Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 13, 2026

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

RE: CCN: 245119

Cycle Start Date: September 24, 2026

Dear Administrator:

On September 24, 2026, 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 actual harm that was not immediate jeopardy (Level G), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other 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), 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)).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 24, 2026. Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 24, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 24, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 24, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your

obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/ Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 24, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon St.
Marshall, MN 56258
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

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.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 24, 2027 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

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.

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,

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

October 13, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 3C57B5-H1

Dear Administrator:

The above facility survey was completed on September 24, 2026 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 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:

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon St.
Marshall, MN 56258
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

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.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 12, 2026

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

RE: CCN: 245119
Cycle Start Date: September 24, 2026

Dear Administrator:

On October 13, 2026, we notified you a remedy was imposed. On November 5, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 20, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 24, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 13, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 24, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 20, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

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

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November 12, 2026

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

Re: Reinspection Results
Event ID: 3C57B5-H2

Dear Administrator:

On November 5, 2026 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 September 24, 2026. 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

An equal opportunity employer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245119	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	**301 MINNESOTA AVENUE SOUTH , AITKIN, Minnesota, 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
F0000	INITIAL COMMENTS On 9/23/26 through 9/24/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed. H51194298C (3206493) with a deficiency and/or deficiencies issued at F689, F804. 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.	F0000		09/21/2026
F0804 SS = G	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to follow procedures for hot liquids for 1 of 3 residents reviewed for hot beverage safety. This resulted in actual harm to R1 when	F0804	"Past Noncompliance - no plan of correction required"	09/21/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245119	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

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AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH , AITKIN, Minnesota, 56431

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F0804 SS = G	Continued from page 1 facility staff heated hot chocolate in the microwave and served it to R1. R1 spilled the beverage and sustained a second degree burn to her upper thigh. The facility had implemented actions to prevent recurrence prior to the survey; therefore, the citation was issued at past non-compliance. Findings include: R1's Transfer/Discharge Report indicated she admitted to the facility 1/13/26. R1's diagnosis included essential tremor (a common neurological disorder that causes involuntary, rhythmic shaking, most often in the hands and arms during movement), peripheral vascular disease (a slow, progressive condition where blood vessels outside the heart, most often the arteries supplying the legs and feet, become narrowed, blocked or spasm) and depression. R1's quarterly Minimum Data Set dated 7/15/26, identified intact cognition. R1 required no assistance with eating. R1's Hot Beverage/Liquid Safety evaluation dated 9/16/26, indicated intact cognition and indicated she was able to lift a cup without spilling and able to drink liquids. The evaluation identified need for a two handled cup with lid and clothing protector when drinking hot liquids in her room. R1's care plan updated 9/17/26, indicated she was alert and oriented and was able to express needs. The care plan indicated a need for adaptive equipment and directed staff to provide a clothing protector when eating or drinking hot liquids or food in room and use of a two handled cup with a lid for hot liquids. R1's Progress Notes indicated the following: 9/13/26, R1 requested hot chocolate and toast at midnight per her usual routine. R1 was given the cup of hot chocolate and toast while seated upright in bed. R1 spilled the hot chocolate on herself. Area noted to be mildly red. 9/14/26, Writer was asked to look at R1's skin. Staff reported during bath, R1 said she had spilled hot chocolate on her leg. Writer assessed skin and noted area on R1's upper right thigh that appeared "like a slap would leave on the skin." 9/14/26, Skin issue, burn to front of thigh identified as a superficial burn. Area red with a small blister formation.	F0804		09/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245119	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	**301 MINNESOTA AVENUE SOUTH , AITKIN, Minnesota, 56431**

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F0804 SS = G	Continued from page 2 9/15/26, R1's burn assessed. Area appeared cherry red and the top layer of skin was absent. R1 complained of pain to area. R1's provider encounter note dated 9/15/26, indicated after spilling hot chocolate on her leg, R1 had blisters that opened. Burn of second degree of thigh. Order for Silvadene ointment. During interview on 9/23/26 at 4:25 p.m., R1 stated she had burned her thigh and said, "I have gone through the mill." When asked if the burn hurt, R1 said, "yes, it still does. It has been a few weeks now." R1 said she had been holding her hot chocolate in her left hand and said it was not good, referring to her hand. R1 said she needed carpel tunnel surgery on her hand. R1 said she was in bed with her hot cocoa and said, "next thing you know I was screaming and had to ring for help." During observation on 9/23/26 at 4:54 p.m., R1 propelled herself down the hall from her room to the dining room. R1 self-propelled with only her right hand. During interview on 9/24/26 at 8:21 a.m., registered nurse (RN)-A stated the morning after R1 burned her thigh she had looked at the wound. RN-A said at the time it looked like a slap mark. RN-A stated she had spoken to RN-B who had provided R1 the hot chocolate and learned the water had been boiled and had not been temped. RN-A said the coffee/hot water machines on both units were running a cycle, so the nurse was unable to use them. RN-A said all staff had been educated on the policies regarding hot beverages and were educated that they should not use the microwave or a Styrofoam cup when heating liquids. During interview on 9/24/26 at 1:12 p.m., the director of nursing (DON) stated all resident had a Hot liquid assessment completed after the incident occurred. The DON stated all staff had been trained on the hot liquid policy within the last year but said she was unsure if RN-B would have been aware of the hot liquid policy. During interview on 9/24/26 at 1:21 p.m., RN-C stated R1's burn was healing and said she did complain of pain. During a subsequent interview on 9/24/26 at 1:25 p.m., RN-A stated R1's burn currently appeared like a moist scab with a dark wound bed. RN-A said the ointment helped because R1 said the burn hurt.	F0804		09/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245119	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

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AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH , AITKIN, Minnesota, 56431

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F0804 SS = G	Continued from page 3 Facility Hot liquid/Beverage policy was requested but not received. The past noncompliance began on 9/13/26. The deficient practice was corrected by 9/14/26, after the facility immediately implemented education to all staff regarding the hot beverage policy, which indicated staff were not to use the microwave to heat beverages. The facility also initiated Hot Beverage Serving Temperature Audits. The education was verified through interview and document review.	F0804		09/21/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to provide adequate supervision to 1 of 3 residents (R2) reviewed for accidents. In addition, the facility failed to ensure chemicals were safely stored out of residents' reach. This had the potential to affect 2 residents (R3 and R4) who had impaired cognition and wandered. Findings include: R2 R2's Transfer/Discharge Report indicated she admitted to the facility 11/13/17. R2's diagnoses included anxiety, dementia and multiple sclerosis (a chronic autoimmune disease of the central nervous system). R2's quarterly Minimum Data Set (MDS) dated 6/29/26, identified moderate cognitive impairment and indicated she was independent with wheelchair mobility. R2's care plan dated 4/22/25, identified a self-care deficit and indicated she used a wheelchair for	F0689	F689D – Free of Accident Hazards/Supervision/Devices Corrective Action for Residents Affected Resident #2 The EVS Director immediately purchased and installed locking doorknobs on both the East and West linen storage rooms on Garden Terrace to prevent resident access and reduce the risk of accidental entry by Resident #2 and all other residents. Automatic locking coded keypad door handles have been ordered and will be installed upon arrival. Towne square does not have a linen storage room; linen is stored on covered linen cart. Residents #3 and #4 The EVS Director immediately purchased and installed new cabinet locks to replace existing locks in both GT & TS tub rooms where chemicals were stored. Upon identification of the concern, Nurse Managers assessed their respective tub rooms (GT & TS) to verify that all chemicals were secured in locked cabinets and inaccessible to residents. "KEEP DOOR CLOSED" signs were placed on the exterior of both GT & TS tub room doors. Automatic door closers and automatic locking coded keypad door handles for GT & TS tub rooms have been ordered and will be installed upon arrival. Identification of Other Residents at Risk An assessment was conducted of all residents residing on Garden Terrace and Towne Square to identify any additional residents at risk for wandering, impaired cognition, or accidental exposure to hazardous areas or chemicals. No additional residents were identified as having been affected by the deficient practice. Environmental rounds were conducted facility-wide to verify that	10/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245119	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AITKIN HEALTH SERVICES	301 MINNESOTA AVENUE SOUTH , AITKIN, Minnesota, 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
F0689 SS = D	Continued from page 4 mobility in the facility. R2 had impaired cognitive function and was at risk for falls related to gait/balance problems. R2's Progress Note dated 9/24/26, indicated upon investigation it was determined that the linen carts in the closet prevented R2 from backing up her wheelchair. During observation on 9/23/26 at 3:16 p.m., a closet door opened at the end of a hallway on the Garden Terrace unit. Movement could be heard coming from inside the closet, but no light was on in the closet. Five of the six rooms at the end of the hallway leading to the closet were empty. After a few seconds the closet door closed. At 3:17 p.m., the door opened again, still no was light on and the door closed again. At 3:20 p.m., the door opened again, a resident (R2) was inside the closet and stated she was looking for a bathroom. Surveyor alerted staff who assisted R2 out of the closet. The closet contained linens, a Gatorade bottle with liquid in it and 2 bottles of shampoo. During interview on 9/23/26 at 3:33 p.m., R2 said, "thank you for finding me. I was stuck for a while." R2 said she got stuck because she needed to use the bathroom. R2 said she was not hurt but did not like being stuck. R2 said she had been in her room reading before she got stuck and said, "I pretty much take care of myself." During interview on 9/23/26 at 3:39 p.m., nursing assistant (NA)-A stated she had last seen R2 at lunch. During interview on 9/24/26 at 10:31 a.m., NA-B stated R2 did not usually wander and knew where she wanted to go. When R2 left the dining room, she could usually find her way back to her room. NA-B thought she had seen R2 in her room at around 2:00 p.m. on 9/23/26. Unsecured Chemicals R3 R3's Transfer/Discharge Report indicated she admitted to the facility 9/16/26. R3's diagnoses included intracranial injury with loss of consciousness and suicidal ideations. R3's admission MDS dated 9/23/26, identified severe cognitive impairment and indicated she	F0689	Continued from page 4 linen storage rooms and chemical storage areas were secured from resident access. Systemic Changes · Locking doorknobs were installed on GT linen storage room doors pending installation of permanent automatic locking coded keypad door handles. · New locks were installed on chemical storage cabinets in both GT & TS tub rooms. · "KEEP DOOR CLOSED" signage was placed on both GT & TS tub room doors. · Staff were educated regarding: o Environmental Cleaning & Disinfecting Program policy o Maintaining secured storage areas. o Ensuring chemicals remain locked and inaccessible to residents. o Monitoring wandering residents and those with impaired cognition. o Reporting unsecured hazardous areas immediately. · Automatic door closers and automatic locking coded keypad door handles have been ordered for both GT & TS tub rooms for enhanced security and will be installed upon receipt. Monitoring The DON or designee will complete audits: · Linen storage rooms: Starting September 25th, 2026, two times per week for four weeks through October 24, 2026, to ensure doors remain locked and inaccessible to residents. · Tub rooms and chemical storage areas: Starting September 25th, 2026, two times per week for four weeks through October 24, 2026, to ensure tub room doors remain closed, and chemicals are secured in locked cabinets. Audit results will be reviewed by the Director of Nursing and reported to the QAPI Committee for	10/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245119	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

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F0689 SS = D	Continued from page 5 ambulated with supervision or touching assistance. R3's care plan dated 9/28/26, identified impaired cognitive function and indicated she was an elopement risk/wanderer, was disoriented to place and wandered aimlessly. The care plan directed staff to supervise R3 off the unit. R4 R4's Transfer/Discharge Report indicated he admitted to the facility 10/7/22. R4's diagnoses included adjustment disorder and vascular dementia. R4's quarterly MDS dated 8/6/26 identified sever cognitive impairment and indicated he ambulated independently. R4's care plan dated 8/18/26, identified impaired cognitive function and indicated he was an elopement risk/wanderer, was disoriented to place and wandered aimlessly. During observation on 9/23/26 at 3:44 p.m., the door to the tub room on the Garden Terrace unit was wide open. Inside the tub room was a bottle that contained Hillyard Vindicator disinfectant cleaner. The bottle was hanging on the back of a shower chair where it could be reached by a resident in a wheelchair. During observation on 9/24/26 at 7:21 a.m., The tub room on Garden Terrace was open again. The same bottle of disinfectant cleaner remained on the back of the shower chair. At 9:42 a.m., the door remained open with the disinfectant cleaner in the same place. During observation on 9/24/26 at 10:02 a.m., the Town Square unit tub room door was open. On the back of the toilet was a bottle of disinfectant. During observation and interview on 9/24/26 at 10:05 a.m., trained medication aide (TMA)-A stated two residents (R3, R4) on the Town Square unit ambulated independently and wandered on the unit. TMA-A confirmed location went to the tub room to remove the disinfectant. The cabinet in the bathroom was open and had chemicals on the top shelf. Hillyard Vindicator Safety Data Sheet identified the following hazards: Combustible liquid. Causes severe skin burns and eye damage. Causes serious eye damage.	F0689	Continued from page 5 review and further action as needed. Date of Compliance October 20, 2026	10/20/2026

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F0689 SS = D	Continued from page 6 If swallowed: rinse mouth. Do not induce vomiting. If on skin or hair, take off contaminated clothing immediately and shower. If inhaled, move person to fresh air and keep comfortable for breathing. If in eyes, rinse cautiously with water for several minutes. Immediately call a poison center/doctor. Storage- keep locked up. Facility policy Environmental Cleaning and Disinfecting Program dated 6/16/26, indicated the care center will adhere to the cleaning and disinfecting principles to include proper storage of the product.	F0689		10/20/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/23/26 through 9/24/26, 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. The following complaint(s) (was/were) reviewed during the survey. H51194298C (3206493) with a licensing order issued at 0830. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		10/20/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/24/2026**

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20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to provide adequate supervision to 1 of 3 residents (R2) reviewed for accidents. In addition, the facility failed to ensure chemicals were safely stored out of residents' reach. This had the potential to affect 2 residents (R3 and R4) who had impaired cognition and wandered. Findings include: R2 R2's Transfer/Discharge Report indicated she admitted to the facility 11/13/17. R2's diagnoses included anxiety, dementia and multiple sclerosis (a chronic autoimmune disease of the central nervous system). R2's quarterly Minimum Data Set (MDS) dated 6/29/26, identified moderate cognitive impairment and indicated she was independent with wheelchair mobility. R2's care plan dated 4/22/25, identified a self-care deficit and indicated she used a wheelchair for mobility in the facility. R2 had impaired cognitive function and was at risk for falls related to gait/balance problems. R2's Progress Note dated 9/24/26, indicated upon investigation it was determined that the linen carts in the closet prevented R2 from backing up her wheelchair. During observation on 9/23/26 at 3:16 p.m., a closet door opened at the end of a hallway on the Garden Terrace unit. Movement could be heard coming from inside the closet, but no light was on in the closet. Five of the six rooms at the end of the hallway	20830	Corrected	10/20/2026

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20830	Continued from page 2 leading to the closet were empty. After a few seconds the closet door closed. At 3:17 p.m., the door opened again, still no was light on and the door closed again. At 3:20 p.m., the door opened again, a resident (R2) was inside the closet and stated she was looking for a bathroom. Surveyor alerted staff who assisted R2 out of the closet. The closet contained linens, a Gatorade bottle with liquid in it and 2 bottles of shampoo. During interview on 9/23/26 at 3:33 p.m., R2 said, “thank you for finding me. I was stuck for a while.” R2 said she got stuck because she needed to use the bathroom. R2 said she was not hurt but did not like being stuck. R2 said she had been in her room reading before she got stuck and said, “I pretty much take care of myself.” During interview on 9/23/26 at 3:39 p.m., nursing assistant (NA)-A stated she had last seen R2 at lunch. During interview on 9/24/26 at 10:31 a.m., NA-B stated R2 did not usually wander and knew where she wanted to go. When R2 left the dining room, she could usually find her way back to her room. NA-B thought she had seen R2 in her room at around 2:00 p.m. on 9/23/26. Unsecured Chemicals R3 R3’s Transfer/Discharge Report indicated she admitted to the facility 9/16/26. R3’s diagnoses included intracranial injury with loss of consciousness and suicidal ideations. R3’s admission MDS dated 9/23/26, identified severe cognitive impairment and indicated she ambulated with supervision or touching assistance. R3’s care plan dated 9/28/26, identified impaired cognitive function and indicated she was an elopement risk/wanderer, was disoriented to place and wandered aimlessly. The care plan directed staff to supervise R3 off the unit. R4 R4’s Transfer/Discharge Report indicated he admitted to the facility 10/7/22. R4’s diagnoses included adjustment disorder and vascular dementia.	20830		10/20/2026

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20830	Continued from page 3 R4's quarterly MDS dated 8/6/26 identified sever cognitive impairment and indicated he ambulated independently. R4's care plan dated 8/18/26, identified impaired cognitive function and indicated he was an elopement risk/wanderer, was disoriented to place and wandered aimlessly. During observation on 9/23/26 at 3:44 p.m., the door to the tub room on the Garden Terrace unit was wide open. Inside the tub room was a bottle that contained Hillyard Vindicator disinfectant cleaner. The bottle was hanging on the back of a shower chair where it could be reached by a resident in a wheelchair. During observation on 9/24/26 at 7:21 a.m., The tub room on Garden Terrace was open again. The same bottle of disinfectant cleaner remained on the back of the shower chair. At 9:42 a.m., the door remained open with the disinfectant cleaner in the same place. During observation on 9/24/26 at 10:02 a.m., the Town Square unit tub room door was open. On the back of the toilet was a bottle of disinfectant. During observation and interview on 9/24/26 at 10:05 a.m., trained medication aide (TMA)-A stated two residents (R3, R4) on the Town Square unit ambulated independently and wandered on the unit. TMA-A confirmed location went to the tub room to remove the disinfectant. The cabinet in the bathroom was open and had chemicals on the top shelf. Hillyard Vindicator Safety Data Sheet identified the following hazards: Combustible liquid. Causes severe skin burns and eye damage. Causes serious eye damage. If swallowed: rinse mouth. Do not induce vomiting. If on skin or hair, take off contaminated clothing immediately and shower. If inhaled, move person to fresh air and keep comfortable for breathing. If in eyes, rinse cautiously with water for several minutes. Immediately call a poison center/doctor. Storage- keep locked up. Facility policy Environmental Cleaning and Disinfecting Program dated 6/16/26, indicated the care center will adhere to the cleaning and disinfecting principles to include proper storage of the product.	20830		10/20/2026

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20830	Continued from page 4 SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review policies and procedures, train staff, and implement measures to ensure appropriate supervision and ensure environmental hazards are not accessible to residents. The DON or designee could educate staff and conduct measurable audits of supervision and accident hazards. The DON or designee could ensure the results of those audits are taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	20830		10/20/2026