Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 1, 2022

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

RE: CCN: 245363
Cycle Start Date: July 19, 2022

Dear Administrator:

On August 19, 2022, 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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
July 27, 2022

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

RE: CCN: 245363
Cycle Start Date: July 19, 2022

Dear Administrator:

On July 19, 2022, 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.

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, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
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 October 19, 2022 (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 January 19, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245363	A. BUILDING _____ B. WING _____	C 07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AICOTA HEALTH CARE CENTER	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 7/18/22 through 7/19/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H53633290C (MN84789), with a deficiency cited at F600. As a result of the investigation, additional deficiencies were cited at F609 and F744. 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		8/12/22

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

Electronically Signed | 08/03/2022

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 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were free from sexual abuse for 2 of 3 residents (R1, R2) reviewed for abuse, when R2 was witnessed touching R1's breast. Findings include: R1's quarterly Minimal Data Set (MDS) dated 4/20/22, indicated R1 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS indicated R1 required extensive assistance by two staff for bed mobility, transfers, dressing, toileting and hygiene and R1 utilized wheelchair for mobility with extensive assistance of one staff for mobility. R1's Individual Abuse Assessment dated 4/27/22, determined R1 had severe confusion, disorientation, and forgetful ness with occasional verbal, and physical abuse and wandering which placed R1 at moderate risk for abuse by others. Review of R1's progress notes revealed, on 72/22 at 3:00 p.m. staff observed R2 with hand on R1's breast in the south dayroom. R1 was not in distress and staff redirected R2 to his room. R2's 5-day MDS dated 6/13/22, indicated R2 had a diagnosis of dementia and had moderately impaired cognition. Further review of MDS indicated R2 required extensive assistance by	F 600	Facility will provide an environment that is free from abuse and neglect by completing and documenting in the resident□s care plan a behavioral assessment and an ability to consent assessment upon admission, quarterly, and with change in condition. R2 has been re-assessed and careplan has been updated to include his sexual behavior and interventions specific to that behavior. Education provided to all staff regarding interventions put in place for R2. Education will be completed on or before 8/12/22 or prior to next shift. All care plans will be reviewed to ensure that they address behavioral concerns and have person-centered interventions directly related to those concerns. DON or designee will complete audits to ensure behavior care plan is completed 5 per week X1 week, 3 per week X 3 weeks, 1 weekly X 1 month, audit results will be brought to Quality Council for further review and recommendation.	

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F 600	Continued From page 2 two staff for transfers and toileting and required extensive assist of one staff for dressing, hygiene, and utilized a wheelchair for mobility. R2's care plan as of 7/18/22, indicated R2 was at risk for falls and directed staff to complete half hour visual checks and utilize wheelchair for transport, activities and meals then transfer R2 to a stationary chair. In addition, R2's care plan indicated had a history of being an affectionate person and would say hi by grabbing hands, hugging, and kissing. However, R2's care plan lacked other interventions to address R2's sexual behaviors towards other female residents following incident with R2. Review of facility report to the State Agency (SA) dated 7/2/22, indicated staff witnessed R2 self-propelling in his wheelchair close to R1. Staff observed R2 had his hand on R1's right breast and was rubbing it above her clothing. Staff immediately removed R2 and brought him back to his room. Staff reported R1 did not show signs of distress and appeared to be unaware of what happened. Further review of report directed staff to continue with "frequency of check" on R2. Review of the facility investigation to the SA dated 7/8/22, indicated facility determined R2's care plan intervention for fall prevention direct staff to place R2 in a stationary chair when not in activities or dining which was not followed at the time of the incident. Through investigation, facility determined R2's care plan was updated to transfer resident to stationary chair unless supervised and all staff were going to be educated on the care plan change to prevent reoccurrence to R1. Further review of facility's investigation lacked evidence R2 was reassessed	F 600		

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F 600	Continued From page 3 for sexual behaviors to determine appropriate intervention to implement to prevent re-occurrence and protect other residents currently residing in the facility. On 7/18/22, at 8:51 a.m. R1 was observed in the commons area in her wheelchair. R2 was also observed in the commons area sitting in a stationary chair in front of R1. R2 appeared to be sleeping as his eyes were closed and there was a female resident observed in her wheelchair next to R2 on his right side. On 7/18/22, at 11:26 a.m. activity aid (AA)-A stated after social hour on 7/2/22, she assisted R2 in his wheelchair from the dining room and placed him in the south commons area and then AA-A returned to the dining room to assist other residents. Further, AA-A stated she was not aware of R2's behaviors but was told he can't be in close contact with female residents and must be placed in a stationary chair and not left in his wheelchair. When asked why that intervention was in place, AA-A was unsure. In addition, following the incident AA-A stated she received education on how and where to access each resident's care plan but did not receive any education on R2 and his behaviors or interventions. On 7/18/22, at 1:41 p.m. nursing assistant (NA)-C stated R2 had a history of sexual behaviors and he was aware of the incident between R1 and R2. NA-C was not sure what intervention was implemented following the incident, but staff were directed to ensure female residents were not next to R2. Further, NA-C stated following the incident all staff completed education related to following care plans, where to find care plans, and abuse	F 600		

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F 600	Continued From page 4 but the education did not specifically include R2's behaviors and interventions updated on his care plan. On 7/18/22, at 2:15 p.m. NA-D stated R2 had a history of sexual behaviors of inappropriate touching and staff were directed not to leave a female resident next to R2 because "he is able to get up and get to them". On 7/18/22, at 2:43 p.m. NA-A sated he was aware of the incident between R1 and R2 but was not aware of interventions that were implemented other than keep R2 separated from "other risks and females should stay away from him". In addition, NA-A stated education on following care plans was provided following the incident, but no education related to R2's behaviors and interventions being implemented. On 7/18/22, 3:24 p.m. RN-A stated since the incident between R1 and R2, R2 was moved to an all-male table in the dining room for meals and staff were directed to keep R1 and R2 separate, placing R2 in a stationary chair and not leaving in his wheelchair, staff continue with half hour visual checks for R2, as well as education provided to staff related to checking resident care plans. On 7/19/22, at 11:00 a.m. director of nursing (DON) stated the social worker who is no longer employed with the facility, completed the investigation on the incident between R1 and R2. DON stated this incident was a new behavior for R2 rather than just being "affectionate". Following the incident, DON stated R2's seating in the dining room was changed and ensure R2 is placed in a stationary chair which was already in place for a fall prevention. Further, DON stated	F 600		

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F 600	Continued From page 5 she had no evidence of education related to R2's behaviors and interventions with care plan changes provided to staff but education was provided to staff related to following each resident care plan. Review of facility policy titled Vulnerable Adult Abuse Prevention Plan dated 2/1/22, indicated the investigation or 5-day report shall include what action has been taken to prevent recurrence of the incident. Further policy directed other appropriate steps will be taken as necessary to protect the resident from further potential abuse.	F 600		
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 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		8/12/22

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F 609	Continued From page 6 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an incident of resident-to-resident sexual abuse to the State Agency (SA) within two hours for 3 of 5 residents (R2,R4,R5), who were reviewed for abuse. Findings include: R2's 5-day Minimal Data Set (MDS) dated 6/13/22, indicated R2 had a diagnosis of dementia and had moderately impaired cognition. Further review of R2's MDS indicated R2 did not exhibit behaviors. R4's quarterly MDS dated 8/31/22, indicated R4 had diagnoses of Alzheimer's and dementia and had severely impaired cognition. Further review of R4's MDS indicated R4 did not exhibit behaviors. R5's annual MDS dated 6/15/22, indicated R5 had diagnoses of Alzheimer's and dementia and had severely impaired cognition. Further review of R5's MDS indicated R5 did not exhibit behaviors. Review of R5's medical record was reviewed and lacked evidence of an incident with R2. Review of R4's progress notes revealed: -On 10/6/21, registered nurse (RN) had intercepted R4 leading R2 into her room. Later R4 was observed attempting to kiss R2 however	F 609	Facility will report all vulnerable adult events per CMS guidance. R2 and R5 have been reassessed to determine capacity to consent to sexual contact, R4 no longer resides in care center. Capacity to Consent assessment was built and put into EMR for use to identify clearly if resident is able to consent. All residents with a BIMS of 12 or under will be assessed for ability to consent to sexual contact. VA policy was reviewed and revised. Capacity to Consent policy was finalized. Additional guidance on what to report will be placed in both VA reporting Information and Instructions Binder. Staff education will be provided regarding reporting requirements as well as definitions of abuse (sexual, physical, emotional, verbal), changes in the VA policy, and contents of Capacity to Consent policy, where to find additional information and who to contact when a vulnerable adult situation is suspected. Education will be completed by 8/12/22 or prior to next shift. DON or designee will perform audits for completion of assessments. Audits will be completed 5 per week X1 week, 3 per week X 3 weeks, 1 weekly X 1 month, audit results will be brought to Quality Council for further review and recommendation.	

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F 609	Continued From page 7 staff were able to intervene. Further, "both residents are independent in their ambulation and would be able to remove themselves from a situation they did not desire. Both residents seek one another out. They both have dementia diagnosis, however, are alert and can communicate their needs." In addition, R4's family was contacted about interactions with R2, and family was agreeable. R4 was placed on half hour visuals and additional education was provided to staff in to ensure appropriate interactions with R4 and other residents. -On 10/8/21, R4 was found naked and on top of covers in bed laying beside R2 in R2's room. R4 was on visual checks and was last observed in her room at 7:20 p.m. fully clothed. R4 was assisted out of R2's bed, a gown was applied and redirected R4 back to her room. R4 did not have any distress noted. R4 will continue half hour visuals. On 7/18/22, at 2:43 nursing assistant (NA)-A stated R2 was able to express his needs but was not able to make good choices due to his cognition. NA-A reported R2 had an incident with R4, "but he didn't ask for that" R4 had walked into R2's room and climbed into his bed naked with him. Further, NA-A stated R4 had severely impaired cognition related to her dementia progression. On 7/18/22, at 3:00 p.m. NA-B stated R2 had a history of being sexually inappropriate with female residents. NA-B stated there was an incident of R2 kissing R5 "a few months ago" and was unsure if this incident was reported to administration. NA-B stated there was another resident who no longer resides in the facility, R4,	F 609		

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F 609	Continued From page 8 who had dementia and severely impaired cognition. Further, NA-B stated "R2 did not understand, R4 did not understand" and the two residents were witnessed naked in bed together and the two residents reported they were going to have sex but didn't. In addition, NA-B stated R2 had impaired cognition and R2 "knows what he wants and needs but there is that part he can't tell wrong from right, and I don't think he understands that the other residents are too far along (with their dementia progression) to know that it is not ok." On 7/18/22, at 3:24 p.m. RN-A stated the facility's policy for reporting abuse to the SA within two hours. RN-A defined sexual abuse as unwanted touching in any of the reproductive areas or breasts. When asked how the facility determined if an incident meets the definition of sexual abuse for cognitively impaired residents, RN-A stated "it comes down to the resident's ability to verbally or non-verbally being able to say no." Further, when asked how the facility determined and assessed if residents had the capacity to consent, RN-A again stated, "if they are able to verbally say it [yes or no]". RN-A stated she was not aware of an incident between R2 and R5 and believes the incident was not reported to administration. RN-A stated there was an incident between R2 and R4 where R4 "initiated everything" and R2 consented. RN-A stated R4's cognition was impaired, "she might not know what is going on around her, but she would tell you what she wanted. She was looking for her husband and she decided that she found him (referring to R2)". In addition, RN-A stated the incident between R2 and R4 was not reported due to R4's ability to say no if she didn't not want to.	F 609		

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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) COMPLETION DATE
F 609	Continued From page 9 On 7/18/22, at 3:58 p.m. RN-B stated R2 was cognitively impaired, impulsive, and not aware of safety or limitation or outcomes. RN-B stated R2 did not have the capacity to consent to sexual activity and was "not aware of consequences or anything. He did not view the female residents as impaired or vulnerable he doesn't understand all that." RN-B stated an incident was reported that occurred between R2 and R4, where R4 was found in R2's room naked next to R2 in bed. Further, RN-B stated R4's cognition was severely impaired, and she would "not be able to make the decision" to consent to sexual activity and R4 thought R2 was her husband. On 7/19/22, at 11:00 a.m. director of nursing (DON) stated abuse was expected to be reported to the SA within two hours and defined sexual abuse as unwanted touching where the resident indicates it was unwanted through verbal or nonverbal ques or "if the capacity to consent is unknown". When asked how the facility determined a resident's capacity to consent, DON stated, "capacity to consent is tricky" and the facility would determine by what each resident was able and unable to do as well as pattern of behaviors. DON stated she would not consider the incident between R2 and R4 as abuse due to both residents being ambulatory and ability to say no or push away "even though they both have memory issues they are able to know what they are doing and have the capacity to consent at the moment". Further, DON stated "you don't know what is in their [resident's] head or a hundred percent certain if they [residents] are smiling you don't know what they are feeling or if its unwanted." In addition, DON stated she was not aware of the incident of R2 kissing R5 and indicated the incident was not documented in the	F 609		

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	245363	A. BUILDING _____ B. WING _____	C 07/19/2022

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F 609	Continued From page 10 medical records. Review of facility policy titled Vulnerable Adult Abuse Prevention Plan dated 2/1/22, defined sexual abuse as non-consensual sexual contact of any type with a resident. Further review of policy indicated reportable incidents include but are not limited to resident-to-resident altercations that involve sexual contact, verbal or physical aggression that causes serious harm as well as any conduct that is not accidental and produces physical pain, or injury or emotional distress for a resident must also be reported. In addition, facility policy direct staff if suspected abuse it shall be reported to the administrator and an online report to the SA will be made no later than two hours.	F 609		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure ongoing sexual behaviors were comprehensively re-assessed following incidents with other residents, and failed to ensure person centered individualized non-pharmacological interventions were developed for 1 of 5 residents (R2) who reviewed for dementia care. Findings include: R2's Individual Abuse Assessment reviewed	F 744	Facility will provide person-centered care to all residents including those with dementia. R2 has been re-assessed and care plan has been updated to include his sexual behavior and interventions specific to that behavior. Capacity to Consent to sexual contact assessment has been implemented in the EMR. Results of this assessment will be care-planned with appropriate interventions. Residents will be re-assessed quarterly and with change in condition. VA policy has been reviewed	8/12/22

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F 744	Continued From page 11 4/19/22, indicated R2 had moderate disorientation to time, confusion and forgetfulness and R2 had occasional socially inappropriateness and staff determined R2 was low risk for abuse to others. R2's assessment directed staff to refer to R2's care plan regarding interventions. R2's 5-day MDS dated 6/13/22, indicated R2 had a diagnosis of dementia and had moderately impaired cognition. Further review of MDS indicated R2 did not exhibit any behaviors. R2's care plan as of 7/18/22, indicated R2 had a history of being an affectionate person and would say hi by grabbing hands, hugging, and kissing. However, R2's care plan lacked other interventions to address R2's sexual behaviors towards other female residents. On 7/18/22, at 11:26 a.m. activities assistant (AA)-A stated R2 did not exhibit any behaviors that she was aware of however she was told R2 could not be in close contact with other female residents in the facility but was unsure why. Further, AA-A stated staff are made aware if a resident has a behavior and interventions that are in place by looking at each resident's care plan which are on the computer or posted in each resident's room. On 7/18/22, at 11:46 a.m. licensed practical nurse (LPN)-A stated R2 had behaviors that consisted of being "too friendly" with female residents and elaborated by stating R2 would "touch inappropriate places of female residents". Further, LPN-A stated she was only employed at the facility part time but was unsure of interventions to address R2's behaviors other than "keep a close eye on him". LPN-A stated	F 744	and revised. Capacity to consent policy has been finalized. Education will be provided to licensed staff regarding care planning of behaviors as well as appropriate interventions. Education will be completed by 8/12/22. DON or designee will complete audits to assure that behavior careplans are completed 5 per week X1 week, 3 per week X 3 weeks, 1 weekly X 1 month, audit results will be brought to Quality Council for further review and recommendation.	

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F 744	Continued From page 12 staff are expected to ask about each resident's behaviors at start of shift and they should be in each resident's plan of care. On 7/18/22, at 1:41 p.m. nursing assistant (NA)-C stated R2 was sexually inappropriate with female residents which consisted of R2 would "extend his hand and touch a lady on their breast" and kiss other female residents. Further, NA-C stated interventions for R2's sexual behaviors included "keep an eye on him all the time". NA-C stated behavior interventions were in each resident's care plan for staff to refer to. On 7/18/22, at 2:33 registered nurse (RN)-C stated R2 was sexually inappropriate with females and other than "keeping an eye on him" RN-C was not aware of any interventions to keep other resident safe from R2 and his behaviors. On 7/18/22, at 2:43 p.m. NA-A stated R2 had sexual behaviors towards female resident and staff were directed to "isolate" resident by keeping females out of R2's range. NA-A stated interventions would be communicated to staff by reviewing each resident's care plan. On 7/18/22, at 3:00 p.m. NA-B stated R2 had a history of sexually touching and kissing female residents. NA-B stated staff were expected to keep all female residents away from R2 and attempting to offer R2 to stay in his room. On 7/18/22, at 3:24 p.m. RN-A stated R2 had a history of being "affectionate" with female resident however RN-A stated she does not classify that as a behavior. On 7/18/22, at 3:58 p.m. at RN-B stated R2 had a	F 744		

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F 744	Continued From page 13 history of sexually inappropriate behaviors and will often fixate on female residents, get too close and touch female residents. On 7/19/22, at 11:00 a.m. director of nursing (DON) stated she was not aware of R2 being sexually inappropriate but stated R2 was an affectionate person and would touch other residents, but not in a sexual manner. However, DON stated R2 recently had an incident with a female resident recently which was determined to be sexual abuse. DON confirmed there were no interventions in R2's careplan other than education to resident. DON stated staff were completing half hour visual checks on R2 and placing R2 in a stationary chair which were implemented for falls interventions but could be used for behaviors as well. DON stated the facility utilizes agency and casual staff which behaviors and interventions would be communicated through verbal report and the communication book staff would be expected to read. In addition, DON stated the social worker would be expected to complete a behavioral care plan and interventions and complete an abuse assessment to determine appropriate interventions, but confirmed R2's care plan did not have behavior interventions implemented. Review of facility policy titled Care Planning Policy and Procedure dated 7/18/19, indicated the purpose of the policy was to promote continuity of resident's care and communicate vital information to all staff providing direct resident care. Further review of policy indicated the focus would be a list of problems requiring care to be provided, the source of the problem will be indicated for example behavior problems. Policy directed interventions will list all cares to be provided	F 744		

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F 744	Continued From page 14 by/through the review date for the problem addressed, cares must be individualized for the unique needs of the resident. In addition, policy directed the licensed nurse must review the resident care plan each time there is a change in the resident ability or condition, update the care plan and reprint Kardex for continuity of care. Review of facility policy titled Assessments dated 9/24/21, indicated the purpose of the policy was to ensure all residents are assessed on admission, quarterly and with change in condition to determine appropriate care plan interventions. Further policy directed assessments will be redone quarterly as indicated and with a change in status and the assessment data will drive care plan interventions and be individualized for each resident.	F 744		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 27, 2022

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

Re: Event ID: GH8W11

Dear Administrator:

The above facility survey was completed on July 19, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 7/18/22 through 7/19/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be in compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H53633290C (MN84789); however, no licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		