

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL  
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 87Z5

Facility ID: 00581

1. MEDICARE/MEDICAID PROVIDER NO. (L1) <b>24E355</b>		3. NAME AND ADDRESS OF FACILITY (L3) <b>AFTENRO HOME</b> (L4) <b>510 WEST COLLEGE STREET</b> (L5) <b>DULUTH, MN</b> (L6) <b>55811</b>			4. TYPE OF ACTION: <u>7</u> (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other  8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) <b>780743100</b>		7. PROVIDER/SUPPLIER CATEGORY <u>10</u> (L7) <b>01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA</b> <b>02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF</b> <b>03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC</b> <b>04 SNF 08 OPT/SP 12 RHC 16 HOSPICE</b>			FISCAL YEAR ENDING DATE: (L35) <b>12/31</b>	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		10.THE FACILITY IS CERTIFIED AS: <b>X A. In Compliance With</b> <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements _____ 2. Technical Personnel _____ 6. Scope of Services Limit Compliance Based On: _____ 3. 24 Hour RN _____ 7. Medical Director _____ 1. Acceptable POC _____ 4. 7-Day RN (Rural SNF) _____ 8. Patient Room Size _____ 5. Life Safety Code _____ 9. Beds/Room				
6. DATE OF SURVEY <b>07/25/2014</b> (L34)		B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: <b>A*</b> (L12)				
8. ACCREDITATION STATUS: _____ (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :				
12.Total Facility Beds <b>54</b> (L18)		14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SNF ICF IID 54 (L37) (L38) (L39) (L42) (L43)			15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)	
13.Total Certified Beds <b>54</b> (L17)		16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):				

17. SURVEYOR SIGNATURE  <u>Brenda Fischer, Unit Supervisor</u> (L19)		Date : <b>07/25/2014</b>	18. STATE SURVEY AGENCY APPROVAL  <u>Kate JohnsTon, Enforcement Specialist</u> (L20)		Date: <b>08/08/2014</b>
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY  <input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____	
22. ORIGINAL DATE OF PARTICIPATION <b>11/12/1981</b> (L24)		23. LTC AGREEMENT BEGINNING DATE (L41)		24. LTC AGREEMENT ENDING DATE (L25)	
25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)			
26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active		28. TERMINATION DATE: (L28)		29. INTERMEDIARY/CARRIER NO. (L31)	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE <b>07/22/2014</b> (L33)			
30. REMARKS  <b>DETERMINATION APPROVAL</b>					



*Protecting, Maintaining and Improving the Health of Minnesotans*

Medicare Provider # 24E355

August 8, 2014

Ms. Roberta Cline, Administrator  
Aftenro Home  
510 West College Street  
Duluth, Minnesota 55811

Dear Ms. Cline:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to [CMS that your facility be recertified for participation in the Medicare and Medicaid program.](#)

Effective July 21, 2014 the above facility is **certified for:**

**54 Skilled Nursing Facility/Nursing Facility Beds**

[Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.](#)

[If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency\(ies\) or renew your request for waiver in order to continue your participation in the Medicare and/or Medicaid Program.](#)

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your [Medicare and Medicaid](#) provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Aftenro Home  
August 8, 2014  
Page 2

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate Johnston, Program Specialist  
Licensing and Certification Program  
Division of Compliance Monitoring  
Telephone: (651) 201-3992 Fax: (651) 215-9697  
Enclosure (s)  
cc: Licensing and Certification File



*Protecting, Maintaining and Improving the Health of Minnesotans*

August 8, 2014

Ms. Roberta Cline, Administrator  
Aftenro Home  
510 West College Street  
Duluth, Minnesota 55811

RE: Project Number SE355024

Dear Ms. Cline:

On June 19, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 11, 2014 that included an investigation of complaint number HE355003 which was found to be unsubstantiated. This survey found the most serious deficiencies 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 were required.

On July 25, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 11, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 21, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 11, 2014, effective July 21, 2014 and therefore remedies outlined in our letter to you dated June 19, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate Johnston, Program Specialist  
Licensing and Certification Program  
Division of Compliance Monitoring  
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

**Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 24E355	<b>(Y2) Multiple Construction</b> A. Building _____ B. Wing _____	<b>(Y3) Date of Revisit</b> 7/25/2014
<b>Name of Facility</b> AFTENRO HOME	<b>Street Address, City, State, Zip Code</b> 510 WEST COLLEGE STREET DULUTH, MN 55811	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <b>F0315</b> Reg. # <b>483.25(d)</b> LSC _____	Correction Completed <b>07/21/2014</b>	ID Prefix <b>F0356</b> Reg. # <b>483.30(e)</b> LSC _____	Correction Completed <b>07/21/2014</b>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By <b>BF/KJ</b>	Date: <b>07/25/2014</b>	Signature of Surveyor: <b>10562</b>	Date: <b>07/25/2014</b>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 6/11/2014	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES      NO
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*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically delivered

June 19, 2014

Ms. Roberta Cline, Administrator  
Aftenro Home  
510 West College Street  
Duluth, Minnesota 55811

RE: Project Number SE355024 & HE355003

Dear Ms. Cline:

On June 11, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the June 11, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number HE355003. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

**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.**

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

**Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**

**Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

**Remedies - the type of remedies that will be imposed with the authorization of the**

**Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

**Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

**Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.**

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

## **DEPARTMENT CONTACT**

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

Brenda Fischer, Unit Supervisor  
Minnesota Department of Health  
3333 West Division, #212  
St. Cloud, Minnesota 56301  
Telephone: (320)223-7338  
Fax: (320)223-7348

## **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 21, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

## **ELECTRONIC PLAN OF CORRECTION (ePoC)**

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

### **PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

## **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

### **Original deficiencies not corrected**

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

### **Original deficiencies not corrected and new deficiencies found during the revisit**

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

### **Original deficiencies corrected but new deficiencies found during the revisit**

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

## **FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

If substantial compliance with the regulations is not verified by September 11, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies

have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 December 11, 2014 (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.

### **INFORMAL DISPUTE RESOLUTION**

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: [http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\\_idr.cfm](http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm)

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor  
Health Care Fire Inspections  
State Fire Marshal Division  
pat.sheehan@state.mn.us  
Telephone: (651) 201-7205  
Fax: (651) 215-0541

Aftenro Home  
June 19, 2014  
Page 6

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate Johnston, Program Specialist  
Licensing and Certification Program  
Division of Compliance Monitoring  
Telephone: (651) 201-3992 Fax: (651) 215-9697  
Enclosure (s)  
cc: Licensing and Certification File

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

PRINTED: 07/01/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24E355</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/11/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>AFTENRO HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 WEST COLLEGE STREET DULUTH, MN 55811</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.  Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.  A standard recertification survey and state licensing survey was conducted and a complaint investigation(s) was also completed at the time of the standard survey. An investigation of complaint HE355003 was not substantiated during this survey.	F 000			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by:	F 315		7/21/14	

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

TITLE

(X6) DATE

Electronically Signed

06/27/2014

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

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

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NAME OF PROVIDER OR SUPPLIER  <b>AFTENRO HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 WEST COLLEGE STREET DULUTH, MN 55811</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	<p>Continued From page 1</p> <p>Based on observation, interview and document review, the facility failed to comprehensively assess a change in urinary continence status for 1 of 1 (R23) reviewed who had a change in continence status.</p> <p>Findings include:</p> <p>R23's admission Minimum Data Set (MDS) (dated 2/3/14), indicated she had diagnoses of cerebral vascular accident and hypertension. The MDS also indicated she was independent with toileting and was occasionally incontinent of urine less than seven episodes. R23's Resident Care Area Assessment dated 02/06/14, indicated she received diuretics (medication to promote urine) and "Resident says she is continent but wears a pad because of urgency when she may dribble urine. May change pad about three times daily. Toilets independently and changes pad independently as needed..." R23's care plan dated 2/17/14 indicated she has urge incontinence, wears protective pad and changes herself independently.</p> <p>R23's quarterly MDS dated 4/30/14, indicated she was independent with toileting and was frequently incontinent of urine seven or more episodes of incontinence, which was a change from her admission MDS of being occasionally incontinent to frequently incontinent of urine.</p> <p>During observation on 6/11/14, at 7:00 a.m. R23 was observed to exit her bathroom and showed no signs of urinary incontinence.</p> <p>During interview on 6/11/14, at 8:00 a.m. nursing assistant (NA)-A stated R23 toilets herself and wears an incontinent products because of urinary</p>	F 315			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24E355</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/11/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>AFTENRO HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 WEST COLLEGE STREET</b> <b>DULUTH, MN 55811</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	Continued From page 2 incontinence. NA-A works both the day and evening shifts and stated R23 was usually continent during these times because of the frequent reminders to use the toilet.  Review of the facility 7 Day Observation Tool dated 4-24 to 4-30-14, identified R23 had 26 episodes of urinary incontinence at night, 3 episodes during the day and 19 episodes during the evening. Although R23 had frequent episodes of urinary incontinence, there was no reassessment completed to determine if there was a pattern of incontinence or plan to help decrease her incontinent episodes.  During interview 6/11/14, at 11:49 a.m. the director of nursing (DON) reviewed the facility's 7 Day Observation Tool and stated they should have reassessed her urinary incontinence to determine a pattern and an appropriate toileting program.	F 315			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION  The facilities Urinary Incontinence-Clinical Protocol (revised April 2013) indicated as part of the initial assessment, the physician will help identify individual with impaired urinary continence. In addition, the nurse shall assess and document/report there assessment.  The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and	F 356		7/21/14	

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24E355</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/11/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>AFTENRO HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 WEST COLLEGE STREET DULUTH, MN 55811</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 356	<p>Continued From page 3</p> <p>unlicensed nursing staff directly responsible for resident care per shift:</p> <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nurse staffing information postings included the census and the actual hours worked for each category of nursing staff. This had the potential to affect all 42 residents who resided in the facility, along with interested family or visitors. Findings include: During initial tour of the facility on 6/9/14, at 3:18 p.m. the facility's nurse staffing information titled, Report of Nursing Staff, was observed in the facility's front hallway way. The posting included</p>	F 356			

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

PRINTED: 07/01/2014  
FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24E355</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/11/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>AFTENRO HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 WEST COLLEGE STREET</b> <b>DULUTH, MN 55811</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 356	Continued From page 4 the facility name, date, and the total number of hours worked by each category of nursing staff. However, the census and actual hours worked by each category of nursing staff was not included in the posting. When interviewed on 6/10/14, at 10:52 a.m. the director of nursing (DON) stated the staff posting did not indicate the actual hours worked by each category of nursing staff. The DON reported a new staff person had completed it and they were trying to improve the form. A policy was requested, but not provided.	F 356			

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

Printed: 06/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

FE355022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>24E355</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/11/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>AFTENRO HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 WEST COLLEGE STREET DULUTH, MN 55811</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p><b>INITIAL COMMENTS</b></p> <p><b>IRE SAFETY</b></p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, AFTENRO HOME was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.</p> <p>AFTENRO HOME is a 3-story building with no basement. The building was constructed at 4 different times. The original 3 story building was constructed in 1921 and was determined to be of Type II(222) construction. In 1935, a 3 story addition was constructed to the North that was determined to be of Type II(222) construction. In 1990, a 2 story addition was constructed to the East that was determined to be of Type II(222) construction. In 2001, a 1 story addition was constructed above the 1990 East addition that was determined to be of Type II(222) construction. Because the original building and the 3 additions are of the same type of construction, the facility was surveyed as one building.</p> <p>This building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 42 at the time of the survey.</p> <p>The requirement at 42 CFR, Subpart 483.70(a) is met.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER <b>AFTENRO HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 WEST COLLEGE STREET DULUTH, MN 55811</b>		
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*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically submitted

June 19, 2014

Ms. Roberta Cline, Administrator  
Aftenro Home  
510 West College Street  
Duluth, Minnesota 55811

Re: Project Number SE355024 & HE355003

Dear Ms. Cline:

The above facility survey was completed on June 11, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number HE355003 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johnston", written in a cursive style.

Kate Johnston, Program Specialist  
Licensing and Certification Program  
Division of Compliance Monitoring  
Telephone: (651) 201-3992 Fax: (651) 215-9697  
Enclosure (s)  
cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00581</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/11/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AFTENRO HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 WEST COLLEGE STREET DULUTH, MN 55811</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 000	<p><b>INITIAL COMMENTS</b></p> <p>*****ATTENTION*****</p> <p><b>BOARDING CARE HOME LICENSING CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p><b>INITIAL COMMENTS:</b> On June 9-11, 2014, surveyors of this Department's staff visited the above provider for a state licensing survey and a complaint investigation(s) was also completed. An investigation of complaint HE355003 was not substantiated during this survey.</p>	3 000		

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

Electronically Signed

TITLE

(X6) DATE  
06/27/14

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00581</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/11/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AFTENRO HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>510 WEST COLLEGE STREET DULUTH, MN 55811</b>
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3 000	<p>Continued From page 1</p> <p>There were no state violations identified during the licensing survey.</p> <p>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.</p> <p>The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p>	3 000		