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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O5J1

Facility ID: 00581

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E355**
2.STATE VENDOR OR MEDICAID NO.
(L2) **780743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AFTENRO HOME**
(L4) **510 WEST COLLEGE STREET**
(L5) **DULUTH, MN** (L6) **55811**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/10/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **54** (L18)
13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

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)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
James Anderson, DSFM 06/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/07/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 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
11/12/1981 (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)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
05/04/2016 (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 E355

On June 10, 2016 The Department of Public Safety conducted a revisit to reverify correction of the remainiing LSC deficiency reissued at the time of the May 16, 2016 revisit. Based on our visit we have found the deficiency corrected as of May 26, 2016. As a result of this revisit, we have rescinded the Category 1 remedy of State monitoring, effective May 26, 2016.

In addition, we recommended the following enforcement action to the CMS RO related to the remedy recommendatoin in our letter of June 13, 2016:

Mandatory denial of payment for new Medicare and Medicaid admissions effective June 18, 2016, be rescinded. (42 CFR 488.417 (b))

Since Denial of Payment did not go into effect, the facility would not be subject to a two year loss of NATCEP that was to begin June 13, 2016. Refer to the CMS 2567b form for Life safety code.

Effective May 26, 2016, the facility is certified for 54 Nursing Facility II beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 24E355

October 7, 2016

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective May 26, 2016 the above facility is certified for:

54 Nursing Facility II Beds

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 Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 13, 2016

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

RE: Project Number FE355024

Dear Ms. Cline:

On May 20, 2016, this Department recommended the following action to the CMS RO for imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 18, 2016. (42 CFR 488.417 (b))

On May 26, 2016, we informed you that the following Category 1 remedy was being imposed:

- State Monitoring effective May 31, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on March 18, 2016, lack of verification of compliance with the life safety code deficiencies at the time of our May 20, 2016 notice and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on May 16, 2016. The most serious deficiencies at the time of the revisit were found 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 June 10, 2016, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on May 16, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 13, 2016. Based on our visit, we have determined that your facility has corrected the deficiency issued pursuant to our PCR, completed on May 16, 2016, as of May 26, 2016. As a result of the revisit findings, the Department is rescinding the Category 1 remedy of state monitoring effective May 26, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of May 20, 2016 and May 26, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 18, 2016, be rescinded. (42 CFR 488.417 (b))

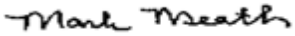
The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective June 18, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective June 18, 2016, is to be rescinded.

In our letters of May 20, 2016 and May 26, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 18, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 26, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
24E355	A. Building 01 - MAIN BUILDING 01 B. Wing	6/10/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0051	Correction Completed 05/26/2016	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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	**REVIEWED BY (INITIALS)** TL/mm	**DATE** 06/13/2016	**SIGNATURE OF SURVEYOR** 27200	**DATE** 06/10/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/15/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O5J1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00581

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E355**
2.STATE VENDOR OR MEDICAID NO.
(L2) **780743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AFTENRO HOME**
(L4) **510 WEST COLLEGE STREET**
(L5) **DULUTH, MN** (L6) **55811**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/03/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **54** (L18)
13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

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)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 05/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/13/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 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
11/12/1981
(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)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
05/04/2016 (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 E355

On May 3, 2016 and May 16, 2016 revisits were completed to verifiy correction of health and life safety code deficiencies issued pursuant to the March 18, 2016 standard survey. Based on the the revisits, health deficiencies were corrected. However, Life Safety Code (LSC) reissued one deficiency (K0051). As a result we imposed the Categoyr 1 remedy of State monitoring, effective May 31, 2016.

In addition, we recommended the following enforcement remedy to the CMS Region V Office for imposition:

Mandatory denial of payment for new Medicare and Medicaid admissions effective June 18, 2016 remain in effect. (42 CFR 488.417 (b))

If DPNA goes into effect the facility would be subject to a two year loss of NATCEP, beginnig June 18, 2016. Refer to the CMS 2567b forms for both health and life safety code, CMS 2567 along with the facility's plan of correction for the life safety code deficiency reissued. Post Certification Revisit (PCR) to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 26, 2016

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

RE: Project Number FE355024

Dear Ms. Cline:

On May 20, 2016, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 18, 2016. (42 CFR 488.417 (b))

Also, the Department notified you in our letter of May 20, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 18, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on March 18, 2016, and lack of verification of substantial compliance with the life safety code deficiencies at the time of our May 20, 2016 notice. The most serious life safety code deficiencies were found 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 May 16, 2016, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey completed March 18, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 13, 2016. Based on our visit, we have determined that your facility has not obtained substantial compliance with the life safety code deficiencies issued pursuant to our standard survey completed March 18, 2016. The deficiency not corrected is as follows:

K0051 -- S/S: D -- NFPA 101 -- Life Safety Code Standard Bld: 01

The most serious deficiencies in your facility were found 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.

As a result of the revisit findings, we are imposing the following Category 1 remedy:

- State Monitoring effective May 31, 2016. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office the following action related to the imposed remedy in our letter of May 20, 2106:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 18, 2016 remain in effect. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of April 4, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 18, 2016.

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 OF PUBLIC SAFETY CONTACT

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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 18, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Electronically delivered
May 20, 2016

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

RE: Project Number SE355026, FE355024

Dear Ms. Cline:

On April 4, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 18, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 3, 2016, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 18, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 13, 2016. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on March 18, 2016.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the March 18, 2016 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey were found 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.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 18, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new

admissions is effective June 18, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 18, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Aftenro Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 18, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

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

Tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 18, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 electronic 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Tamika Brown, CMS Region V Office

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
24E355 Y1	A. Building B. Wing Y2	5/3/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0159	Correction	ID Prefix F0164	Correction	ID Prefix F0309	Correction
Reg. # 483.10(c)(2)-(5)	Completed	Reg. # 483.10(e), 483.75(l)(4)	Completed	Reg. # 483.25	Completed
LSC	04/25/2016	LSC	04/25/2016	LSC	04/25/2016
ID Prefix F0323	Correction	ID Prefix F0329	Correction	ID Prefix F0334	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.25(n)	Completed
LSC	04/25/2015	LSC	04/25/2016	LSC	04/25/2016
ID Prefix F0356	Correction	ID Prefix F0371	Correction	ID Prefix F0428	Correction
Reg. # 483.30(e)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.60(c)	Completed
LSC	04/25/2016	LSC	04/25/2016	LSC	04/25/2016
ID Prefix F0441	Correction	ID Prefix F0514	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. # 483.75(l)(1)	Completed	Reg. #	Completed
LSC	04/25/2016	LSC	04/25/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TA/mm	05/20/2016	34983	05/03/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/18/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **05/16/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

(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
{K 000}	INITIAL COMMENTS Based on an on-site revisit, the facility is not in complete compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 000}		
{K 051} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on an on-site revisit conducted on 05/16/2016, it was identified that the manual fire alarm pull boxes have not been installed and/or corrected at the time of their post certification revisit.	{K 051}	The vendors have been contacted, and the parts for repair have been ordered. The vendors will begin work on the project next week to complete repairs by 6/8/2016, as long as no issues arise with vendors.	5/26/16

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

Electronically Signed | 05/26/2016

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
24E355 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/16/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0038	04/25/2016	LSC K0048	05/13/2016	LSC K0050	04/29/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0052	05/02/2016	LSC K0054	05/02/2016	LSC K0056	05/13/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0064	04/15/2016	LSC K0066	04/29/2016	LSC K0073	04/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0104	04/25/2016	LSC K0147	05/06/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TL/mm	05/26/2016	27200	05/16/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/15/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 20, 2016

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

Re: Reinspection Results - Project Number SE355026

Dear Ms. Cline:

On May 3, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 18, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
00581		5/3/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20302 Reg. # MN State Statute 144.6503 LSC	Correction Completed 05/03/2016	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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) TA/mm	DATE 05/20/2016	SIGNATURE OF SURVEYOR 34983	DATE 05/03/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/18/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO			

 EVENT ID: O5J112

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00581 Y1	A. Building B. Wing Y2	5/3/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 30601	Correction	ID Prefix 30745	Correction	ID Prefix 30830	Correction
Reg. # MN St. Statute 144.56 Subp. 2c	Completed	Reg. # MN Rule 4655.4150 Subp. 2	Completed	Reg. # MN Rule 4655.4700 Subp. 1	Completed
LSC	05/03/2016	LSC	04/25/2016	LSC	04/25/2016
ID Prefix 31235	Correction	ID Prefix 31320	Correction	ID Prefix 31825	Correction
Reg. # MN Rule 4655.8520 D	Completed	Reg. # MN Rule 4655.8670 Subp. 4	Completed	Reg. # MN Rule 144.651 Subd. 9	Completed
LSC	04/25/2016	LSC	04/25/2016	LSC	04/25/2016
ID Prefix 31855	Correction	ID Prefix 31942	Correction	ID Prefix	Correction
Reg. # MN Rule 144.651 Subd. 15	Completed	Reg. # MN Rule 144A.10 Subd. 8b	Completed	Reg. #	Completed
LSC	04/25/2016	LSC	05/03/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TA/mm	05/20/16	34983	05/03/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/18/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O5J1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00581

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E355**
2.STATE VENDOR OR MEDICAID NO.
(L2) **780743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AFTENRO HOME**
(L4) **510 WEST COLLEGE STREET**
(L5) **DULUTH, MN** (L6) **55811**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/18/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **54** (L18)
13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

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): **YES** (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 04/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 05/03/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 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
11/12/1981
(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)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O5J1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00581

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E355**
2. STATE VENDOR OR MEDICAID NO.
(L2) **780743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AFTENRO HOME**
(L4) **510 WEST COLLEGE STREET**
(L5) **DULUTH, MN** (L6) **55811**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/18/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds **54** (L18)
13. Total Certified Beds **54** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
__ 1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

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): **YES** (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date:
Kimberly Settergren, HFE NEII 04/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist 05/03/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
__ 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
11/12/1981
(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)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
5/4/16 (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

020499

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 4, 2016

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

RE: Project Number SE355026

Dear Ms. Cline:

On March 18, 2016, 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: pam.kerssen@state.mn.us
Phone: (218) 308-2129
Fax: (218) 308-2122

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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 April 27, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 27, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

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.

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 June 18, 2016 (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 September 18, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 electronic 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(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 electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate	F 159		4/25/16

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

Electronically Signed | 04/15/2016

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

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F 159	Continued From page 1 accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident personal fund accounts over fifty dollars were maintained in an interest bearing account for 19 of 30 (R47, R27, R14, R10, R16, R31, R8, R39, R4, R46, R38, R7, R34, R26, R6, R29, R5, R24, R23) residents. Findings include: R47 had a balance of $80.00 on 3/16/16, in her personal funds account. R27 had a balance of $147.94 on 3/16/16, in her	F 159	All Resident Trust Accounts have been reviewed. All Resident funds were transferred to an interest bearing account by 3/18/16 All future Resident funds will be deposited in interest account. The Resident Trust Account system in PCC was updated to process interest deposits. Business Office manager will monitor and complete an interest deposit to the Residents at the end of every month and a report given to Executive	

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F 159	Continued From page 2 personal funds account. R14 had a balance of $181.51 on 3/16/16,in his personal funds account. R10 had a balance of $138.06 on 3/16/16, in her personal funds account. R16 had a balance of $85.00 on 3/16/16, in her personal funds account. R31 had a balance of $73.00 on 3/16/16, in her personal funds account. R8 had a balance of $584.56 on 3/16/16, in her personal funds account. R39 had a balance of $60.74 on 3/16/16, in her personal funds account. R4 had a balance of $111.25 on 3/16/16, in her personal funds account. R46 had a balance of $292.20 on 3/16/16, in her personal funds account. R38 had a balance of $153.45 on 3/16/16, in her personal funds account. R7 had a balance of $116.00 on 3/16/16, in her personal funds account. R34 had a balance of $88.86 on 3/16/16, in her personal funds account. R26 had a balance of $334.37 on 3/16/16, in her personal funds account. R6 had a balance of $137.50 on 3/16/16, in her	F 159	Director/Administrator for review and verification of interest accruals. A Resident Trust Account Policy and Procedure are being finalized. A quarterly report will be made to the QAA Committee.	

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F 159	Continued From page 3 personal funds account. R29 had a balance of $128.56 on 3/16/16, in her personal funds account. R5 had a balance of $428.00 on 3/16/16, in her personal funds account. R24 had a balance of $469.25 on 3/16/16, in her personal funds account. R23 had a balance of $96.00 on 3/16/16, in her personal funds account. On 3/16/16, at 2:40 p.m. the business office manager (BOM)-E was interviewed and confirmed the list of current resident personal funds was accurate. BOM-E stated the facility did not maintain the funds in an interest bearing account. A policy on resident personal funds account was requested but not provided.	F 159		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this	F 164		4/25/16

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F 164	Continued From page 4 section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain privacy during administration of an eye drop for 1 of 2 residents (R10) who were reviewed for privacy. Findings include: R10 was observed to receive eye drops while in the main dining room. R10's Admission Record dated 3/3/16, identified diagnoses that included cerebrovascular disease, peripheral vascular disease and depression. A quarterly Minimum Data Set dated 12/9/15, indicated R10 had no cognitive impairment. On 3/17/16, at 11:40 a.m. licensed practical nurse (LPN)-A approached R10 while in the main dining room (MDR) and asked R10 if she would like the	F 164	A policy is being written regarding privacy for the administration of medication drops, as well as administering accu checks, and injectables to ensure the resident□s rights to privacy is honored and respected during personal care. The nurse who administered the eye drops in the dining room was reminded of HIPPA compliance and instructed not to give eyes drops in the dining room. Staff has been re-educated regarding HIPPA compliance, and the resident□s right to privacy while receiving personal care. Reminder cards with written directions not to administer eye drops, injectables, or accu checks in the dining room have been placed on medication carts, and diabetic carts. Compliance audits are being conducted	

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F 164	Continued From page 5 eye drops in the MDR or later when she was in her room. R10 stated, "right here." Present in the MDR were several other residents including three residents at R10's table. The LPN did not ask any of the other residents in the dining room if it bothered them to see R10 receive eye drops. The LPN then administered R10's eye drops. All of the residents in the MDR were eating their lunch, including the three other residents at R10's table. On 3/17/16, at 11:55 LPN-A stated he/she usually asked the resident but not the other residents at the table or in the dining room. That was the way the LPN usually did it. On 3/17/16, at 3:15 p.m. the director of nursing (DON) stated staff should not be administering eye drops in the dining room. The staff should take the resident to the chapel outside the dining room for privacy. The facility's Instillation of Eye Drops policy revised on 10/10, directed staff to allow the resident as much privacy as possible.	F 164	on both the day and evening shift daily for one week, and then two times a week day and evening shifts for 2 weeks, and then monthly until the June 2016 QAA meeting to determine the need for ongoing audits.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		4/25/16

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F 309	Continued From page 6 Based on observation, interview and document review, the facility failed to provide sufficient relief for increased shortness of breath symptoms for 1 of 1 residents (R22). Findings include: R22's undated Admission Record identified diagnoses that included airway obstruction, congestive heart failure (CHF), shortness of breath (SOB) and pulmonary fibrosis. The quarterly Minimum Data Set (MDS) dated 12/23/15, indicated R22 was cognitively intact, on a scheduled pain management regimen and received as needed (PRN) pain medications. R22's undated care plan identified a problem with congestive heart failure (CHF) and shortness of breath (SOB). R22's undated care plan directed morphine be given as ordered as needed for dyspnea (difficulty breathing) and chest pain. On 3/14/16, at 4:09 p.m. R22 was interviewed and stated she had SOB. At 4:18 p.m. R22 was observed with labored breathing, SOB. At 5:32 p.m. R22 complained her heart was pounding, and stated she had requested morphine and said it took 20 minutes to get it, leaving her anxious. On 3/16/16, 1:21 p.m., R22 stated she has had discomfort with SOB, and she had previously requested morphine and was told she'd have to wait if she had a recent pain pill. R22 said her physician had said she may have the morphine anytime she had difficulty breathing. R22 stated the longest she's had to wait for morphine is 15-20 minutes and stated she thought the average wait was 15 minutes. R22 further stated	F 309	1.R22: The resident has agreed to, and is currently receiving hospice services for comfort care. Nursing staff have been reminded of the importance of timely medication administration and correct medication use in those with shortness of breath. Pathway Health Services (director of nursing manual 2014): Assessment of Body System guidelines have been made available to nursing staff to ensure proper monitoring of symptoms. 2.Review the pain data collection and management policy and update the policy accordingly, Initiate, review and update care plans as appropriate for new and current residents who have pain Anticipate and assess resident□s pain control needs, follow prescribed orders for pain and assess effectiveness. Determine other alternative method for pain control that can be implemented and make adjustments as indicated and ordered. 3.An education session will be scheduled for professional nursing staff about COPD and CHF resident assessment, medical and non-medical interventions for COPD and CHF symptoms, timeliness of/and treatment interventions, resident follow up, including the safe use of narcotics for shortness of breath and pain. Resources for standard of care guidelines will be included in a policy for assessment of those with COPD and CHF including guidelines for reporting to licensed providers The policy is in process	

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F 309	Continued From page 7 other interventions used for SOB have been oxygen and two tiny little pills (unable to name this medication). R22 stated she cannot take nebulizers or other respiratory treatments, because she is allergic to these medications and they made her heart race. R22 stated her SOB has gradually worsened since her admission to the facility, and she has increasing heart issues. R22's breathing was observed to be labored and she was noted to have difficulty answering questions due to SOB. At 1:25 p.m. R22 used her call light, and staff answered the call light via intercom. R22 requested morphine for SOB. At 1:58 p.m. R22 had not received morphine as requested. The surveyor informed registered nurse (RN))-D that R22 had requested morphine 38 minutes ago, and R22 stated she was uncomfortable with SOB. RN-D said she was aware, and was headed to R22's room. RN-D stated she was getting an oxygen saturation (SaO2) monitor (used to monitor blood oxygen content.) At 2:02 p.m. RN-D administered morphine to R22. At 2:10 p.m. R22 stated she felt better and her breathing was observed to be non-labored. R22 was able to answer questions without SOB. At 2:06 p.m. RN-D stated R22 was on many "heavy duty meds" including Percocet and Dilaudid (narcotic pain relievers.) The Medication Administration Record (MAR) from 3/3/16 to 3/16/16 indicated R22 received morphine twelve times for SOB or difficulty breathing with relief documented seven times. A physician's note dated 2/12/16, directed morphine 20 milligrams/milliliter (mg/ml) concentrated solution be given as 5 mg or 0.25 ml every two hours as needed for chest pain or dyspnea. There was no physician order related to	F 309	of being written and will be formalized and posted within the time period for correction (21 days) 4.Nurse manager will audit effectiveness of pain control plan for any resident on pain control management weekly for 1 month and then every 2 weeks until reviewed at the June 2016 QAA meeting to determine the need for ongoing auditing.	

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F 309	Continued From page 8 the administration of pain medications and the timing of the morphine administration. A policy on SOB/difficulty with breathing was requested but not provided.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure side rails/mobility bars were assessed to be within federal safety guidelines for 2 of 4 residents (R21, R26). In addition, the facility failed to ensure headboards were assessed to be within federal safety guidelines for 8 of 38 (R26, R47, R40, R10, R11, R24, R34, R27) residents. Findings include: R21's mobility bar had not been assessed for proper fit and safety. R21's Admission Record dated 3/3/16, indicated R21's diagnoses included osteoarthritis, transient cerebral ischemic attack (small stroke), and dementia. R21's quarterly Minimum Data Set (MDS) dated 12/29/15, indicated R21 had a severe cognitive	F 323	On 2/26/2016, Wellness Coordinator assessed (R21) bed rails for FDA criteria for side rails. At that time, the hospital had not sent PT home care documentation to Aftenro home and the Wellness Coordinator□s note of 3/4/16 did not include the side rail assessment. The bed was pushed against the wall on 3/17/16 to prevent mattress from scooting away from bed rail. Anti-skid material will be placed between the mattress and box spring to prevent the mattress from moving. An additional mobility bar will be secured on the wall side of the bed (non-transfer side) to secure alignment of mattress. Plexiglass will be applied to the back of the headboard to eliminate gaps between the slats for R21 by date certain. On 3/17/16, the headboard was removed	4/25/16

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F 323	Continued From page 9 impairment (memory loss), required limited assistance of one staff for bed mobility and extensive assistance of one staff for transfers during the assessment period, and had no falls or balance concerns. R21's care plan revised 3/4/16, indicated R21 was at risk for falls related to gait and balance problems and a right foot drop related to a stroke. The care plan indicated R21 had a low bed frame, low box spring, single mattress, and mobility bar on the bed. R21's progress notes dated 3/4/16, indicated R21's mattress had been changed from a full size mattress to a twin size mattress to better meet the resident's needs and accommodate a mobility bar purchased by the family. The progress note indicated physical therapy evaluated the single bed with a low profile frame and boxspring and determined it would be appropriate for the resident. The progress note lacked indication that the mobility bar had been assessed. R21's medical record lacked an assessment of the mobility bar. R21's initial Resident Room Safety Audit was dated 9/19/13, and had been updated on 3/4/16 to reflect the change in mattress, low bed and mobility bar. The audit did not assess the fit of the mobility bar, change in mattress or low bed. On 3/14/16, at 5:04 p.m. R21's mattress was observed to have slid away from the mobility bar, creating a large gap. Nursing assistant (NA)-A verified the gap between the mobility bar and the mattress, and stated R21 used to have a different bed.	F 323	from R26□s bed and the head of bed was pushed up against wall to eliminate the need for a headboard. Anti-skid material is between mattress and box spring. The bed has no wheels on bed frame so bed does not move on carpeting. R 47: changed to solid headboard R 34: changed to solid headboard R 40: headboard to be replaced by April 20 2016. R 10, R11, R24: Headboards will have plexiglass installed, the beds need to be stabilized to prevent shifting by April 25 2016. If beds cannot be stabilized. R 27: The vertical gap between the mattress and headboard was reduced by cutting the legs of the headboard to lower it. Plexiglass will be applied to the back of all facility owned spindle type headboards by date certain to eliminate the gaps between the slats that pose a safety hazard. Beds belonging to residents that have this safety issue will be brought to the attention of the resident and/or family member with a request to have the headboard replaced with one that would be compliant with the safety requirements or that they authorize Aftenro to apply plexiglass to that headboard at their expense. These changes to take place no later than April 25, 2016. Aftenro will use the safety risk data collection form and follow the FDA criteria for current residents who have mobility bars/side rails, new admits, and readmissions. Current residents will have	

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F 323	Continued From page 10 On 3/14/16, at 6:46 p.m. registered nurse (RN)-A measured the gap between the rail and the mattress was 5 3/4 inches when the mattress slid against the wall. RN-A verified R21 could become entrapped between the mobility bar and the mattress. RN-A further indicated the exposed edge of the box spring could be a tripping hazard for R21 when she got out of bed independently. On 3/15/16, at 11:58 a.m. the maintenance manager (MM)-A stated he relies on nursing to check the side rails and stated they should be aware of what the resident needs. MM-A thought they checked quarterly. MM-A verified the gap between R21's mattress and mobility bar was a problem. On 3/17/16, at 4:00 p.m. the director of nursing (DON) stated there was an assessment for side rails/mobility bars and it should be on the risk form. On 3/17/16 at 4:08 p.m. MM-A stated he went through all room and identified 4 residents who had beds with mattresses that had the potential for sliding over and forming a gap between the mattress and the rail. On 3/17/16, at 4:18 p.m. the wellness coordinator (WC)-F stated she did the risk assessment for the room and documented the devices on that form. WC-F stated she reviewed it quarterly, and looked at the mobility bar with the resident sitting on the bed and determined whether it was appropriate for the resident to use properly and looked at the fit for the resident. On 3/17/16, at 4:18 p.m. during an observation of the resident rooms identified as having	F 323	data collection forms completed by April 25 2016 In absence of the wellness coordinator, the nurse manager or designee will complete the safety risk data collection form. The resident room safety audit form has been updated to include guidelines for headboards. Side Rails/Mobility Bars: " New Side Rail/Mobility Bar Policy was implemented 3-16-16. " Documentation will be completed on the Safety Risk Data Collection form. Headboards on beds: " Policy will be written addressing potential entrapment areas involving headboards and mattresses and clinical guidelines for Zones 3 & 7. " Assessment of headboards will be addressed and documented on the newly revised Resident Room Safety Audit. By April 25 2016, training will be given to nursing staff, maintenance, and housekeeping regarding the clinical guidelines from the HBSW (Hospital Bed Safety Workgroup). An audit form will be initiated to monitor headboards, side rails, mattresses, to ensure compliance with recommendations and guidelines. Audits will be conducted by designated staff assigned by Wellness Coordinator and reviewed with DON. Audits will be conducted for 5 residents with any of these devices every week, times four weeks, and then 5 residents with any of these devices every other week. Audit results to be reviewed at the	

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F 323	Continued From page 11 mattresses with the potential to slide and form a gap between the mattress and mobility bar, R26's concave mattress (a light-weight thinner mattress with raised perimeters on the sides) slid easily with the potential to form a gap of greater than 4 3/4 inches. MM-A and WC-F verified the potential gap and potential for entrapment. During the observation, it was noted that because the mattress had been changed from a regular mattress to the concave mattress and the bed frame had been lowered, there was a gap of 5 inches between the mattress and the bottom rail of the headboard when the mattress was compressed with light weight applied. MM-A verified the potential of entrapment. The headboard also had spindles which were 5 1/2 inches apart. WC-F and MM-A verified the gap of greater than 4 3/4 inches and the potential for entrapment. WC-F stated she looked at the distance between the bars on the rail, but had not looked at the distance between the be spindles or the mattress and the headboard. WC-F stated she was using the Care Providers of Minnesota guideline for Using Bed Siderails in Home Care and Assisted Living Settings dated 2014, as a guideline for proper measurements. R26's face sheet dated 3/10/16, indicated R26's diagnoses included transient cerebral ischemic attack (small stroke), dementia, Parkinson's Disease, and arthritis. R26's quarterly MDS dated 2/3/16, indicated R26 had a severe cognitive impairment. R26's care plan revised 2/12/15, indicated R26 was at a high risk for falls related to cognitive impairment, poor safety awareness, gait and balance problems and diagnoses. The care plan identified the use of a concave mattress to avoid	F 323	June 2016 QAA meeting to determine need for further audits.	

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rolling off the bed and mobility bar on the left side of the bed to assist with transfers.

R26's medical record lacked assessment of the mobility bar, concave mattress or bed. R26's Resident Room Safety Audit was initially completed on 5/7/12, with an update on 8/2/13, noting the mobility bar on the left side of the bed and on 10/10/14, noting the concave mattress with a regular height box spring.

On 3/18/16, at 8:35 a.m. MM-A stated he and WC-F went through each room again and made a list of all rooms that had the headboards with spindles that were greater than 4 3/4 inches apart. MM-A stated they located headboards that meet the measurement regulations and would replace current headboards that posed a risk for residents. MM-A verified the headboards with spindles greater than 4 3/4 inches apart posed a risk for entrapment.

On 3/18/16, at 9:11 a.m. WC-F provided a list of headboards that had spindles greater than 4 3/4 inches apart. WC-F stated those headboards that are flat against the wall would not pose a high risk. WC-F identified residents whose headboards were not flat up against the wall would pose a high risk of entrapment. These headboards were to be replaced first.

Residents whose headboards had spindles greater than 4 3/4 inches apart and identified at high risk for entrapment by the facility in addition to R26 were:

-R47, whose Admission record dated 3/8/16, indicated R47's diagnoses included legal blindness. R47's quarterly MDS dated 2/24/16,

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indicated R47 was cognitively intact.

-R40, whose Admission Record dated 1/28/16, indicated R40's diagnoses included chronic obstructive pulmonary disease (respiratory disease causing breathing problems) and dizziness. R40's quarterly MDS dated 12/23/15, indicated R40 was cognitively intact.

-R10, whose Admission Record dated 3/3/16, indicated R10's diagnoses included polyarthritis. R10's quarterly MDS dated 12/2/15, indicated R10 was cognitively intact.

-R11, whose Admission Record dated 3/10/16, indicated R11's diagnoses included chronic kidney disease, anemia, osteoarthritis, chronic obstructive pulmonary disease, and history of falling. R11's quarterly MDS dated 12/9/16, indicated R11 was cognitively intact.

-R24, whose Admission Record dated 1/28/16, indicated R24 diagnoses included rheumatoid arthritis and anemia. R24's quarterly MDS dated 2/10/16, indicated R24 was cognitively intact.

-R34, whose Admission Record dated 3/3/16, indicated R34's diagnoses included a fracture of the arm. R34's quarterly MDS dated 12/30/15, indicated R34 was cognitively intact.

-R27, whose Admission Record dated 3/10/16, indicated R27's diagnoses included anemia, osteoarthritis, macular degeneration (vision impairment), and abnormalities of gait and mobility. R27's quarterly MDS dated 1/20/16, indicated R27 was cognitively intact.

On 3/18/16, at 10:48 a.m. the DON verified there

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F 323	Continued From page 14 had been no accidents involving entrapment. The DON stated MM-A and WC-F assess all mobility bars quarterly, with changes, upon admission, and as needed. The DON stated if nursing finds the mobility bars are loose, they notify MM-A and WC-F. The facility was unable to provide a policy and procedure for side rails that was in place at the start of survey on 3/14/16.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		4/25/16

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F 329	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain proper consent for psychotropic medications for 4 of 5 residents (R8, R12, R35, R3) reviewed for unnecessary medications. Findings include: R35 or her representative did not provide consent prior to the administration of antipsychotic, antidepressant and antianxiety medications. R35's Diagnosis Report dated 3/15/16, indicated R35's diagnoses included schizophrenia, depression with psychotic symptoms, dissociative identity disorder, post traumatic stress disorder (PTSD), respiratory disorder and dyspnea (difficulty breathing). The quarterly Minimum Data Set (MDS) dated 12/31/15, indicated R35 had no cognitive impairment. R35 was independent with all activities of daily living (ADL's) and received antipsychotic, antidepressant and antianxiety medications seven of seven days during the assessment period. The Physician's Orders dated 2/9/16, included orders for Abilify (antipsychotic) 10 milligrams (mg) by mouth daily for depression and anxiety. R35 started the dose of Abilify on 1/29/16. Cymbalta (antidepressant) 100 mg by mouth daily for depression. R35 started the dose of Cymbalta on 3/9/16. Buspirone (antianxiety) 15 mg by mouth three times a day for PTSD. R35 started the dose of Buspirone on 2/10/16. Ativan	F 329	1. Psychotropic consents will be obtained for all new admissions, readmissions and residents who have new doctor□s orders. 2. An audit of all resident charts who are currently on psychotropic medications for the presence of consent(s) for psychotropic medications, and they will be obtained for those residents who do not such consents on file. 3. Aftenro policies for gradual dose reduction calendar; unnecessary medications; psychopharmacological medications and sedatives hypnotics are in process of being updated to reflect current practice as well as care plan interventions for those on psychotropic medications include monitoring for drug side effects, purpose of medication, behaviors to monitor, including non-medication and medication interventions. Residents will be educated on black box□ warnings. Behavior tracking will include documentation of specific behaviors for anxiety. 4. Along with the Pharm.D, the nurse manager or DON will monitor monthly and prn for resident consent, dose reduction as indicated, monitoring side effects, completion of AIMs, drug interactions, behavior tracking, documentation of/and education. Monitoring results will be brought to the QAA Committee for review and recommendation.	

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F 329	Continued From page 16 (antianxiety) 0.5 mg by mouth four times a day as needed for dyspnea and anxiety. R35 started the dose of Ativan on 10/20/15. R3 or her representative did not provide consent prior to the administration of antipsychotic, antidepressant and antianxiety medications. R3's Diagnosis Report dated 3/15/16, indicated R3's diagnoses included depression, insomnia and chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) dated 12/16/15, indicated R3 had no cognitive impairment. R3 needed the assistance of staff with activities of daily living (ADL) and received an antidepressant medication seven of seven days during the assessment period. The Physician's Orders dated 2/9/16, included orders for Citalopram (an antidepressant) 40 milligrams (mg) by mouth daily. R3 started the dose of Citalopram on 2/10/16. Remeron (an antidepressant, may also be used for insomnia) 7.5 mg by mouth at bedtime for insomnia. R3 started the dose of Remeron on 2/10/16. Consent was not obtained from R8 prior to the administration of antidepressant and antianxiety medications.	F 329		

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F 329	Continued From page 17 R8's Diagnosis Report printed 3/15/16, indicated R8's diagnoses included generalized anxiety disorder and recurrent major depressive disorder. R8's comprehensive annual Minimum Data Set (MDS) assessment dated 12/22/15, indicated R8 was cognitively intact, and a diagnosis of anxiety and depression, and received an antidepressant and antianxiety medication. R8's physician's orders included orders for: -lorazepam (antianxiety) 0.25 milligrams (mg) by mouth twice a day. This order was dated 1/15/16. -doxepin (antidepressant) 50 mg by mouth at bedtime. This order was dated 2/19/16. Consent was not obtained from R12 prior to the administration of antidepressant and antianxiety medications. R12's Diagnosis Report dated 3/15/16, indicated R12's diagnoses included adjustment disorder with mixed anxiety and depressed mood, pot-traumatic stress disorder, insomnia, and major depressive disorder. R12's comprehensive admission MDS dated 12/30/15, indicated R12 was cognitively intact and had received antipsychotic, antianxiety, and antidepressant medications during the assessment period. R12's current physician's orders, included orders for: -sertraline (antidepressant) 50 mg by mouth daily. This order started 12/10/15. -olanzapine 2.5 mg by mouth in the evening. This order started 12/10/15.	F 329		

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F 329	Continued From page 18 On 3/17/16, at 3:25 p.m. the director of nursing (DON) verified they do not obtain consents for psychotropic medications (mood and behavior altering medications) and stated the facility did not have a policy and procedure for obtaining consents. On 3/18/16, at 12:01 p.m. the consultant pharmacist stated the facility had been doing consents for psychotropic medications previously and verified the facility should inform the resident or family about the risks and benefits for psychotropic medications. The consultant pharmacist verified she had not checked for consents.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal	F 334		4/25/16

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F 334	Continued From page 19 representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or	F 334		

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	24E355	A. BUILDING _____ B. WING _____	03/18/2016

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F 334	Continued From page 20 the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the influenza vaccination and pneumococcal vaccination were done for 1 of 5 residents (R25) reviewed for vaccinations. Findings include: R25's undated Admission Record identified an admission date of 2/23/26. R25's medical record lacked documentation of a history of the administration of the influenza and pneumococcal vaccinations. On 3/17/16 at 2:30 p.m. the director of nursing (DON) stated the vaccinations had not been administered to R25. The facility's resident Influenza Vaccination policy dated 2/23/15, directed if a resident has not received the influenza vaccination during the influenza season (October through March) the resident and/or resident's legal representative will be educated on the benefits and potential side effects of the immunization and would be offered the influenza vaccination. The facility's Pneumococcal Vaccination policy dated 2/23/15, directed if the resident's pneumococcal vaccination was not up to date, the resident and/or resident's legal representative will be educated on the benefits and potential side	F 334	1. The HIC has re-reviewed electronic and paper chart for documentation of influenza and pneumococcal vaccinations for R25. The HIC obtained a password from the MDH to track vaccinations of new and current Aftenro residents. There was no influenza vaccination documentation available for R25. 2. Currently R25 is receiving rehab services at another facility. We will review the facility provided medical record for immunizations when the resident is re-admitted to Aftenro. 3. New resident□s vaccination history will be reviewed upon admission and the provider will be contacted for additional records as needed. The MDH tracking system will also be used as necessary. 4. If a resident refuses vaccination of any kind, a refusal of medical treatment consent form will be signed by the resident or the responsible party. Aftenro standing orders will be updated to reflect this action. 5. An audit of all current resident records will be completed to determine if any other residents and missing documentation of influenza and pneumococcal vaccinations. Where none are found the MDH website will be used to determine vaccination status.	

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F 334	Continued From page 21 effects of the immunization and would be offered the pneumococcal vaccination.	F 334	6. The policies titles influenza vaccination and pneumococcal vaccination are being reviewed and updated as needed. 7. The HIC will conduct audits to monitor compliance every 2 weeks and turn them into the DON for review. An audit summary will be presented at the 2016 QAA meeting to determine the need for further auditing.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION 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 unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. 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: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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.	F 356		4/25/16

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F 356	Continued From page 22 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. This REQUIREMENT is not met as evidenced by: Based on observation,interview, and document review, the facility failed to post the required information on the nurse staff posting on two of five days. This had the potential to affect all 38 residents residing in the facility. Findings include: On 03/18/16, the Report of Nursing Staff Directly Responsible for Resident care forms were reviewed for 3/14/16, through 3/18/16. On 3/17/16 and 3/18/16, the nurse staff posting was not posted in the facility. On 3/18/16, at 3:05 p.m. the director of nursing (DON) confirmed the nursing staff postings were not posted on 3/17/16, or 3/18/16. The Posted Nursing Staff policy dated 2/19/15, directed staff to post each a.m. the facility name, current date, the scheduled nursing staff hours for each shift for registered nurses, licensed practical nurses and nursing assistants, total actual hours worked and total hours worked.	F 356	The Health Information Coordinator is posting, in addition to the daily posting, an additional 3 days of staffing information so postings will always be present and current. The charge nurse adjusts the staffing hours as indicated every shift. The current policy has been revised and Nursing staff will be educated on how to complete the posting form. Audits will be conducted by the nurse manager or DON weekly for 4 weeks and then every 2 weeks until review at the June 2016 QAA meeting to determine the need for ongoing audits. Record of posting audits will continue to be completed for QAA.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		4/25/16

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F 371	Continued From page 23 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to store, prepare and distribute food in a safe and sanitary manner. This practice had the potential to affect all 38 residents who received food items from the facility kitchen. Findings include: During a kitchen tour on 3/14/16, at 11:35 a.m., with the Dietary Manager (DM) the following was observed and confirmed by DM: -A pipe above the facility stove had dust on it and a cobweb from the pipe to the hood. The hood itself was clean. The DM stated that the hood is cleaned monthly by maintenance. -The walk in freezer had meat, in a previously opened plastic bag without a date. The DM stated that the date stickers don't stick on anything frozen. She stated that they use it [frozen food that is undated] within a week for a substitute meal. In an observation on 3/17/16, at 8:42 a.m., the dust and the cobweb were still on the pipe over the stove. In an observation on 3/17/16, at 11:47 a.m., Dietary Aide (DA)-B was observed to walk from the dining room to the serving counter and,	F 371	Environmental Services will complete a thorough cleaning of the kitchen by 4/25/16 and routine cleaning to be completed per preventative maintenance plan and as needed CDM will revise routine cleaning schedule for dietary staff, train and implement Weekly audit of kitchen cleanliness will be completed by CDM or designee and audit results reported to QAA Committee quarterly Safe Food handling and Storage Policy and Procedure have been updated. All dietary staff will be trained on the revised policy and procedure by date certain by Consultant and CDM. Dietary Manager &/or assigned cook to audit all food storage M-W-F-Sat for 4 weeks, then 2 times per week on day & pm shift including a weekend shift, until QA&A Committee determines next steps. Consultant to do spot audits. All audit results to be presented to the QAA Committee to determine future audits and time tables. Review and update policy on proper food handling and serving Re-educate all dietary staff for both shifts on proper food handling and serving by Consultant and CDM.	

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F 371	Continued From page 24 without washing hands or using hand sanitizer, reached into a container of saltine crackers with bare hands, grabbed several and placed them on a resident's plate. The plate was taken to a resident. In an observation on 3/17/16, at 11:56 a.m., DA-A was observed to walk from the dining room to the serving counter and, without washing hands or using hand sanitizer, reached into a container of saltine crackers with bare hands, grabbed several and placed them on a resident's plate. The plate was taken to a resident. DA-B and DA-A both confirmed they used bare hands to place saltine crackers on residents' plates. DA-B and DA-A separately stated they usually use tongs, but did not at the time they were observed. In an observation on 3/18/16, at 8:38 a.m., the following items were in the facility freezer without dates: chicken wings, ravioli, potatoes, turkey and chicken breasts. The DM provided 2013 Becky Dorner & Associates Policies when facility policies were requested: -The policy on Bare Hand Contact with Food directed staff to use clean barriers, such as single-use gloves, when handling ready-to-eat foods. -The facility policy titled, Employee Sanitary Practices directed staff to use utensils to handle food. -The facility policy, Food Safety and Sanitation read foods are protected from contamination including dust.	F 371	Manager and/or assigned Cook will audit food service handling daily each shift and document findings. Consultant to do spot audits. Documentation of audits will be shared at the QAA meeting for input to determine future audits and time tables. All staff will attend and demonstrate proper hand washing and proper use of serving utensils to Consultant or CDM.	

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F 428	Continued From page 25	F 428		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consultant pharmacist failed to ensure informed consent for psychotropic medications for 4 of 5 residents (R8, R12, R35, R3) reviewed for unnecessary medications. Findings include: R35 or her representative did not provide consent prior to the administration of antipsychotic, antidepressant and antianxiety medications. R35's Diagnosis Report dated 3/15/16, indicated R35's diagnoses included schizophrenia, depression with psychotic symptoms, dissociative identity disorder, post traumatic stress disorder (PTSD), respiratory disorder and dyspnea (difficulty breathing). The quarterly Minimum Data Set (MDS) dated 12/31/15, indicated R35 had no cognitive impairment. R35 was independent with all	F 428	1. Psychotropic consents will be obtained for all new admissions, readmissions and residents who have new doctor□s orders. 2. An audit of all resident charts who are currently on psychotropic medications for the presence of consent(s) for psychotropic medications, and they will be obtained for those residents who do not such consents on file. 3. Aftenro policies for gradual dose reduction calendar; unnecessary medications; psychopharmacological medications and sedatives hypnotics are in process of being updated to reflect current practice as well as care plan interventions for those on psychotropics include monitoring for drug side effects, purpose of medication, behaviors to monitor, including non-medication and medication interventions. Residents will be educated on black box□ warnings. Behavior tracking will include	4/25/16

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F 428	Continued From page 26 activities of daily living (ADL) and received antipsychotic, antidepressant and antianxiety medications seven of seven days during the assessment period. The Physician's Orders dated 2/9/16, included orders for Abilify (an antipsychotic medication) 10 milligrams (mg) by mouth daily for depression and anxiety. R35 started the dose of Abilify on 1/29/16. Cymbalta (an antidepressant) 100 mg by mouth daily for depression. R35 started the dose of Cymbalta on 3/9/16. Buspirone (an antianxiety agent) 15 mg by mouth three times a day for PTSD. R35 started the dose of Buspirone on 2/10/16. Ativan (an antianxiety medication) 0.5 mg by mouth four times a day as needed for dyspnea and anxiety. R35 started the dose of Ativan on 10/20/15. Consultant Pharmacist Reviews from 9/15, through 2/16, lacked recommendations to obtain consent for psychotropic medications. R3 or her representative did not provide consent prior to the administration of antipsychotic, antidepressant and antianxiety medications. R3's Diagnosis Report dated 3/15/16, indicated R3's diagnoses included depression, insomnia and chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) dated 12/16/15, indicated R3 had no cognitive impairment. R3 needed the assistance of staff with activities of daily living (ADL) and received an antidepressant medication seven of seven days during the assessment period. The Physician's Orders dated 2/9/16, included	F 428	documentation of specific behaviors for anxiety. 4. Along with the Pharm.D, the nurse manager or DON will monitor monthly and prn for resident consent, dose reduction as indicated, monitoring side effects, completion of AIMs, drug interactions, behavior tracking, documentation of/and education. Monitoring results will be brought to the QAA Committee for review and recommendation.	

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F 428	Continued From page 27 orders for Citalopram (an antidepressant) 40 milligrams (mg) by mouth daily. R3 started the dose of Citalopram on 2/10/16. Remeron (an antidepressant, may also be used for insomnia) 7.5 mg by mouth at bedtime for insomnia. R3 started the dose of Remeron on 2/10/16. Consultant Pharmacist Reviews from 12/15, through 2/16, lacked recommendations to obtain consent for psychotropic medications. R8 did not provide consent prior to the administration of antidepressant and antianxiety medications. R8's Diagnosis Report printed 3/15/16, indicated R8's diagnoses included generalized anxiety disorder and recurrent major depressive disorder. R8's comprehensive annual Minimum Data Set (MDS) assessment dated 12/22/15, indicated R8 was cognitively intact, and a diagnosis of anxiety and depression, and received an antidepressant and antianxiety medication. R8's physician's orders included orders for: -lorazepam (antianxiety) 0.25 milligrams (mg) by mouth twice a day. This order was dated 1/15/16. -doxepin (antidepressant) 50 mg by mouth at bedtime. This order was dated 2/19/16. There was no consultant pharmacist documentation identifying a concern related to no	F 428		

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F 428	Continued From page 28 consents for the psychotropic medications. R12 did not provide consent prior to the administration of antidepressant and antianxiety medications. R12's Diagnosis Report dated 3/15/16, indicated R12's diagnoses included adjustment disorder with mixed anxiety and depressed mood, pot-traumatic stress disorder, insomnia, and major depressive disorder. R12's comprehensive admission MDS dated 12/30/15, indicated R12 was cognitively intact and had received antipsychotic, antianxiety, and antidepressant medications during the assessment period. R12's current physician's orders, included orders for: -sertraline (antidepressant) 50 mg by mouth daily. This order started 12/10/15. -olanzapine 2.5 mg by mouth in the evening. This order started 12/10/15. There was no consultant pharmacist documentation identifying a concern related to no consents for the psychotropic medications. On 3/17/16, at 3:25 p.m. the director of nursing (DON) verified they do not obtain consents for psychotropic medications (mood and behavior altering medications) and stated the facility did not have a policy and procedure for obtaining consents. On 3/18/16, at 12:01 p.m. the consultant pharmacist stated the facility had been doing consents for psychotropic medications previously	F 428		

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F 428	Continued From page 29 and verified the facility should inform the resident or family about the risks and benefits for psychotropic medications. The consultant pharmacist verified she had not checked for consents.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		4/25/16

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F 441	Continued From page 30 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain an ongoing, comprehensive infection control surveillance program related to the tracking and trending of infections. This had the potential to effect all 38 residents who resided in the facility. Findings include: On 3/18/16, at 11:07 a.m. the director of nursing (DON) confirmed she was responsible for the infection control program. The facility's Line Listing of Resident Infections (infection control log) (1/16 - 3/16) were reviewed with the DON, and contained the following information: Month and year Total census and census by floor Resident name and room number Signs and symptoms with dates Lab/X-ray Type of infection Antibiotic with dates Resolved with dates The infection control log lacked identified organisms and method of infection acquisition. On 3/18/16, at 11:07 a.m. the DON confirmed that the facility did not list identified organisms nor	F 441	1. Aftenro employees a part time infection control RN, who has oversite over our infection control program and policies and procedures. As of May 2015, Anne Phinney, RN is the infection control agent. The role of the Aftenro infection control RN is to investigate, control, and prevent the spread of infection in the facility. On 9/22/2015, a mandatory staff in service was presented; Guidance for the selection and use of personal protective equipment in healthcare settings. On Oct 27 2015, a mandatory staff in-service was presented Infection control, influenza, TB, blood borne pathogens, c-diff, handwashing and linen handling policy. The session included a procedure check list and employee demonstration of hand washing and linen handling. 2. Currently, we are using an updated infection tracking form including listing the infectious organism. The form will be updated to include how the infection was acquired/source of the infection and the Infection Control RN will monitor the information and extrapolate data as needed and put in place needed responses with the DON as back-up.	

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F 441	Continued From page 31 method of infection acquisition. An infection tracking policy was requested but not received.	F 441	3. Staff will be mandated to watch the previously recorded infection control presentation again by April 25 2016. Infection control, influenza, TB, blood borne pathogens, c-diff, handwashing and linen handling policy. 4. The Infection control tracking log will be audited on a monthly basis by the DON, and results will be presented at the next QAA meeting for review and analysis.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: The facility failed to ensure that monthly consultant pharmacist recommendations were readily available in the resident record for 1 of 5 residents (R4) reviewed for unnecessary medications. Findings include:	F 514	1-2. Electronic copies of the pharmacist report for 2/16, 5/15, 6/15, 8/15, and 9/15 are available from Thrifty White and have been emailed to the DON. Paper copies of the reports have been placed in the 2015 and 2016 binders. The pharmacist confirmed with the state that no order was	4/25/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(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 514	Continued From page 32 R4's annual Minimum Data Set (MDS) dated 12/30/15, included diagnoses of diabetes mellitus, atrial fibrillation, hypertension, and dementia. The MDS indicated R4 had been taking insulin, an anticoagulant, and a diuretic. On 3/17/16, at approximately 11:00 a.m. an initial review of R4's medical record revealed no consultant pharmacist reviews in R4's medical record. The following information was found in the separate consultant pharmacist book placed at the nursing station: -October 2015: irregularities, see report. The Consultant Pharmacist Medication Review was in the pharmacist book at the nursing station. -December 2015: irregularities, see report. Report not found. -January 2016: irregularities, see report. Report not found. -February 2016: irregularities, see report. Report not found. -March 2016-no irregularities. No documentation was found from 9/15 back to the previous survey exit date of 1/30/15. Upon request, the Director of Nursing (DON) found additional information which was provided between 3/17/16, at 3:42 p.m. until the survey exit on 3/18/16, at 2:30 p.m. Specifically, the following documentation was provided regarding R4: -2/16 nursing report. -1/16 nursing report. -12/16 nursing report. -11/15 Consultant Pharmacist Medication Review found under a different tab in R4's medical record. -10/15 nursing report for R4 and the Consultant	F 514	needed for R4 and as a result of the pharmacist□s review, the consultant pharmacist review can go into the pharmacy binder at the nurse□s desk. All residents□ pharmacy reviews will be kept in the pharmacy binder at the desk. If there is an order needed as a result of the pharmacist□s review, the document is placed in the resident□s medical record by the PharmD and Aftenro receives a report from Thrifty White each month detailing the reports. 3. Thrifty white policies and procedures will be reviewed by Thrifty White. Aftenro policy and procedure will be written and reviewed with affected nursing staff. 4. The HIC will audit the pharmacy binder each month to ensure that all necessary documents have been placed in the pharmacy binder and orders are in the medical record as indicated. Results of the monthly audit will be brought to the quarterly QAA for review and determination of need for continued or altered audit process.	

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F 514	Continued From page 33 Pharmacist Medication Review for the physician. -7/15 summary report indicating no irregularities. -4/15 nursing report for R4 be sure to document when given digoxin on MAR per order. -3/15 summary report indicating no irregularities. Although monthly documentation was requested, no consultant pharmacist documentation was provided for 2/15, 5/15, 6/15, 8/15, or 9/15. In an interview on 3/17/16 at 3:42 p.m., the DON stated the consultant pharmacist reviews were not in R4's medical record. The DON stated that the 2016 Consultant Pharmacist Medication Review sheets were in the pharmacy book at the nursing station. In an interview on 3/18/16, at 9:19 a.m., the DON stated there were two binders for consultant pharmacist reviews: one at the nursing station for 2016 and another in a locked room with 2015 information. The DON also stated that the reviews were not in order in those binders and it took a while to find R4's information. The DON again confirmed that the reviews were not in R4's medical record. In an interview on 3/18/16, at 11:49, the Consultant Pharmacist stated if there was no order needed as a result of the pharmacist review, then the Consultant Pharmacist Review can go in the pharmacy book at the nursing station and not in the medical record.	F 514		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Aftenro Home was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/14/2016

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

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K 000	Continued From page 1 By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency 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. This building is fully sprinklered throughout. The facility has a fire alarm system with smoke	K 000		

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K 000	Continued From page 2 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 38 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.2.1 and 7.2.1.5.1 and the 2007 MN State Fire Code, Appendix I. This deficient practice could affect 38 of 38 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM to 4:00 PM on 03/15/2016, observation revealed that the doors to exit stairwells have a coded keypad used to unlock the doors to the stairwells, but did not have a the code or instructions on how to open the door posted at the location of the keypad. This deficient condition was verified by the Maintenance Supervisor.	K 038	Instruction for codes to the keypads for all magnetically locked doors will be posted by each affected door. These doors currently have a delayed egress feature built in to them with posted instruction, also the doors currently unlock with the actuation of the fire alarm system. Staff training will be done on or before this issue on 4-25-16.	4/25/16
K 048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD	K 048		5/13/16

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K 048	Continued From page 3 There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current fire evacuation policy in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.2.2. This deficient practice could affect 38 of 38 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM to 4:00 PM on 03/15/2016, during the documentation review it was revealed that the facility's Fire Emergency Evacuation Plan did not address all eight element outlined in the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.7.2.2. The elements that were not provided in the plan presented at the time of the inspection were, transmission of the fire alarm to the fire department, evacuation of the smoke compartment, and the preparation of the floors and building for evacuation. This deficient condition was verified by the Maintenance Supervisor.	K 048	A fire evacuation plan is being drafted at this time that will address all the elements of this code requirement. Aftenro staff will be trained on this plan and training on the plan will be incorporated into the New Employee orientation program and the annual fire safety review.	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and	K 050		4/29/16

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K 050	Continued From page 4 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.1.2; during the last 12-month period. This deficient practice could affect 38 of 38 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM to 4:00 PM on 03/15/2016, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility had the following deficient conditions affecting the facility's fire drills: 1. The facility conducted 4 of 12 fire drills on the 29th day of the month and 3 of 12 fire drills on the 30th day of the month and failed to vary the dates of the fire drills. 2. The facility could not provide documentation for 1 Overnight shift fire drill in the 1st calendar quarter. 3. The facility conducted 3 fire drills in the 9 PM hour and 2 in the 11 PM hour and and failed to vary the times of the fire drills.	K 050	A detailed schedule has be drafted and will be implemented and maintained so as to have the required number of fire drills occur at random times and dates and meet NFPA standards for this code requirement. A quarterly report will be made to the QAA Committee to verify compliance.	

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K 050	Continued From page 5 This deficient condition was verified by the Maintenance Supervisor.	K 050		
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and staff interview it was revealed that the facility failed to correctly install manually actuated alarm-initiating devices throughout the facility in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.3.4.2 and 9.6.2, NFPA 72 National Fire Alarm Code (99), Sections 2-8.1 and 2-8.2, and the MN State Fire Code 907.3.3.1. This deficient condition could adversely affect the ability to initiate the fire alarm system and delay emergency actions, and emergency forces	K 051	An audit of the building was done on 4-7-16 to determine the location of manual pull stations and the height of these stations, ESC systems will help in determining where to add the necessary manual pull station so as to become compliment with NFPA requirements for these devices. ESC system was contacted on 4-8-16 and they will conduct a review of these stations week of 4/18/16 and provide Aftenro with a plan and	5/2/16

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K 051	Continued From page 6 notification in the event of an emergency, thus negatively affecting 38 of 38 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM to 4:00 PM on 03/15/2016, observation revealed the following deficient conditions affecting the facility's fire alarm system: 1. The manually actuated alarm-initiating device located in at the front entrance was mounted greater than 42 to 54 inch range from the floor. 2. During the facility walk through it was noted that the facility only had 2 manually actuated alarm-initiating devices and that the third floor of the facility did not contain a manually actuated alarm-initiating device at any of the exits, nurses stations, or constantly attended locations. the closest manually actuated alarm-initiating devices to the 3rd floor is located at the main nurses station located on the 2nd floor as specified. This deficient condition was verified by the Maintenance Supervisor.	K 051	implementation timeline.	
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by:	K 052		5/2/16

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K 052	Continued From page 7 Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.3.4., 9.6, as well as 1999 NFPA 72, Section 7-5.2. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 38 of 38 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM to 4:00 PM on 03/15/2016, observations revealed the the device counts listed on the 2014 and 2015 annual fire alarm test documentation did not contain device quantities and descriptions as outlined by NFPA 72 !999 edition. The device counts also did not match between both reports, at the time of the inspection the Maintenance Supervisor could not provide any documentation explaining the device count discrepancies. This deficient condition was verified by the Maintenance Supervisor.	K 052	ESC Systems will review the testing procedures for 2014 and 2015 to determine why there is a discrepancy in the device quantity count and the tested device count. This review will occur on 4/18/16.	
K 054 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the	K 054	ESC systems will review the testing procedures for 2014 and 2015 to determine why there is this discrepancy.	5/2/16

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K 054	Continued From page 8 smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), section 7-3.2.1. This deficient practice could affect 38 of 38 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM to 4:00 PM on 03/15/2016, a review of the facility's available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility's smoke detector sensitivity testing failed to test 2 smoke detectors in both 2014 and 2015. This deficient condition was verified by the Maintenance Supervisor.	K 054	The two untested heads maybe in the duct detectors and are of older style and type that wonl it generate a sensitivity test result. ECS will conduct this review on 4/18/16.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the	K 056	An audit of the building was done on 4/6 & 4/7/16 to determine the location of all sprinkler heads in the facility. Craig from	5/13/16

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K 056	Continued From page 9 Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 38 of 38 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM to 4:00 PM on 03/15/2016, observations reveled the following deficient conditions affecting the facility's fire sprinkler system: 1. There are standard and quick response fire sprinkler heads located in the living room on the 2nd floor, and in the corridor near resident room 333 and 354. 2. It was found that the fire sprinkler system gauges located at the main sprinkler riser have not been replaced or recalibrating since 2006. 3. The fire sprinkler spare head box did not contain at least 2 spares of every style and type of sprinkler heads that are located throughout the facility. This deficient condition was verified by the Maintenance Supervisor.	K 056	A.G. O'Brien will be here on the week of April 18 to assess the problem and the make a proposal as how best to remedy the situation and give us a timeline for completion. The out of date gauges will be replaced on the sprinkler system. The spare head box will be updated to include a minimum of two replacement heads of each type in the facility.	
K 064 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10.	K 064		4/15/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

(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
K 064	Continued From page 10 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to maintain portable fire extinguishers in accordance with NFPA 101-2000 edition and NFPA 10. This deficient practice could affect 38 of 38 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 AM to 4:00 PM on 03/15/2016, observations revealed that the fire extinguisher locating on the 3rd floor by room 309 was found to be blocked by a door being held on a magnetic door hold that is tied into the fire alarm system. This same fire extinguisher has also obscured from immediate view by the door. This deficient condition was verified by the Maintenance Supervisor.	K 064	The fire extinguisher that was blocked by a door has been relocated to the other side of the hallway. All other fire extinguishers are in proper locations at this time.	
K 066 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.	K 066		4/29/16