) confirmed RN-A had not received the required annual Abuse and VA training. The DON verified the last Abuse and VA training for staff was held 5/23/19. The DON stated Abuse and VA training was available online for all staff, however, just didn't get done. The DON stated all staff were required to have annual training which included Abuse and VA reporting. The facility policy Vulnerable Adult Abuse Prevention Plan last reviewed 7/18/19, directed all employees will be required to attend training through orientation, annual in-service, and as needed on abuse prohibition practices, which included prevention of abuse and vulnerable adult law.	F 943			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 8, 2020

Administrator
Aicota Health Care Center
850 Second Street Northwest
Aitkin, MN 56431

Re: State Nursing Home Licensing Orders
Event ID: T62E11

Dear Administrator:

The above facility was surveyed on October 20, 2020 through October 21, 2020 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

Aicota Health Care Center

November 8, 2020

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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:

**Teresa Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151**

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

Please feel free to call me with any questions.

Sincerely,



Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2020
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NAME OF PROVIDER OR SUPPLIER AICOTA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 850 SECOND STREET NORTHWEST AITKIN, MN 56431
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 10/20/20, through 10/21/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities</p> <p>The following complaint(s) were found to be</p>	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE
11/13/20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2020
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2 000	Continued From page 1 substantiated: H5363012C, with no deficiency cited. However, related deficiencies were issued. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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.	2 000		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately, but no later than two hours,	21990	Corrected.	11/27/20

Minnesota Department of Health

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21990	<p>Continued From page 2</p> <p>to the State Agency (SA) for 1 of 3 residents (R1) reviewed for staff to resident abuse.</p> <p>Findings include:</p> <p>R1's Admission Record printed 10/21/20, indicated R1's diagnoses included dementia with behavioral disturbances, and Parkinson's.</p> <p>R1's care plan initiated 10/13/20, indicated R1 required behavioral management, and interventions included staff to allow resident to vent, explain procedures before initiating, and reproach with different staff. R1's care plan directed staff to assist with all activities of daily living (ADLs) including toileting and personal cares.</p> <p>A facility employee warning for registered nurse (RN)-A dated 10/16/20, indicated on 10/16/20, registered nurse (RN)-A was reported to the director of nursing (DON) regarding an incident on 10/16/20, involving potential verbal abuse towards R1. According to the report, on 10/16/20, during morning cares nursing assistant (NA)-A had observed RN-A threaten to harm R1 while providing toileting assistance. The report further indicated RN-A performed an act which was inappropriate towards R1.</p> <p>Review of the facility's working schedule indicated RN-A worked the nightshift on 10/16/20, the night of the alleged incident. Facility records indicated on 10/16/20, RN-A was suspended on 10/16/20, and ultimately terminated per the facilities own investigation of the allegation of abuse.</p> <p>On 10/21/20, at 8:33 a.m. an interview was conducted with the DON. The DON confirmed the incident involving R1 was not reported to the SA</p>	21990		

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21990	<p>Continued From page 3</p> <p>timely, and should have been. The DON verified the incident occurred on 10/16/20, at approximately 2:30 a.m., however, it was not reported to the SA until 12:30 p.m. that day. The DON stated RN-A had not provided additional cares for R1 after the incident. The DON stated she arrived to the facility at approximately 5:45 a.m. and immediately suspended RN-A. The DON stated RN-A was ultimately terminated on 10/16/20.</p> <p>The facility policy Vulnerable Adult Abuse Prevention Plan last reviewed 7/18/19, directed staff that any suspicion of abuse must be reported to the administrator or designated representative who then would notify the state agency no later than two hours.</p> <p>SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee and social service director could develop, review, and/or revise policies and procedures to ensure abuse and vulnerable adult education is completed for all staff annually. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21990		