STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245119	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aitkin Health Services	301 Minnesota Avenue South Aitkin, MN 56431

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and document review the facility failed to ensure linens were handled properly to help prevent the spread of infection. In addition, the facility failed to maintain a water management program which identified potential areas for water-borne bacteria and maintain records of water management activities. Findings include:Linen HandlingDuring an observation on entrance on 6/1/26 at 1:50 p.m., in an alcove next to the elevator down to the conference room, stood a three-shelved unit storing clean linens, the cover was observed up over the top of the unit and there were items stored up on top of the cover which was folded back. A sign on the cart indicated please close the cover. During an observation on 6/3/26 at 12:23 p.m., the linen cart was observed to be uncovered as it was on 6/1/26.During an observation and interview on 6/3/26 at 2:56 p.m., licensed practical nurse (LPN)-A, who identified as the facility infection preventionist (IP) observed the uncovered linen cart and stated this didn't meet his expectations and would be a risk for bacteria to get on them and then get spread all over.A policy, Linen Handling dated 3/10/26, identified its purpose was to provide clear and consistent guidelines for the safe handling of linen to protect residents, staff, and the environment from infection and occupational exposure. The policy didn't address clean linen handling practices.Water ManagementDuring an interview on 6/4/26 at 8:40 a.m., maintenance worker (MW)-A, who identified as the maintenance director and responsible for the water management plan stated he didn't know how the water flowed through the building and didn't have a diagram. MW-A identified that the faucets and showers were flushed daily by the housekeeping staff, but he didn't have it documented anywhere. MW-A wasn't aware of current municipal water quality. MW-A noted the monthly cleaning of air conditioner units but didn't have further documentation of water management activities.A map of the facility was supplied and identified where the water main shut-off valve was, identified three hot water heaters and a statement of facility has no water tempering or mixing valves. All hot water is controlled by the hot water heaters.A policy, Water Management Program Legionella Prevention dated 11/19/25, identified its purpose was to provide directions to staff to prevent, identify and manage hazardous conditions that inhibit the growth of and spread of Legionella. The most common form of Legionella transmission is inhalation of contaminated aerosols produced with water sprays, jets, or mists of contaminated water sources. The Water Management Program (WMP) reduces the threat of Legionella. The WMP will identify:Where the domestic water supply source enters the care center and the size of the water main.Where water is distributed to vulnerable dead leg or other bacteria growth sources including empty/non-used rooms, water features, ice machines, faucet fixtures, shower heads, ice machines, plumbed eye wash stations, etc.Where cold water is heated and to what temperature including water heaters that serve resident rooms, laundry, dietary and public restrooms.Changes in municipal water quality can increase sediment, lower disinfectant levels, increase turbidity or cause PH to be outside the recommended ranges.PH balance maintained through use of disinfectants are most effective within a narrow range of 6.5 to 8.5 PH.The policy also identified inadequate disinfectant in the water and therefore can allow Legionella spores to grow into harmful numbers. Water considered high quality entering the care center may have Legionella and processes such as heating, storing, and filtering can further degrade the quality of the water depleting the disinfectants. Water stagnation encourages biofilm growth by (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	way of reduced water temperature and disinfectant levels. Common stagnation points include capped water supply lines and areas of reduced resident occupancy which results in water fixtures (faucets, showers, eye wash stations, etc.) being unused for an extended length of time.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to date opened products, dispose of expired products, and failed to have a process to ensure stored food was labeled with an expiration date that staff could understand. This deficient practice had the potential to affect all residents who received food from facility kitchen.Findings include:During the initial kitchen tour on 6/1/26 at 2:39 p.m., with the kitchen manager (KM), the following was observed:In dry storage, there was an unopened jar of Molly's vegetable base with no discernable expiration date. KM stated they were not aware the product had no expiration date, and they would need to date the product when received so staff would know when to discard the product.In the walk-in cooler, there was an open, undated bottle of lemon juice with a best use by date of 10/6/25. KM removed the lemon juice from the cooler and stated they would discard it. They stated a concern for food quality when a product was beyond its best used by date.In freezer 2, there were 4 bags of corn and black bean fiesta mix dated 4/15/26 with no indication of what the date referenced. KM stated they received the frozen vegetable mix the previous week, and they needed to reach out to their supplier for clarification on the expiration date.During an interview on 6/1/26 at 4:27 p.m., KM stated per their food supplier, the date on the bags of corn and black bean fiesta mix was a packing date and the product was good for 547 days from the packing date. KM confirmed that the kitchen staff would not know the expiration date and stated they needed to label the product with an expiration date when received.During the observation in the Garden Terrace dining room on 6/3/26 at 10:57 a.m., there was an open, undated gallon of 1% milk and an open, undated half gallon bottle of chocolate milk in the kitchenette refrigerator.During the observation in the Bears Den dining room on 6/3/26 at 11:08 a.m., there was an open, undated half gallon bottle of chocolate milk in the kitchenette refrigerator.During an interview on 6/3/26 at 10:57 a.m., cook (C)-A stated milk should be dated when it was opened.During an interview on 6/4/26 at 9:07 a.m., KM stated milk should be dated when it was opened. They stated they would be concerned not knowing how long it was open and would dump any open, undated milk.Facility Non-Perishable Food Management policy instructed to clearly label all foods with the best by or use by dates upon receipt.Facility Perishable Food Management policy instructed products should be discarded one day past the use by date.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to consistently educate, offer, or administer influenza and pneumococcal immunizations for 4 of 5 residents.Findings include:R1's quarterly minimum data set (MDS) dated [DATE], identified resident was rarely if ever understood and a cognitive assessment was not performed.R1's admission record identified an admission date of 11/1/2024, and diagnoses of congestive heart failure (CHF), atrial fibrillation, hypertension, and dementia.A report, Aitkin Health Services (AHS) Immunization Report dated 1/1/2005 to 6/30/26 identified R1 hadn't had influenza or pneumococcal vaccinations.An undated form, Vaccination Consent, identified R1 hadn't had an influenza, but wished to receive one. Also, R1 hadn't had a pneumococcal vaccination and there was no entry indicating if she did or didn't want to receive one. The form didn't contain evidence the resident or resident representative was offered education regarding vaccinations.R4's quarterly MDS dated [DATE], identified intact cognition and diagnoses of hypertension, chronic pain, gastroesophageal reflux disease (GERD), and hypokalemia.R4's admission record identified an admission date of 7/21/25.A report, AHS Immunization Report dated 1/1/2014 to 6/30/26 identified R4 had the influenza or pneumococcal vaccinations on 3/22/18.An undated form, Vaccination Consent, identified R4 hadn't had an influenza or pneumococcal vaccination and didn't' want to receive either. The form didn't contain evidence the resident or resident representative was offered education regarding vaccination. The form was not signed by R4.During an interview on 6/4/26 at 10:50 a.m. licensed practical nurse (LPN)-A, who identified as the facility infection preventionist (IP) stated the vaccinations were reviewed by whichever nurse was doing the admission, the facility's process was to use the CDC PneumoRec application. The IP confirmed the Vaccination Consent form didn't contain evidence of education provided.R23's quarterly MDS dated [DATE], identified intact cognition and diagnoses of CHF, persistent atrial fibrillation, and diabetes mellitus.R23's admission record identified an admission date of 1/13/26.A report, AHS Immunization Report dated 1/1/2010 to 6/30/26, identified R23 had a Prevnar 13 on 9/10/15, and Pneumovax 23 on 9/26/20. R23 didn't have any history of receiving influenza vaccinations.A form, Vaccination Consent signed by R23 on 1/13/26, identified R23 wanted to receive a pneumococcal vaccination, but didn't want to receive the influenza vaccination. The form didn't contain evidence the resident or resident representative was offered education regarding vaccination. According to the Centers for Disease Control (CDC) PneumoRec application, R23 would have been eligible for shared decision making with her provider regarding a pneumococcal vaccination.R39's admission record dated 6/4/26, identified an admission date of 5/18/26 and diagnoses of lymphedema, hypothyroidism, diabetes mellitus, and chronic kidney disease.A report, AHS Immunization Report dated 1/1/2007 to 6/30/26, identified R39 had Prevnar 13 on 11/4/16, and PPSV23 on 1/4/18A form, Vaccination Consent signed by R39 on 5/18/26, identified he had received pneumococcal vaccinations, would like to receive one, and had received the education. However, there is no evidence R39 received the vaccine. According to the Centers for Disease Control (CDC) PneumoRec application, R39 would have been eligible for shared decision making with his provider regarding a pneumococcal vaccination.During an interview on 6/4/26 at 10:55 a.m., the IP confirmed the missing education for the residents, the missing vaccinations for those residents wishing to receive one and stated the risks of not being vaccinated would be they could catch and spread illness, and without education they can't really say what the vaccine would do for them. Policies regarding vaccinations were requested as part of the infection control program but were not received.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure residents were educated about and offered the COVID-19 vaccination for 3 of 5 residents (R1, R4, R23) reviewed for vaccinations.Findings include:R1's quarterly minimum data set (MDS) dated [DATE], identified resident was rarely if ever understood and a cognitive assessment was not performed.R1's admission record identified an admission date of 11/1/2024, and diagnoses of congestive heart failure (CHF), atrial fibrillation, hypertension, and dementia.A report, Aitkin Health Services (AHS) Immunization Report dated 1/1/2005 to 6/30/26 identified R1 hadn't had the COVID-19 vaccinations.An undated form, Vaccination Consent, identified R1 hadn't had a COVID-19 vaccination and didn't want to receive one. The form didn't contain evidence the resident or resident representative was offered education regarding vaccination.R4's quarterly MDS dated [DATE], identified intact cognition and diagnoses of hypertension, chronic pain, gastroesophageal reflux disease (GERD), and hypokalemia.R4's admission record identified an admission date of 7/21/25.A report, AHS Immunization Report dated 1/1/2014 to 6/30/26 identified R4 hadn't had the COVID-19 vaccinations.An undated form, Vaccination Consent, identified R4 hadn't had a COVID-19 vaccination and didn't' want to receive one. The form didn't contain evidence the resident or resident representative was offered education regarding vaccination. The form was not signed by R4.R23's quarterly MDS dated [DATE], identified intact cognition and diagnoses of CHF, persistent atrial fibrillation, and diabetes mellitus.R23's admission record identified an admission date of 1/13/26.A report, AHS Immunization Report dated 1/1/2010 to 6/30/26, identified R23 had a COVID-19 vaccination on 4/10/21.A form, Vaccination Consent signed by R23 on 1/13/26, identified R23 didn't want to receive the COVID-19 vaccination. The form didn't contain evidence the resident or resident representative was offered education regarding vaccination.Policies regarding vaccination were requested but not received.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to review and revise the resident care plans to reflect changes in resident care for 2 of 5 residents (R4, R23) reviewed for care planning.Findings include:R4:R4's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and a diagnosis of legal blindness as defined in the United States. R4 propelled her own wheelchair and could wheel 150 feet independently.R4's care plan dated 7/21/25, identified R4 was at risk for falls related to vision problems and included interventions to assist with mobility and transfers, assure call light was in reach, reorient her to her room, assess fall risk every quarter and with changes in condition. R4's care plan didn't identify R4 needed supervision outside.According to a Nursing Home Incident Report dated 6/3/26, R4 had a fall from her wheelchair on the facility's outdoor patio on 5/27/26. Actions to prevent recurrence included direct supervision when R4 was outside for activities.During an interview on 6/4/26 at 12:39 p.m., registered nurse (RN)-A, who identified as the nurse manager for R4, stated she hadn't seen the incident report yet and therefore hadn't made any changes to the care plan. During an interview on 6/4/26 at 2:08 p.m., the director of nursing (DON) stated they had done verbal education with activity staff about supervision on the patio for R4 but hadn't updated her care plan. R23:R23's quarterly MDS dated [DATE], identified intact cognition and diagnoses of chronic congestive heart failure (CHF, a condition whereby the heart can't pump blood efficiently to meet the body's needs and may lead to accumulation of fluids in the lungs, legs and other areas), and peripheral vascular disease (PVD, a disorder of blood vessels). R23 had impaired range of motion (ROM) on one upper extremity and both lower extremities (LE) and needed moderate assistance with putting on or taking off footwear.R23's care plan dated 2/17/26, identified the need for assistance with compression stockings, but was not updated for resident's refusals to wear them. In addition, the care plan didn't include interventions to educate and encourage R23 to wear footwear.R23's provider order dated 1/13/26, to apply TEDs or [NAME] stockings (compression socks) in the morning and remove in the evening.R23's progress notes didn't contain refusals of care. R23's TAR, identified resident refused TEDs on 6/1 and 6/3/26, but charted as wearing them on 6/2 and 6/4/26.During an interview on 6/4/26 at 12:39 p.m., RN-A stated she would expect the care plan to reflect R4's refusals of care, and for staff to offer care even when R4 would normally refuse.A policy, Person Centered Care Planning dated 4/20/23, defined its purpose was to provide guidance to care center staff on developing the residents' person-centered care plan. Person centered care planning includes identifying individualized personal strengths, needs, preferences, interests, supports, and goals. From the perspective of the resident, the heart of person-centered care planning is defined as, I plan my care with people who work together to understand me and my care partners, allow me control, and bring together services to achieve the outcomes important to me. The care plan should emphasize the residents' strengths and goals, including supporting self-determination and participation. The care plan will be reviewed every 90 days or more frequently if needed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure activities of daily living (ADL) tasks were performed for a resident dependent on others to complete ADLs for 1 of 1 resident (R3) reviewed for ADLs.Findings include:R3's significant change in assessment (SCSA) minimum data set (MDS) dated [DATE], identified intact cognition and diagnoses of hemiplegia and hemiparesis of the right side related to a cerebral vascular accident (CVA, or stroke), fracture of the upper and lower end of the left fibula, unspecified fracture of the upper end of the left tibia, other fracture of the upper and lower end of the right fibula, unspecified fracture of upper end of right tibia, and unspecified fracture of the shaft of the right fibula. The MDS also identified R3 was dependent for personal hygiene.R3's care plan dated 2/26/25, identified a focus statement for ADL self-care deficit and included interventions for a bath scheduled Sunday afternoons and preferred to be shaved if facial hair was present. R3 needed assistance with set-up for personal and oral hygiene.R3's electronic medical record (EMR) confirmed she had a bed bath on 5/31/26.During an observation on 6/1/26 at 5:17 p.m., R3 was observed wearing a hospital gown and had white chin hair of about one-third of an inch, she stated she had just come from the dining room. There were food and coffee stains on the front of the gown. R3 stated she was supposed to have a bath yesterday, but she still hadn't gotten it and she didn't know why. During an observation on 6/2/26 at 12:21 p.m., R3 was observed in her bed and stated again she didn't get her bath on Sunday and asked if her chin hair was visible while she was feeling it with her hand. On observation, R3 did have white chin hair of about one-third of an inch.During an interview on 6/2/26 at 1:23 p.m. nursing assistant (NA)-A stated they would look in Point Click Care (PCC, an electronic medical record) for the Kardex to see what to do with each resident, and there was a bath schedule in the nursing station, or in PCC. NA stated she hadn't gotten R3 ready this morning, so she didn't really notice if she had chin hair. At 1:38 p.m., NA-A confirmed there was visible chin hair. During an interview on 6/2/26 at 2:45 p.m., the director of nursing (DON) stated since R3 had had her injury she had been getting a bed bath but would expect to at least offer to shave R3's chin with daily care if there were hair visible. During an interview on 6/4/26 at 12:56 p.m., registered nurse (RN)-A identified she was the nurse manager for R3 and would have expected her to still be shaved, even with a bed bath.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide edema management and provide root cause analysis, care, and monitoring for a skin injury for 1 of 1 resident (R23) reviewed for quality of care.Findings include:R23's quarterly minimum data set (MDS) dated [DATE], identified intact cognition and diagnoses of chronic congestive heart failure (CHF, a condition whereby the heart can't pump blood efficiently to meet the body's needs and may lead to accumulation of fluids in the lungs, legs and other areas), and peripheral vascular disease (PVD, a disorder of the blood vessels). R23 had impaired range of motion (ROM) on one upper extremity and both lower extremities (LE) and needed moderate assistance with putting on or taking off footwear.R23's care plan dated 2/17/26, identified the need for assistance donning and doffing TEDs (compression stockings) or [NAME] (specific brand of compression stockings) stockings. On 1/15/26, a focus statement for the risk of increased edema (collections of fluid) related to CHF. Interventions included applying ACE wraps to both LE daily, to elevate LE while in bed, to inspect skin weekly, to observe for edema, including blisters and weeping edema, and to observe skin daily with cares. On 1/15/26, a focus statement for DM including interventions to check for breaks in skin and treat promptly as ordered by the doctor, inspect feet daily for open sores, pressure areas, blisters, edema or redness, and ensure proper footwear when mobilizing wheelchair. R23's care plan didn't include recusals of care.R23's provider order dated 1/13/26, to apply TEDs or [NAME] stockings in the morning and remove in the evening. On 1/23/26, an order to elevate LE as much as possible every shift, and to elevate legs in bed in the morning and afternoon for one hour as resident allowed. An order on 6/2/24 to have occupational therapy see R23 for lymphedema treatment. R23's provider orders didn't contain an order for treatment to the injury on her third toe of the right foot.R23's progress notes didn't contain refusals of care, or identification of an injury to resident's toe.R23's TAR, identified resident refused TEDs on 6/1 and 6/3/26, but charted as wearing them on 6/2 and 6/4/26.During an observation and interview on 6/1/26 at 5:44 p.m., R23 had a band-aid on the third toe of her right foot, both LE and feet were noted to be edematous, R23 was bare-footed. R23 stated she snagged it on something in her room, either her wheelchair or something else but she wasn't sure. A pair of edema shoes were noted on a chair in R23's room. During an observation on 6/3/26 at 9:55 a.m., R23 was sitting in her wheelchair in her room with feet flat on the floor, had no socks or shoes on, both feet appeared red and edematous. During an observation on 6/3/26 at 12:33 p.m., R23 was observed sitting in her wheelchair in her room visiting with family. R23 was wearing edema shoes, but no compression socks.During an interview on 6/3/26 at 12:59 p.m., nursing assistant (NA)-C stated R23 got herself dressed most days and didn't know if she could put socks on but did know she could put the slipper shoes on. NA-C also stated R23 did tub grips (a type of light compressing tubing) but didn't like to wear them all the time, most of the time she refuses.During an interview on 6/3/26 at 1:13 p.m., trained medication assistant (TMA)-A stated R23 hated the compression socks so she didn't wear them and refused the tubi-grips and would pull the ACE wraps off when they put them on. TMA-A stated she could chart refusals on the treatment administration record (TAR). TMA-A added she wasn't working when R23 hurt her toe, but they do normally fill out incident reports for that.During an observation on 6/4/26 at 7:24 a.m., R23 was up in her wheelchair, dressed in clothes and edema shoes, but didn't have any compression socks on.During an interview on 6/4/26 at 12:24 p.m., Registered Nurse (RN)-A who identified as the nurse manager for R23 stated R23 was able to put on her own socks and shoes, but the NAs would be responsible for applying (compression) stockings and added R23 preferred to be barefoot. RN-A confirmed she didn't see an incident report or orders for treating R23's third toe of her right foot and the risks for her could be needing her toe amputated. RN-A stated she would still expect staff to offer compressing stockings even if she refused, and if she did refuse then staff should let the nurse know and document it. During an interview on 6/4/26 at 2:03 p.m., the director of nursing (DON) stated she (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would expect staff still offer R23 her compression socks when she got dressed in the morning and would expect licensed nurses to be looking at the foot, depending on stage of healing, if not every day, then every other day. A policy, Skin Integrity dated 3/10/26, identified its purpose was to provide guidance to nursing staff on preventing, identifying, evaluating and monitoring resident skin integrity. Appropriate interventions will be promptly implemented to prevent the development of skin integrity issues. Licensed nurse will:i. Assess the area and identify the cause, if possible.ii. Remove any source of pressure or trauma to the area.iii. Clean the area and provide treatment per care center House Standing Orders.iv. Determine if the skin integrity issue is reportable to the State Agency (SA). If yes, notify the Administrator and Director of Nursing and proceed with the SA reporting process. (CCEP.MP.SNF.005 Maltreatment Investigation & Reporting)v. Complete a Skin Incident report in the resident EHR.vi. Notify resident and/or responsible party.vii. Notify Provider and request treatment orders, if applicable.viii. Notify the Nurse Manager, Wound Nurse, or designee.ix. Initiate a new tissue tolerance for any newly opened area or redness.x. Initiate appropriate preventive measures based on the immediate root cause.For evaluation:a. Nurse Manager, Wound Nurse, or designee will assess and complete a root cause analysis.b. Interdisciplinary Team (IDT) will review the skin incident report and evaluation of root cause for further recommendations.c. The provider will review, to diagnosis, if root cause was not related to an injury (i.e., skin tear, bruise), make recommendations, and/or initiate order(s).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to offer annual audiology services or assist with routine hearing aid care for 1 of 1 resident (R3) reviewed for hearing maintenance.Findings include:R3's significant change is status (SCSA) minimum data set (MDS) dated [DATE], identified intact cognition and moderate difficulty hearing with hearing aids in place. R3 was dependent on staff for upper and lower body dressing, personal hygiene, and bed mobility. R3's care plan dated 2/26/25, identified a focus statement for being hard of hearing with a goal for her hearing aid to be accessible, clean, and available for use. Interventions included assisting to place and remove hearing aids daily, assist with charging, to review hearing status quarterly, and to offer audiology services annually. The care plan didn't identify to check or clean hearing aid filters.R3's provider orders didn't contain hearing aid maintenance.An assessment, Long Term Care Evaluation dated 12/15/25, identified R3 had minimal difficulty hearing with hearing aids. A form, Care Conference dated 3/6/26, was incomplete and unsigned.R3's electronic medical record (EMR) identified R3 was seen for an initial hearing aid fitting on 4/3/25. During a follow up visit on 5/1/25, it was noted the hearing aid filters were partially plugged.R3's progress notes didn't contain an entry regarding a March 2026 care conference or offering of audiology services.During an interview on 6/1/26 at 5:24 p.m., it was observed R3 was having difficulty hearing at level of conversation, she was wearing bilateral hearing aids. R3 stated when she first got her hearing aids she could hear everything, now she can't hear very well. During an interview on 6/2/26 at 2:52 p.m., registered nurse (RN)-A stated there had been issues in the past with charging R3's hearing aids, but now they have been fine and R23 didn't have any problems hearing her. RN-A stated she would look at the care conference notes to see if audiology was offered. The director of nursing (DON) added that residents were asked at every care conference if they wanted to go to audiology. If they did, the social worker would let the scheduler know and help them make arrangements. At 3:08 p.m., RN-A stated she thought she knew what might be wrong with R3's hearing aids; they had filters that needed to be cleaned.During an interview on 6/3/26 at 9:04 a.m., the DON stated they didn't see that R3 had a care conference, but the social service designee (SSD) was not available to ask about what happened. The DON added R3 wasn't in the facility at the time of her scheduled care conference, and there were no notes as to rescheduling or what happened.During an interview on 6/4/26 at 12:56 p.m., RN-A stated she assessed R23's hearing for the MDS cycle by talking with her. RN-A added it appeared the SSD never rescheduled R23's care conference and it was forgotten about; normally they offer those services at the RCC.A policy regarding hearing aid care was requested but not received.

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	245119	A. Building B. Wing	06/04/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure safe hot water temperatures in resident bathrooms in an area where 5 of 6 residents had potential to use the bathroom sink, and 1 of 6 residents (R23) expressed concern with hot water temperatures when reviewed for environmental concerns. In addition, the facility failed to follow care plan interventions for fall prevention for 1 of 2 residents (R39) reviewed for falls. Findings include: According to the State Operations Manual (SOM), as published by the Centers for Medicare and Medicaid Services (CMS), Revision 232, page 366: Water temperature of 100 degrees Fahrenheit (F) would be deemed a safe temperature for bathing. At 120 degrees F the time required for a third-degree burn (burns penetrate the entire thickness of the skin and permanently destroy tissue) was five minutes; at 140 degrees F the time required for a third-degree burn would be five seconds. R23's quarterly minimum data set (MDS) dated [DATE], identified intact cognition and diagnoses of peripheral vascular disease and diabetes mellitus (DM, a condition where the body can't properly use blood sugar leading to high blood sugar. Long term effects may include loss of nerve sensation). R23 was independent with oral, personal, and toilet hygiene, and was mobile with independent wheelchair propulsion and transfers. R23's care plan dated 1/23/26, identified she was independent with hygiene and oral care. The plan also identified on 1/15/26, R23 had DM and should avoid exposure to extreme heat or cold. Review of Facility Domestic Water Temperature Log for Aitkin Health Services supplied by MW-A and dated May 2026, identified water temperatures taken 5/14/26 for rooms 102 to 109 didn't exceed 112 degrees F. During an interview on 6/1/26 at 5:51p.m., R23 stated the water in her bathroom sink was scalding hot, she stated she had told people but wasn't sure who. During an interview on 6/3/26 at 12:59 p.m., nursing assistant (NA)-C reported she had noticed the hot water was really hot and thought it would be an issue for residents who liked to wash their own hands. During an interview on 6/3/26 at 1:13 p.m., NA-D confirmed R23 was basically independent with activities of daily living (ADLs) and she did use the bathroom sink. During an interview on 6/3/26 at 1:28 p.m., NA-E stated the whole one side of Garden Terrace got extremely hot water and that maintenance knew this. During an observation and interview on 6/3/26 at 1:41 p.m., the administrator took the temperature of the hot water at R23's bathroom sink. The temperature with a food thermometer measured 138.2 degrees Fahrenheit (F)and a temperature gun measured 139.4 degrees F. The administrator stated it should be about 115 degrees F and rushed off to find the hot water heater. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/26 at 11:15 a.m., the administrator stated he didn't want the water to be as hot as it was yesterday due to the risk of burns and added the maintenance director would have a log of hot water temperatures. During an interview on 6/4/26 at 1:42 p.m., maintenance worker (MW)-A, who identified as the maintenance director, stated he used a temperature gun to get the hot water temperature in all of the sinks in all the rooms. MW-A added he had never had a temperature up there that was that high and that the gauge on the hot water tank was not working properly. A policy, Water Temperatures dated 4/16/24, identified its purpose was to provide direction to environmental services (ES) staff in testing and recording water temperatures at faucets and fixtures. Required temperatures were identified to be maintained at 105 to 115 degrees F and should not exceed 115 degrees F. Tests shall be conducted weekly at a minimum of one (1) faucet location per area or wing being serviced by a domestic water heater. Different fixture locations should be tested each week until they are recorded at least once annually. Tests at hot water faucet locations should be conducted by turning the hot water supply control valve to the hottest setting. The faucet and/or hot water supply at the fixture should be turned on to the fully open position, allowing the water to run for at least 30 seconds before taking any water temperature recording. Nursing staff shall report to ES staff if a resident or staff member reports that a water temperature seems excessively hot to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water). ES staff will test and record the water temperature at the reported fixture location. R39: R39's admission MDS dated [DATE], was in progress and ready for export. The cognition assessment indicated R39 was cognitively intact. R39's facesheet date 6/4/26, included diagnoses of diabetes, lymphedema, and muscle weakness. R39's care plan initiated 5/18/26, indicated R39 used a recliner. Goals for lift recliner implemented on 5/26/26 included: I will continue to use my lift recliner with staff assistance for the lift function. Interventions for the chair updated 5/27/26, instructed staff to unplug R39's lift chair after positioning. R39's Fall Risk assessment dated [DATE], indicated R39 was at a high risk for falls. Progress note entry made on 5/24/26, included: Family brought in recliner yesterday, resident is safe to sit in recliner and knows how to use the chair remote but because resident requires assistance with transfers, resident uses call light to get up and out of the recliner and if resident wants to go into it from w/c. Risk assessment completed. Leave remote unplugged or out of reach so residents don't accidentally put it up or down and fall from it. Resident did call all day/evening when wanting to transfer from w/c to recliner and vice versa. Uses call light appropriately, alert and oriented. Progress note entry made on 5/27/26, included: R39 is able to use remote properly, but when staff is not in room lift chair is unplugged and R39 is to call staff to use remote, reasoning is safety purposes. During an interview on 6/1/26 at 3:30 p.m., R39 was seated in a recliner chair with legs partially elevated on the footrest. The recliner chair remote was tucked along R39's left leg and the side of the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chair. R39's family member (FM-A) stated R39's chair was from home and R39 had been using the chair remote at home just fine, but facility staff said the chair would have to be unplugged when staff were not in the room for safety. FM-A said occupational therapy had assessed R39 for safety, and some staff had been unplugging it, but some hadn't, and the chair was currently plugged in now, so FM-A wasn't sure how it was supposed to be. R39's chair was plugged into outlet directly behind the chair. During an observation on 6/2/26 at 2:30 p.m., R39 was seated in their recliner. The recliner remote was on the left side of R39's lap. During an observation on 6/3/26 at 8:51 a.m., R39 was seated in their recliner alone in their room. The recliner was plugged in to the outlet behind the recliner. The chair remote was on the left side of R39's lap. R39 confirmed their chair was plugged in and they could move the chair with the remote. During an observation on 6/3/26 at 1:43 p.m., R39 was seated in recliner in room. The catheter bag was attached to the chair pocket and in direct contact with the floor. During an interview on 6/3/26 at 2:19 p.m., licensed practical nurse (LPN-A) stated R39 was very cognitive with the use of their chair remote. The problem was if R39 got into a position on accident with seat raised up, R39 would not have the strength to stop themselves from falling. During an interview on 6/3/26 at 2:34 p.m., R39 was seated in their recliner with their chair remote on the left side of their lap. R39 stated their chair was plugged in. During an observation on 6/4/26 at 7:33 a.m., R39 was seated in their recliner. The recliner remote was on R39's lap and the recliner was plugged in behind the chair. During an interview on 6/4/26 at 10:39 a.m., occupational therapist (OT-A) confirmed they had done a safety assessment on R39. They found that R39 could cognitively operate the remote, but R39 did not have strength in their legs for balance and independent transfer out of the chair in a lifted position. For safety, OT-A had recommended that R39's recliner remain unplugged when staff were not present to standby assist with transfers and repositioning of the chair. During an interview on 6/4/26 at 11:36 a.m., R39 was seated in their chair and stated it was plugged in and working. R39 held up their right hand to show they had their recliner remote. The remote was lit up with a green back light. During an interview on 6/4/26 at 12:20 p.m., nursing assistant (NA-B) stated they looked at the care plan to see how to care for residents, but they also got updates in shift report. NA-B stated they believed R39's chair was supposed to be unplugged every time staff left the room. During an interview on 6/4/26 at 12:23 p.m., NA-A stated they were not certain if anything special was supposed to be done with R39's chair or if it was in the care plan. Usually if they had questions about care, they asked the nurse. They also got information about residents during report at the start of their shift. During an interview on 6/4/26 at 12:48 p.m., registered nurse (RN-B) stated R39's chair was okay to keep plugged in. From what they knew in that moment R39's chair could stay plugged in so R39 could reposition themselves for comfort and safety. If a resident was unsafe then physical therapy or OT (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would let nursing know that. During an interview on 6/4/26 at 1:01 p.m., LPN-A stated the assistant director of nursing (ADON) had gone over chair safety with R49. R49 had said they understood the safety risks of being ejected from the chair and had signed an agreement to have the chair unplugged. LPN-A explained cognitively R39 was able to use the remote, but assessments indicated physically R39 did not have the strength to prevent a fall should R39 accidentally put the chair too far into lift mode. R39 was care planned for the chair to be unplugged when staff were not in the room. The chair should not be left plugged in when staff were not in the room. Staff were expected to unplug the chair before they left R39's room. During an interview on 6/4/26 at 1:28 p.m., LPN-A exited R39's room and stated the chair had been unplugged. During an interview on 6/4/26 at 1:30 p.m., the occupational therapist (OT-A) stated when they went into R39's room to do R39's treatment today R39's chair had been plugged in. They had unplugged the chair and then followed up with nursing staff to let them know R39's chair needed to be unplugged for safety. During an interview on 6/4/26 at 1:36 p.m., the director of nursing DON stated in addition to shift report, staff were expected to look at the dashboard in PCC (the electronic medical record) and the kardex. The dashboard alerted staff to care changes. The DON expected nurses to follow R39's care plans. R39's chair should only be plugged in when staff were present and assisting R39 to safely use the chair remote features. Otherwise for safety staff should be making sure R39's chair was unplugged before leaving the room. The facility policy Fall Prevention and Management indicated the purpose of the policy was to assess each resident and identify interventions to assist in preventing falls. The resident signed document regarding safety and agreement to have recliner unplugged when staff were not in the room was requested but not received.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection prevention measures were followed as care planned for 1 of 2 residents (R39) who had a indwelling catheter. Findings include:R39's admission Minimum Data Set (MDS) dated [DATE], was in progress and ready for export. The cognition assessment indicated R39 was cognitively intact.R39's Facesheet dated 6/4/26, included diagnoses of diabetes, lymphedema, muscle weakness, and urinary retention.R39's care plan initiated 5/18/26, indicated R39 had an indwelling foley catheter related to urinary retention. 5/18/26, goals included R39 will show no signs or symptoms of urinary infection. Interventions for the catheter initiated 5/18/26, instructed staff to keep R39's catheter bag off the floor.During an observation on 6/1/26 at 3:30 p.m., R39 was seated in a recliner chair with legs partially elevated on the footrest. R39's catheter drainage bag was hanging off the side pocket of the chair on R39's right side facing the door. The bottom of the bag was in direct contact with the floor.During observations on 6/2/26:-at 1:30 p.m., R39 was seated in their recliner with their catheter bag hooked on the side pocket of the recliner facing the door. The catheter bag was touching the floor. A staff member was in the room applying lotion to R39's legs.-at 2:43 p.m., R39 was seated in recliner. Catheter bag remained attached to side of chair with the catheter bag resting directly on the floor.During an observation on 6/3/26 at 8:51 a.m., R39 was seated in their recliner. R39's catheter bag was hanging on the right-side pocket of R39's recliner. The bottom of the bag was resting on the floor.During an observation on 6/3/26 at 1:43 p.m., R39 was seated in recliner in room. The catheter bag was attached to the right-side chair pocket and in direct contact with the floor.During an interview on 6/3/26 at 1:45 p.m., nursing assistant (NA-A) stated they thought catheter bags should probably not touch the floor, and they knew for sure it was important for the catheter bag to be low so it could drain downhill.During an observation on 6/3/26 at 1:55 p.m., the assistant director of nursing (ADON) confirmed R39's foley bag was touching the floor. The ADON stated the bag should not be touching the floor because of the risk for contamination and infection.During interview on 6/3/26 at 2:19 p.m., licensed practical nurse LPN-A stated R39's catheter should not be hanging in a manner that allowed it to touch the floor. LPN-A entered R39's room. R39's catheter bag was hanging on the side of R39's garbage can not touch the floor. LPN-A removed the catheter bag from the garbage bag, placed a sanitized bin on the floor next to R39's recliner, and hung the bag on the side of the recliner so the bag sat in the bin instead of on the floor. After exiting the room LPN-A explained the catheter bag should not be hung on the side of the garbage can or come in contact with the floor because it created a risk for bag contamination and infection for the resident.During an observation on 6/3/26 at 4:11 p.m., R39 was seated in their recliner. Their catheter bag was hanging on the side of the recliner with the bottom of the catheter bag resting in a bin.During an observation on 6/4/26 at 7:33 a.m., R39 was seated in their recliner. R39's catheter bag was sitting inside the side pocket of R39's recliner. During an observation on 6/4/26 at 10:49 a.m., R39 was wearing shorts and was seated in their recliner. Staff was in the room. R39's foley bag was tucked inside the side pocket of their recliner.During an observation on 6/4/26 at 11:36 a.m., R39's catheter bag was tucked into the pocket of their recliner. The tubing tube was filled with clear yellow urine from the drainage bag up to the bottom edge of R39's shorts.During an interview on 6/4/26 at 12:20 p.m., NA-B stated they looked at the care plan to see how to care for residents, but they also got updates in shift report. Cather bags should be hung for good drainage and should not come in contact with the floor for infection prevention reasons.During an interview on 6/4/26 at 12:48 p.m., registered nurse (RN-B) stated catheter bags should not touch the floor for infection prevention reasons.During an interview on 6/4/26 at 1:01 p.m., LPN-A stated R39's care plan had been updated, and staff were to put R39's catheter bag into a clean bin on the floor when R39 was in their recliner to prevent contamination and promote drainage. The (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bag should not be hung on the side of the recliner or placed in the side pocket of the chair due to risk for back flow and contamination of the bag. Both back flow of urine and contamination of the bag could lead to an infection and or even sepsis. LPN-A stated they would follow up with some staff education. They expected staff to follow the care plan and read the system alerts that went out to staff anytime an update or change was made to the resident plan of care.On 6/4/26 at 1:28 p.m., LPN-A exited R39's room and stated they had removed R39's catheter bag from the chair pocked and hooked it on the chair so the bag sat in a clean bin.During an interview on 6/4/26 at 1:36 p.m., the director of nursing (DON) stated foley catheter drainage bags should be hung lower than the body in a manner to prevent back flow. The drainage bag and tubing should not come in contact with the floor or other potentially unclean surfaces. These measures were important to follow to help prevent infection.Policies pertaining to catheter care were requested but not received.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure proper storage of open enteral feeding solutions and failed to date tube feeding supplies for 1 (R8) of 2 residents reviewed for tube feeding.Findings include:R8's annual Minimum Data Set (MDS) dated [DATE], indicated R8 was cognitively intact. Diagnoses included frontotemporal neurocognitive disorder, dysphagia, diabetes mellitus type 2, non-Alzheimer dementia, and anxiety disorder.R8's care plan revised 2/26/26, tube feeding care included:Bolus feeding.Change feeding solution container and syringe every 24 hours. Follow manufacturers' recommendations or per registered dietician regarding how long formula can be open.R8's provider orders dated 6/4/26, included:Change syringe and water container daily before breakfast.Please have dietician eval resident tube feeding needs and make recommendations.Jevity 1.2 Calorie Oral Liquid (Nutritional Supplements) Give 553 milliliters (mL) via gastrostomy tube (G-tube) three times a day (TID) for Bolus feeding or 2 1/3 cartons TID (can split one carton TID if cover, refrigerate & use within 24 hours).R8's treatment administration record (TAR) instructed staff to change syringe and water container daily before breakfast.During an observation on 6/2/26 at 9:29 a.m., an open and undated Jevity 1.2 calorie, 1.5-liter, bottle was on R8's bedside table, not connected to R8's G-tube. Tube feeding supplies were lying next to the Jevity bottle, including two rinsed, undated extension tubes.During an observation on 6/2/26 at 11:57 a.m., an open and undated Jevity 1.2 calorie, 1.5-liter, bottle was on R8's bedside table, not connected to R8's G-tube. Tube feeding supplies were lying next to the Jevity bottle, including a rinsed, undated 60 mL syringe.During an observation on 6/4/26 at 7:41 a.m., an open Jevity 1.2 calorie, 1.5-liter, bottle was on R8's bedside table, not connected to R8's G-tube. Tube feeding supplies were lying next to the Jevity bottle, including a rinsed, undated 60 mL syringe.During an interview on 6/4/26 at 11:04 a.m., licensed practical nurse (LPN)-A stated the Jevity nutritional supplement, graduated cylinder, and syringe was changed daily and dated. They stated a new Jevity bottle was opened each morning to administer via gravity feeding three times through the day as ordered for R8, and the open Jevity bottle could remain at room temperature for 24 hours. They were concerned about potential bacteria growth if supplies were used for more than one day.During an interview on 6/4/26 at 11:15 a.m., director of nursing (DON) stated the Jevity bottle was labeled each morning when it was opened for the first feeding, and tube feeding supplies were labeled when changed. They stated staff follow storage and refrigeration instructions on Jevity bottle. They were concerned it could potentially put the resident at risk if not dated and stored per policy. During an interview via email correspondence dated 6/4/26 at 3:50 p.m., facility-contracted dietician stated if the Jevity should be covered and refrigerated between gravity feeds to help prevent bacterial growth and dated with the date and time it was opened. Facility policy Enteral Feeding Tube Usage instructed staff to label the feeding solution container with the date, time and nurses initials, and change and date the 60 mL syringe daily. It instructed to follow manufacturer's recommendation or registered dietician instructions for use and storage.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to initiate orders and maintain documentation to ensure oxygen supplies were properly cleaned and maintained for 1 of 1 resident (R1) reviewed for respiratory care.Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was severely cognitively impaired. Diagnoses included atrial fibrillation, heart failure, hypertension, pneumonia, non-Alzheimer's dementia.R1's care plan did not include oxygen use.R1's had a provider order dated 1/6/26, for oxygen 2 liters as needed (prn) to keep oxygen saturations above 90% and as needed for shortness of breath.R1's treatment administration record (TAR) reviewed on 6/2/26, included oxygen 2 liters prn to keep oxygen saturations above 90% as needed and for shortness of breath as needed, but had no instructions for cleaning, maintenance, or changing of oxygen tubing. TARs dated 3/2026, 4/2026, and 5/2026, also had no instructions for cleaning, maintenance, or changing of oxygen tubing. During an observation on 6/2/26 at 1:07p.m., R1's oxygen concentrator was in their room with undated oxygen tubing connected, hanging off the concentrator and cascading to floor, and an undated, partially filled humidifier attached.During an interview on 6/3/26 at 10:03 a.m., nursing assistant (NA)-F stated R1 had used oxygen with an illness but had not needed oxygen for several weeks. They indicated the concentrator was in R1's room to be used as needed. NA-F confirmed the tubing and humidifier were undated and stated oxygen tubing and humidifiers were usually changed weekly, should be dated, and the nurse would check off the change on the TAR.During an interview on 6/3/26 at 1:04 p.m., assistant director of nursing (ADON) stated R1 had used oxygen with an illness but had not needed oxygen for several weeks. They stated oxygen tubing and humidifiers were changed on Sundays, and staff were instructed to date and label the humidifier and all connecting tubing. The ADON had concern for potential bacteria growth if the tubing was not changed, confirmed there was not an order on R1's TAR, and stated they would add it.During an interview on 6/4/26 at 7:41 a.m., director of nursing (DON) stated oxygen tubing and humidifier should be changed weekly and scheduled on the TAR. The DON had concern for potential risk of infection.Facility policy Oxygen did not address maintenance, cleaning, and changing of oxygen tubing.Facility policy related to oxygen administration and tubing change was requested but not received.