Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 8, 2021

Administrator
Aftenro Home
510 West College Street
Duluth, MN 55811

RE: CCN: 24E355
Cycle Start Date: January 19, 2021

Dear Administrator:

On January 19, 2021, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 23, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 23, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 23, 2021.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 23, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Aftenro Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 23, 2021. You will receive further information regarding this from the State agency. 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.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 19, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161   Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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	24E355	A. BUILDING ______ B. WING ______	C 01/19/2021

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

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F 000	INITIAL COMMENTS On 1/14/21, through 1/19/21, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: HE355007C with a deficiency cited at F689. The following complaint was found to be substantiated with NO deficiencies cited due to actions implemented by the facility prior to survey: HE355009C. The following complaint was found to be UNSUBSTANTIATED: HE355008C. 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 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		2/23/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 02/17/2021

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 689	Continued From page 1 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to perform a comprehensive root cause analysis which identified individualized risk factors to reduce the likelihood of subsequent falls, and failed to develop a comprehensive care plan which identified fall risk factors and/or implement resident centered interventions to reduce the risk of falls for 2 of 4 residents (R1, R4) reviewed for accidents. This resulted in actual harm for R1 who fell and suffered a head injury which required medical intervention. Findings include: R1's Admission Record printed 1/19/21, indicated R1's diagnoses included weakness, abnormalities of gait and mobility, congestive heart failure (CHF), and generalized anxiety disorder. R1's significant change Minimum Data Set (MDS) dated 6/14/20, indicated R1 had moderate cognitive impairment. R1's MDS identified she required extensive assistance with bed mobility, transfers, and toilet use. R1's MDS further identified she used a wheelchair and was frequently incontinent of bladder. No behavioral symptoms were identified. R1's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated	F 689	The facility□s Medical Director, Dr. Mark Boyce was notified of the deficiency. The DON will review POC and employee education at the next scheduled QAPI meeting to be held in March 2021. R1 expired on 7/8/20. R4□s care plan will be corrected to have identified fall risk factors and associated interventions. All resident□s that reside at Aftenro have the potential to be affected by this practice. The facility will complete a Fall Risk Assessment on all Residents. Each assessment will be reviewed by the DON, ADON, or designee. Care plans will be adjusted based on the findings of the assessment. All nurses will be educated on completing the Fall Risk Assessment after each fall. The facility□s fall policy will be updated to reflect changes. Fall paperwork will include an updated Incident Report, a Fall Huddle form, Witness Statements from each employee on duty at the time of the fall, and a Fall Risk Assessment. All	

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6/17/20, indicated R1 had delirium, restricted mobility, and urinary urgency.

R1's Falls CAA dated 6/17/20, indicated R1 received antipsychotic, antidepressant, opioid (pain), and diuretic (water pill) medication. The CAA further indicated R1 had delirium, cognitive impairment, anxiety disorder, incontinence, and cardiac dysrhythmias. R1 was referred to a hospice agency.

R1's care plan revised 7/13/20, indicated R1 had impaired cognitive function and thought processes related to dementia. R1's care plan further indicated R1 had an activity of daily living (ADL) self-care deficit related to activity intolerance, fatigue, impaired balance, and shortness of breath. R1 had the potential for urinary leakage/bladder incontinence related to diuretic use and impaired mobility. The care plan identified R1 required assistance of one staff for surface-to-surface transfers and directed staff to assist R1 with toileting, as needed, per "resident request."

R1's care plan revised on 7/13/20, indicated R1 was at risk for falls related to weakness, gait/balance problems, psychoactive drug use, and hearing problems. The care plan directed staff to perform cares, at bedtime, after Seroquel (antipsychotic medication) was administered (created 7/10/20), safety checks every two hours for functionality and placement of silent alarm (created 7/10/20), silent pressure alarm to bed and wheelchair (created 6/30/20), and increased safety checks dated (created 6/3/20).

An incident report dated 4/11/20, at 11:50 p.m. indicated R1 was found on the floor in her room.

F 689

nurses will be educated on completing the updated Incident Report, Fall Huddle Form, and Witness Statement.

The facility will complete a Falls Management Root Cause Analysis using the Balance in Action: A Root Cause and Intervention Guide during the IDT fall review. This will be included with the Incident Report. Interventions will be added to the resident□s care plan. The DON or designee will summarize all falls at the conclusion of the IDT event and document in the resident□s progress notes.

The DON, ADON, or designee will audit each resident fall paperwork packet that is completed for a total time period of 90 days. Care plans will be audited 3 per week x 1 month, then 2 per week x 1 month, then 1 per week x 1 month for a total of 90 days. Results will be reviewed at QAPI meetings.

The facility will develop a mandatory all-staff in-service packet that will be reviewed and turned in by nursing staff by February 23rd, 20201. This will include all corrected items identified in the SOD.
02/23/21

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R1 was dressed, but barefoot. R1's wheelchair was to her left side. The wheelchair backrest was towards the bathroom. R1 was half-way from the bathroom. R1 stated she was "going to get" oxygen tubing and "slipped on a blanket." No blanket was observed near R1. R1's call light was noted to be on. The facility root cause analysis (RCA) dated 4/13/20, indicated R1 had "poor safety awareness and balance." The RCA further indicated R1 walked through her room to get oxygen tubing, leaned on her wheelchair, and fell to the floor as the wheelchair breaks were unlocked. The RCA lacked indication of how long R1 waited for her call light to be answered, or if she needed to use the bathroom. New interventions included assisting R1 to bed after Seroquel administration, and applying gripper socks. The facility did not complete a fall risk assessment for R1.

An incident report dated 4/21/20, at 11:45 p.m. indicated R1 was found on the floor in her room. R1 was sitting with her back up against her bed. R1's wheelchair was pushed to the side of a table. A telephone cord was wrapped around a table. R1 stated she leaned forward to clip her toenails and slipped out of bed. The facility RCA dated 4/21/20, indicated R1 had, poor safety awareness, cognitive deficit, and poor balance. The RCA further indicated R1 slipped off her bed and was not wearing non-skid footwear. Corrective actions included "continuing plan of care." No new interventions were identified. The facility did not complete a fall risk assessment for R1.

An incident report dated 5/3/20, at 11:30 a.m. indicated R1 was found on the floor near her bed. R1 was "facedown" and her head was at the base

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F 689	Continued From page 4 of a bedside table. R1's wheelchair was to the left of her. R1 stated she was sitting on her bed and the "next thing I knew I was on the floor." R1 had a laceration, to the top of her head, which measured 4 centimeters (cm.). Additionally, R1 had a 5 cm. contusion (bruise) to her forehead. The facility RCA dated 5/4/20, indicated R1 was sent to the emergency department and it was noted she had an elevated digoxin (cardiac medication) level. New interventions included daily digoxin toxicity monitoring. The facility did not complete a fall risk assessment for R1. A progress note dated 5/17/20, at 12:11 p.m. indicated R1 believed an individual across the hall was attempting to sleep in her bed. The room across the hall was unoccupied. R1's representative expressed concern regarding Trazadone (antidepressant) medication R1 was recently ordered. R1 was scheduled for virtual rounds on 5/18/20. An incident report dated 5/31/20, at 6:45 a.m. indicated R1 was found on the floor in her room. R1's left arm was near the front of the toilet and she was halfway in the bathroom. R1 stated she was attempting to pull up her pants after using the bathroom. R1's oxygen tubing was found on the floor, but not near her. The facility RCA dated 6/2/20, indicated R1 had weakness, decreased safety awareness, visual limitations, heart conditions, chronic respiratory failure, and cognitive impairment. The RCA further indicated R1 toileted herself and fell trying to pull her pants up. R1 was not wearing non-skid footwear. New interventions included "increased" safety checks and "long-term" plan to move R1 to the second floor near the nurses' station. The facility did not complete an assessment of R1's toileting needs.	F 689		

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F 689	Continued From page 5	F 689		

The facility did not complete a fall risk assessment for R1.

An incident report dated 6/4/20, at 12:00 p.m. indicated R1 was found sitting in front of the toilet in her room. R1's wheelchair was near her bed. R1's pants were around her knees. R1 stated she was going to her wheelchair from the toilet. R1 was reminded to call for help when pulling up her pants. The facility RCA dated 6/5/20, indicated R1 had weakness, decreased safety awareness, cognitive impairment, visual limitations, heart conditions, chronic respiratory failure, and history of falls. The RCA further indicated R1 toileted herself independently and fell while in the bathroom. New interventions included a hospice referral for care and medication management. The facility long-term plan remained moving R1 to the second floor near the nurses' station. The facility was to continue increased safety checks. The facility did not complete an assessment of R1's toileting needs. The facility did not complete a fall risk assessment for R1.

A progress note dated 6/5/20, at 11:59 a.m. indicated R1's representative contacted a hospice agency. The progress note further indicated R1 would be screened for hospice due to failing health related to "cardiac issues, cognitive decline, wt [weight] changes, and falls."

An incident report dated 6/6/20, at 11:30 p.m. indicated R1 was found sitting on the floor, and was midway between the bathroom and her bed. R1 was dressed and a wheelchair was beside her. The wheelchair breaks were unlocked and R1 was incontinent of urine. Urine was also noted in R1's toilet. R1 was unable to explain

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F 689	Continued From page 6 what had happened. R1's room had "no clutter on floor" and R1 did not have her oxygen on. R1 was reminded to call for help. The facility RCA dated 6/9/20, indicated R1 had weakness, decreased safety awareness, cognitive impairment, visual limitations, heart conditions, history of falls, and chronic respiratory failure. The RCA further indicated R1 tried to sit on the edge of her bed and the bed mattress had a "dip" in it. Additionally, it was noted R1 was admitted to hospice the previous week and R1's room was very "cluttered." New interventions included a room cleaning, R1's mattress was turned, and a room change. The facility did not complete an assessment of R1's toileting needs. The facility did not complete a fall risk assessment for R1. An incident report dated 6/23/20, at 7:15 a.m. indicated R1 was found laying under her bedside table. R1's wheelchair was near a closet. R1 stated she was picking dandelions. The facility RCA dated 6/24/20, indicated R1 had poor safety awareness, poor balance, weakness, fatigue, recent medication changes, cognitive impairment, was barefoot. The RCA further indicated R1 had end-of-life restlessness and impulsivity. New interventions included a silent pressure alarm to R1's bed and wheelchair. The facility did not complete a fall risk assessment for R1. An incident report dated 6/23/20, at 9:20 a.m. indicated R1 was found sitting in front of her wheelchair near a television. The facility RCA dated 6/24/20, indicated R1 had poor safety awareness, poor balance, weakness, fatigue, and recent hospice admission. The RCA further indicated R1 had recent medication changes done by hospice, due to a decline in condition. Additionally, R1 had end-of-life restlessness and	F 689		

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agitation. New interventions included adding a silent pressure alarm to R1's bed and wheelchair. Additionally, the facility indicated they would consult with hospice regarding medication changes. The facility did not complete a fall risk assessment for R1.

A progress note dated 7/5/20, at 11:02 a.m. indicated R1 was found on the floor. R1 was seated "opposite" of her chair and was holding her head. R1's wheelchair was near her. R1 was sent to the emergency department.

An incident report dated 7/5/20, at 10:25 a.m. indicated R1 was found on the floor and was bleeding from the left side of her head. R1 was sitting opposite of her chair. R1 was noted to have a 2-inch (in.) laceration to the side of her head. R1 was sent to the hospital for treatment. The facility RCA dated 7/5/20, indicated R1 had poor safety awareness, poor balance, altered mental status, and had declining health. The RCA further indicated the facility reached out to the pharmacist and hospice for guidance and medications to reduce anxiety and wandering. Additionally, the incident report indicated nursing assistants (NAs) were to be educated prior to their next shift on silent pressure alarm function. A "second" silent pressure alarm was installed on R1's wheelchair. The facility did not complete a fall risk assessment for R1.

A progress note dated 7/5/20, at 5:20 p.m. indicated R1 returned from the hospital. R1 was "confused and refusing cares." A new silent pressure alarm was placed on R1's wheelchair. R1 had a laceration, to her head, and staples were in-place. R1 was also noted to have bruises on her left shoulder and left hip. Education was

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	24E355	A. BUILDING ______ B. WING ______	C 01/19/2021

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

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provided to NAs on the new silent pressure alarm and expected response. Two-hour safety checks, to ensure silent pressure alarm function, were initiated.

An investigation summary dated 7/5/20, indicated R1 was noted to be a "historically poor decision maker" and had an anoxic (lack of oxygen) brain injury related to coronary bypass surgery. On 7/5/20, at 8:30 a.m. R1's bed silent pressure alarm sounded. R1 was cleaned up, dressed, her bed was made, and the silent pressure alarm control box was placed on R1's bedside stand. R1 was seated, in bed, and her breakfast was placed in front of her. Staff left R1's room at approximately 8:45 a.m. R1's status from 8:45 a.m. to 10:15 a.m. was uncertain. At 10:15 a.m. staff walked past R1's room and R1 was found sitting on the floor, near the room entry, and was holding her head. R1 was unable to state what she was doing. R1's silent pressure alarm did not sound. R1 had a laceration to the back-left side of her head, was transferred to the emergency department, and had 16 staples placed to repair the laceration. The investigation indicated it was undetermined if R1's silent pressure alarm was unplugged or malfunctioned. The silent alarm was tested, and it was functional. The facility did not complete a fall risk assessment for R1.

An emergency department physician note signed 7/10/20, at 10:25 a.m. for the ED visit on 7/5/20, indicated R1 had an unwitnessed fall and was impulsive. R1 was noted to "get up without ringing staff." R1 had a large left scalp laceration which was stapled. R1 was noted to have a progressive decline, with minimal intake, and had been sleepy.

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A progress note dated 7/6/20, at 5:19 a.m. indicated R1 attempted to crawl out of bed at 11:30 p.m. R1 complained of head pain, was restless, agitated, and aggressive. R1 received Ativan and morphine at 11:50 p.m. R1 went to sleep. At 4:45 a.m., R1 woke up and stated, "ouch, ouch." R1 was again attempting to crawl out of bed. Morphine was administered and R1 slept since 5:15 a.m.

A progress note dated 7/6/20, at 10:36 a.m. indicated hospice was updated of R1's fall. A medication review was requested, and hospice indicated a nurse would evaluate R1 today. Additionally, hospice ordered a different wheelchair for R1.

A progress note dated 7/6/20, at 3:47 p.m. indicated R1 slept most of the shift. R1 was also noted to become restless and Ativan was administered. R1 "was not awake enough" to administer oral scheduled medications.

A progress note dated 7/7/20, at 2:36 a.m. indicated R1 complained of pain with repositioning. R1 stated "ouch, ouch" and grabbed for her hips and legs. R1 had a "distant" look to her face and was unable to focus. R1's color was dusky.

A progress note dated 7/7/20, at 3:49 p.m. indicated R1 was having apneic (period of not breathing) episodes lasting 20-30 seconds. Hospice was notified.

A progress note dated 7/8/20, at 4:28 p.m. indicated R1 died at 11:31 a.m.

On 1/19/21, at 10:01 a.m. an interview was

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F 689	Continued From page 10 conducted with NA-A. NA-A stated from the start, R1's cognition was "skewed" and R1 hallucinated a lot. NA-A stated R1 would use her call light to request assistance, however, it was "hit or miss." NA-A stated R1 was "notorious for doing her own thing." NA-A stated R1 was able to self-propel her wheelchair, however, long distances were difficult for her. NA-A stated R1 was historically independent with toileting, however, R1 required assistance toileting around the time R1 was admitted to hospice. NA-A stated R1 needed help pulling her pants up and performing perineal care. NA-A stated she did not remember if R1 was on a toileting schedule and stated she "probably was." NA-A stated R1's fall interventions included frequent checks, a silent pressure alarm, and R1 was moved closer to the second-floor nurses' station. NA-A stated she worked on 7/5/20, and attended to R1 when she fell and hit her head. NA-A stated she heard R1 yell for help and she responded to R1's room. NA-A stated R1 was on the floor, near her wheelchair, and R1's head was bleeding. NA-A stated the silent pressure alarm was located on R1's bed. NA-A stated there was not a silent pressure alarm on R1's wheelchair. NA-A stated R1's silent pressure alarm did not alert staff R1 had gotten up. NA-A stated she asked another staff-person for help, left the room, and found a nurse. NA-A stated a nurse assessed R1, called 911, and R1 was transferred to the hospital. NA-A stated NA-C got R1 ready in the morning. NA-A stated NA-C told her R1 was seated on the bed, with a bedside table in front of R1, when she left the room. NA-A stated she did check R1's silent pressure alarm and it "was working." NA-A stated she did not know why R1's silent pressure alarm did not alert staff R1 had gotten up.	F 689		

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F 689	Continued From page 11 On 1/19/21, at 10:21 a.m. an interview was conducted with trained medication assistant (TMA)-A. TMA-A stated R1's cognition was "totally gone," and had progressively worsened long before R1 had died. TMA-A stated R1 received hospice services and started to decline in April or May. TMA-A stated it was "impossible" to administer R1's medications. TMA-A stated R1 was terminally ill and did not understand what was being said. TMA-A stated towards the end of R1's life she would use the call light, however, sometimes she forgot she had it. TMA-A stated, at times, R1 would use her call light and informed staff there was a man in her closet. TMA-A stated R1 was unable to verbalize what she needed. TMA-A stated R1 required the assistance of one staff, with a gait belt, for transfers and toileting. TMA-A stated she did not recall R1 being "badly" incontinent or wearing a brief for very long. TMA-A stated R1 was known to get up and toilet herself, especially towards the end of her life. TMA-A stated toileting was an additional source of falls for R1. TMA-A stated R1 frequently leaned in her wheelchair "like she was too tired to sit up." TMA-A stated R1 spent a lot of time leaning against things and slid out of her wheelchair a couple of times. TMA-A stated "everyone" had a concern regarding R1's wheelchair, however, she did not believe anyone had assessed it. TMA-A stated facility administration was aware of the wheelchair concern; however, it was not "high on their priority list." TMA-A stated R1's fall interventions included a room close to the nurses' station, two-hour safety checks/toileting schedule, supportive shoes, and a silent pressure alarm. TMA-A stated she worked when R1 fell on 7/5/20, however, she only provided medications to the resident. TMA-A stated she was unsure if R1's	F 689		

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F 689	Continued From page 12 silent alarm alerted staff when the R1 got up. TMA-A stated staff had "some issues" with the silent alarm not alerting staff previously. TMA-A stated the alarm had to be reset when moved from the bed to the wheelchair and it was a "hassle." On 1/19/21, at 1:18 p.m. an interview was conducted with the interim director of nursing (DON). The DON stated R1 had poor cognition/memory and had a history of delusions/hallucinations. The DON stated R1's cognition had progressively declined prior to being admitted to hospice. The DON stated R1 was on an ambulation program and did well. The DON stated R1 was able to self-propel her wheelchair, however, towards the end of R1's life it was easier for R1 to propel her wheelchair backwards rather than forward. The DON stated R1 was able to use her call light, and for the most part, used it appropriately. The DON stated, at times, R1 would ask for items which were in front of her. The DON stated "towards the end" she believed R1 used her call light a "little less" when she faded physically and mentally. The DON stated R1 was initially able to toilet herself, however, she required assistance of one staff towards the end of her life. The DON stated R1 was occasionally incontinent of bladder. The DON stated R1 told staff when she needed use the bathroom, however, R1 would use the bathroom without staff assistance, at times. The DON confirmed R1 was known to self-transfer and stated it was concerning as R1 had oxygen tubing. The DON stated, at the end, she did not know if a toileting plan would had benefited R1, however, stated a toileting plan may had benefited R1 prior to the last month of her life. The DON confirmed a toileting schedule was not	F 689		

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F 689	Continued From page 13 part of R1's care plan. The DON stated she did not recall if R1 leaned to the side of her wheelchair and remembered R1 sliding out of her wheelchair. The DON stated R1 would "slump" forward in her wheelchair. The DON stated R1 was in a "standard" wheelchair and verbalized R1 had the capability to get up and out of her wheelchair. The DON stated she did not believe the facility considered auto-lock brakes as part of the root cause analysis. The DON stated R1 received hospice services and had CHF with significant heart issues. The DON stated R1 was showing signs of terminal restlessness and anxiety towards the end of her life. The DON stated R1's fall interventions included a room near the second-floor nurses' station, increased safety checks, a silent pressure alarm, and scheduled bedtime cares. The DON stated she did not feel R1's behaviors changed. The DON stated as part of a root cause analysis the facility evaluates factors which are noted at the time of the fall, medication changes, and medical diagnoses. The DON stated on 7/5/20, R1 was found on the floor in her room. The DON stated a blood spot was toward the center of R1's room near the television. The DON stated she did not believe R1 was attempting to the use the bathroom. The DON stated it was hard to figure out what the root cause of the fall was, but there was a thought process that R1 may had went towards her wheelchair. The DON stated R1 hit her head and needed 16 staples to repair a laceration. The DON confirmed R1's silent pressure alarm did not alert staff when R1 had changed position. The DON stated the facility was unable to determine if the device was not plugged in, had malfunctioned, or failed due to user error. The DON stated the silent pressure alarm was tested and determined to be	F 689		

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functional. The DON stated she was not in her role when the investigation was conducted. The DON stated, prior to the incident on 7/5/20, staff needed to move the silent pressure alarm back and forth from the bed to wheelchair. The DON added, after the incident, a second silent pressure alarm was added to R1's room so staff did not need to move the alarm back and forth. The DON stated NAs were also provided education. The DON stated the facility used silent pressure alarms for approximately one year and did not have any similar issues.

Two attempts were made to interview NA-C, however, contact was unable to be established.

R4

R4's Admission Record dated 1/20/21, indicated R4's diagnoses included Parkinson's disease, and abnormalities of gait and mobility.

R4's quarterly MDS dated 12/9/20, indicated R5 had intact cognition. R4 required extensive assistance with bed mobility, transfers, walking, and toilet use. R4 was not steady moving from a seated to standing position and used a walker and wheelchair. R4 was frequently incontinent of bladder and had one fall without injury.

R4's Falls CAA dated 6/11/20, indicated R4 had difficulty maintaining sitting balance and impaired balance during transitions. R4's CAA further indicated R4 had a cognitive impairment, cardiac dysrhythmias, and the overall objective of the care plan was to minimize risks.

R4's care plan lacked indication of fall risk factors and associated interventions.

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An incident report dated 12/10/20, at 4:45 p.m. indicated R4 was found sitting upright near his bathroom door. R4 stated he was coming out of the bathroom, bent over to pick up a "grabber," and fell.

An incident report dated 12/2/20, at 11:45 p.m. indicated R4 was found on the floor in his room. R4 was naked from the waist down and his legs were towards the bathroom. R4 stated he got out of bed, headed for the bathroom, and his legs gave out.

An incident report dated 1/8/21, at 6:19 p.m. indicated R4 was found on the floor near his bathroom doorway. R4 stated he was reaching downward, grabbed the doorway, and fell.

On 1/19/21, at 3:48 p.m. an interview was conducted with R4. R4 stated he used a walker to get to the bathroom. R4 stated at times, he will take himself to the bathroom without assistance. R4 stated he had previously fallen when trying to go to the bathroom independently as he lost his balance. R4 stated staff has told him not to bother them and he does not get "any answers" when he pushes his call light.

On 1/19/21, at 3:56 p.m. an interview was conducted with TMA-B. TMA-B stated R4 was cognitively intact and used a walker to ambulate. TMA-B stated R4 kept a urinal on his walker and usually would urinate while sitting in his chair. TMA-B stated R4 needed assistance of one staff to use the toilet and he frequently called for help. TMA-B stated a care plan was located at the third-floor nurses' station regarding fall interventions and toileting needs. At 4:02 p.m.

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F 689	Continued From page 16 TMA-B went to the third-floor nurses' station and confirmed he was unable to locate R4's care plan. On 1/19/21, at 4:09 p.m. an interview was conducted with the DON. The DON stated R4 was cognitively intact, however, could get "a little" confused. The DON confirmed R4's care plan did not address fall risks and interventions, nor information regarding R4's bowel and bladder. The DON stated the resident's care plan should be reviewed and updated quarterly. An untitled, undated facility policy directed, "The Interdisciplinary Plan of Care (IPOC) team will meet within the same time period of time and discuss the causative factors, interventions to prevent another fall, make therapy referral as necessary and revise the care plan if necessary."	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 8, 2021

Administrator
Aftenro Home
510 West College Street
Duluth, MN 55811

Re: State Nursing Home Licensing Orders
Event ID: 2YIC11

Dear Administrator:

The above facility was surveyed on January 14, 2021 through January 19, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00581	A. BUILDING: ______ B. WING ______	C 01/19/2021

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On 1/14/21, through 1/19/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

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AFTENRO HOME	**510 WEST COLLEGE STREET DULUTH, MN 55811**

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: HE355007C HE355009C The following complaint was found to be UNSUBSTANTIATED: HE355008C. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to perform a comprehensive root cause analysis which identified individualized risk factors to reduce the likelihood of subsequent falls, and failed to develop a comprehensive care plan which identified fall risk factors and/or	2 830	The facility□s Medical Director, Dr. Mark Boyce was notified of the deficiency. The DON will review POC and employee education at the next scheduled QAPI meeting to be held in March 2021.	2/23/21

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implement resident centered interventions to reduce the risk of falls for 2 of 4 residents (R1, R4) reviewed for accidents. This resulted in actual harm for R1 who fell and suffered a head injury which required medical intervention.

Findings include:

R1's Admission Record printed 1/19/21, indicated R1's diagnoses included weakness, abnormalities of gait and mobility, congestive heart failure (CHF), and generalized anxiety disorder.

R1's significant change Minimum Data Set (MDS) dated 6/14/20, indicated R1 had moderate cognitive impairment. R1's MDS identified she required extensive assistance with bed mobility, transfers, and toilet use. R1's MDS further identified she used a wheelchair and was frequently incontinent of bladder. No behavioral symptoms were identified.

R1's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 6/17/20, indicated R1 had delirium, restricted mobility, and urinary urgency.

R1's Falls CAA dated 6/17/20, indicated R1 received antipsychotic, antidepressant, opioid (pain), and diuretic (water pill) medication. The CAA further indicated R1 had delirium, cognitive impairment, anxiety disorder, incontinence, and cardiac dysrhythmias. R1 was referred to a hospice agency.

R1's care plan revised 7/13/20, indicated R1 had impaired cognitive function and thought processes related to dementia. R1's care plan further indicated R1 had an activity of daily living (ADL) self-care deficit related to activity

R1 expired on 7/8/20.
R4s care plan will be corrected to have identified fall risk factors and associated interventions.

All residents that reside at Aftenro have the potential to be affected by this practice.

The facility will complete a Fall Risk Assessment on all Residents. Each assessment will be reviewed by the DON, ADON, or designee. Care plans will be adjusted based on the findings of the assessment. All nurses will be educated on completing the Fall Risk Assessment after each fall.

The facilitys fall policy will be updated to reflect changes. Fall paperwork will include an updated Incident Report, a Fall Huddle form, Witness Statements from each employee on duty at the time of the fall, and a Fall Risk Assessment. All nurses will be educated on completing the updated Incident Report, Fall Huddle Form, and Witness Statement.

The facility will complete a Falls Management Root Cause Analysis using the Balance in Action: A Root Cause and Intervention Guide during the IDT fall review. This will be included with the Incident Report. Interventions will be added to the residents care plan. The DON or designee will summarize all falls at the conclusion of the IDT event and document in the residents progress notes.

Minnesota Department of Health

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intolerance, fatigue, impaired balance, and shortness of breath. R1 had the potential for urinary leakage/bladder incontinence related to diuretic use and impaired mobility. The care plan identified R1 required assistance of one staff for surface-to-surface transfers and directed staff to assist R1 with toileting, as needed, per "resident request."

R1's care plan revised on 7/13/20, indicated R1 was at risk for falls related to weakness, gait/balance problems, psychoactive drug use, and hearing problems. The care plan directed staff to perform cares, at bedtime, after Seroquel (antipsychotic medication) was administered (created 7/10/20), safety checks every two hours for functionality and placement of silent alarm (created 7/10/20), silent pressure alarm to bed and wheelchair (created 6/30/20), and increased safety checks dated (created 6/3/20).

An incident report dated 4/11/20, at 11:50 p.m. indicated R1 was found on the floor in her room. R1 was dressed, but barefoot. R1's wheelchair was to her left side. The wheelchair backrest was towards the bathroom. R1 was half-way from the bathroom. R1 stated she was "going to get" oxygen tubing and "slipped on a blanket." No blanket was observed near R1. R1's call light was noted to be on. The facility root cause analysis (RCA) dated 4/13/20, indicated R1 had "poor safety awareness and balance." The RCA further indicated R1 walked through her room to get oxygen tubing, leaned on her wheelchair, and fell to the floor as the wheelchair breaks were unlocked. The RCA lacked indication of how long R1 waited for her call light to be answered, or if she needed to use the bathroom. New interventions included assisting R1 to bed after Seroquel administration, and applying gripper

The DON, ADON, or designee will audit each resident fall paperwork packet that is completed for a total time period of 90 days. Care plans will be audited 3 per week x 1 month, then 2 per week x 1 month, then 1 per week x 1 month for a total of 90 days. Results will be reviewed at QAPI meetings.

The facility will develop a mandatory all-staff in-service packet that will be reviewed and turned in by nursing staff by February 23rd, 2021. This will include all corrected items identified in the SOD.
02/23/21

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socks. The facility did not complete a fall risk assessment for R1.

An incident report dated 4/21/20, at 11:45 p.m. indicated R1 was found on the floor in her room. R1 was sitting with her back up against her bed. R1's wheelchair was pushed to the side of a table. A telephone cord was wrapped around a table. R1 stated she leaned forward to clip her toenails and slipped out of bed. The facility RCA dated 4/21/20, indicated R1 had, poor safety awareness, cognitive deficit, and poor balance. The RCA further indicated R1 slipped off her bed and was not wearing non-skid footwear. Corrective actions included "continuing plan of care." No new interventions were identified. The facility did not complete a fall risk assessment for R1.

An incident report dated 5/3/20, at 11:30 a.m. indicated R1 was found on the floor near her bed. R1 was "facedown" and her head was at the base of a bedside table. R1's wheelchair was to the left of her. R1 stated she was sitting on her bed and the "next thing I knew I was on the floor." R1 had a laceration, to the top of her head, which measured 4 centimeters (cm.). Additionally, R1 had a 5 cm. contusion (bruise) to her forehead. The facility RCA dated 5/4/20, indicated R1 was sent to the emergency department and it was noted she had an elevated digoxin (cardiac medication) level. New interventions included daily digoxin toxicity monitoring. The facility did not complete a fall risk assessment for R1.

A progress note dated 5/17/20, at 12:11 p.m. indicated R1 believed an individual across the hall was attempting to sleep in her bed. The room across the hall was unoccupied. R1's representative expressed concern regarding

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Trazadone (antidepressant) medication R1 was recently ordered. R1 was scheduled for virtual rounds on 5/18/20.

An incident report dated 5/31/20, at 6:45 a.m. indicated R1 was found on the floor in her room. R1's left arm was near the front of the toilet and she was halfway in the bathroom. R1 stated she was attempting to pull up her pants after using the bathroom. R1's oxygen tubing was found on the floor, but not near her. The facility RCA dated 6/2/20, indicated R1 had weakness, decreased safety awareness, visual limitations, heart conditions, chronic respiratory failure, and cognitive impairment. The RCA further indicated R1 toileted herself and fell trying to pull her pants up. R1 was not wearing non-skid footwear. New interventions included "increased" safety checks and "long-term" plan to move R1 to the second floor near the nurses' station. The facility did not complete an assessment of R1's toileting needs. The facility did not complete a fall risk assessment for R1.

An incident report dated 6/4/20, at 12:00 p.m. indicated R1 was found sitting in front of the toilet in her room. R1's wheelchair was near her bed. R1's pants were around her knees. R1 stated she was going to her wheelchair from the toilet. R1 was reminded to call for help when pulling up her pants. The facility RCA dated 6/5/20, indicated R1 had weakness, decreased safety awareness, cognitive impairment, visual limitations, heart conditions, chronic respiratory failure, and history of falls. The RCA further indicated R1 toileted herself independently and fell while in the bathroom. New interventions included a hospice referral for care and medication management. The facility long-term plan remained moving R1 to the second floor

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near the nurses' station. The facility was to continue increased safety checks. The facility did not complete an assessment of R1's toileting needs. The facility did not complete a fall risk assessment for R1.

A progress note dated 6/5/20, at 11:59 a.m. indicated R1's representative contacted a hospice agency. The progress note further indicated R1 would be screened for hospice due to failing health related to "cardiac issues, cognitive decline, wt [weight] changes, and falls."

An incident report dated 6/6/20, at 11:30 p.m. indicated R1 was found sitting on the floor, and was midway between the bathroom and her bed. R1 was dressed and a wheelchair was beside her. The wheelchair breaks were unlocked and R1 was incontinent of urine. Urine was also noted in R1's toilet. R1 was unable to explain what had happened. R1's room had "no clutter on floor" and R1 did not have her oxygen on. R1 was reminded to call for help. The facility RCA dated 6/9/20, indicated R1 had weakness, decreased safety awareness, cognitive impairment, visual limitations, heart conditions, history of falls, and chronic respiratory failure. The RCA further indicated R1 tried to sit on the edge of her bed and the bed mattress had a "dip" in it. Additionally, it was noted R1 was admitted to hospice the previous week and R1's room was very "cluttered." New interventions included a room cleaning, R1's mattress was turned, and a room change. The facility did not complete an assessment of R1's toileting needs. The facility did not complete a fall risk assessment for R1.

An incident report dated 6/23/20, at 7:15 a.m. indicated R1 was found laying under her bedside table. R1's wheelchair was near a closet. R1

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stated she was picking dandelions. The facility RCA dated 6/24/20, indicated R1 had poor safety awareness, poor balance, weakness, fatigue, recent medication changes, cognitive impairment, was barefoot. The RCA further indicated R1 had end-of-life restlessness and impulsivity. New interventions included a silent pressure alarm to R1's bed and wheelchair. The facility did not complete a fall risk assessment for R1.

An incident report dated 6/23/20, at 9:20 a.m. indicated R1 was found sitting in front of her wheelchair near a television. The facility RCA dated 6/24/20, indicated R1 had poor safety awareness, poor balance, weakness, fatigue, and recent hospice admission. The RCA further indicated R1 had recent medication changes done by hospice, due to a decline in condition. Additionally, R1 had end-of-life restlessness and agitation. New interventions included adding a silent pressure alarm to R1's bed and wheelchair. Additionally, the facility indicated they would consult with hospice regarding medication changes. The facility did not complete a fall risk assessment for R1.

A progress note dated 7/5/20, at 11:02 a.m. indicated R1 was found on the floor. R1 was seated "opposite" of her chair and was holding her head. R1's wheelchair was near her. R1 was sent to the emergency department.

An incident report dated 7/5/20, at 10:25 a.m. indicated R1 was found on the floor and was bleeding from the left side of her head. R1 was sitting opposite of her chair. R1 was noted to have a 2-inch (in.) laceration to the side of her head. R1 was sent to the hospital for treatment. The facility RCA dated 7/5/20, indicated R1 had poor safety awareness, poor balance, altered

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mental status, and had declining health. The RCA further indicated the facility reached out to the pharmacist and hospice for guidance and medications to reduce anxiety and wandering. Additionally, the incident report indicated nursing assistants (NAs) were to be educated prior to their next shift on silent pressure alarm function. A "second" silent pressure alarm was installed on R1's wheelchair. The facility did not complete a fall risk assessment for R1.

A progress note dated 7/5/20, at 5:20 p.m. indicated R1 returned from the hospital. R1 was "confused and refusing cares." A new silent pressure alarm was placed on R1's wheelchair. R1 had a laceration, to her head, and staples were in-place. R1 was also noted to have bruises on her left shoulder and left hip. Education was provided to NAs on the new silent pressure alarm and expected response. Two-hour safety checks, to ensure silent pressure alarm function, were initiated.

An investigation summary dated 7/5/20, indicated R1 was noted to be a "historically poor decision maker" and had an anoxic (lack of oxygen) brain injury related to coronary bypass surgery. On 7/5/20, at 8:30 a.m. R1's bed silent pressure alarm sounded. R1 was cleaned up, dressed, her bed was made, and the silent pressure alarm control box was placed on R1's bedside stand. R1 was seated, in bed, and her breakfast was placed in front of her. Staff left R1's room at approximately 8:45 a.m. R1's status from 8:45 a.m. to 10:15 a.m. was uncertain. At 10:15 a.m. staff walked past R1's room and R1 was found sitting on the floor, near the room entry, and was holding her head. R1 was unable to state what she was doing. R1's silent pressure alarm did not sound. R1 had a laceration to the back-left side

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of her head, was transferred to the emergency department, and had 16 staples placed to repair the laceration. The investigation indicated it was undetermined if R1's silent pressure alarm was unplugged or malfunctioned. The silent alarm was tested, and it was functional. The facility did not complete a fall risk assessment for R1.

An emergency department physician note signed 7/10/20, at 10:25 a.m. for the ED visit on 7/5/20, indicated R1 had an unwitnessed fall and was impulsive. R1 was noted to "get up without ringing staff." R1 had a large left scalp laceration which was stapled. R1 was noted to have a progressive decline, with minimal intake, and had been sleepy.

A progress note dated 7/6/20, at 5:19 a.m. indicated R1 attempted to crawl out of bed at 11:30 p.m. R1 complained of head pain, was restless, agitated, and aggressive. R1 received Ativan and morphine at 11:50 p.m. R1 went to sleep. At 4:45 a.m., R1 woke up and stated, "ouch, ouch." R1 was again attempting to crawl out of bed. Morphine was administered and R1 slept since 5:15 a.m.

A progress note dated 7/6/20, at 10:36 a.m. indicated hospice was updated of R1's fall. A medication review was requested, and hospice indicated a nurse would evaluate R1 today. Additionally, hospice ordered a different wheelchair for R1.

A progress note dated 7/6/20, at 3:47 p.m. indicated R1 slept most of the shift. R1 was also noted to become restless and Ativan was administered. R1 "was not awake enough" to administer oral scheduled medications.

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A progress note dated 7/7/20, at 2:36 a.m. indicated R1 complained of pain with repositioning. R1 stated "ouch, ouch" and grabbed for her hips and legs. R1 had a "distant" look to her face and was unable to focus. R1's color was dusky.

A progress note dated 7/7/20, at 3:49 p.m. indicated R1 was having apneic (period of not breathing) episodes lasting 20-30 seconds. Hospice was notified.

A progress note dated 7/8/20, at 4:28 p.m. indicated R1 died at 11:31 a.m.

On 1/19/21, at 10:01 a.m. an interview was conducted with NA-A. NA-A stated from the start, R1's cognition was "skewed" and R1 hallucinated a lot. NA-A stated R1 would use her call light to request assistance, however, it was "hit or miss." NA-A stated R1 was "notorious for doing her own thing." NA-A stated R1 was able to self-propel her wheelchair, however, long distances were difficult for her. NA-A stated R1 was historically independent with toileting, however, R1 required assistance toileting around the time R1 was admitted to hospice. NA-A stated R1 needed help pulling her pants up and performing perineal care. NA-A stated she did not remember if R1 was on a toileting schedule and stated she "probably was." NA-A stated R1's fall interventions included frequent checks, a silent pressure alarm, and R1 was moved closer to the second-floor nurses' station. NA-A stated she worked on 7/5/20, and attended to R1 when she fell and hit her head. NA-A stated she heard R1 yell for help and she responded to R1's room. NA-A stated R1 was on the floor, near her wheelchair, and R1's head was bleeding. NA-A stated the silent pressure alarm was located on

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R1's bed. NA-A stated there was not a silent pressure alarm on R1's wheelchair. NA-A stated R1's silent pressure alarm did not alert staff R1 had gotten up. NA-A stated she asked another staff-person for help, left the room, and found a nurse. NA-A stated a nurse assessed R1, called 911, and R1 was transferred to the hospital. NA-A stated NA-C got R1 ready in the morning. NA-A stated NA-C told her R1 was seated on the bed, with a bedside table in front of R1, when she left the room. NA-A stated she did check R1's silent pressure alarm and it "was working." NA-A stated she did not know why R1's silent pressure alarm did not alert staff R1 had gotten up.

On 1/19/21, at 10:21 a.m. an interview was conducted with trained medication assistant (TMA)-A. TMA-A stated R1's cognition was "totally gone," and had progressively worsened long before R1 had died. TMA-A stated R1 received hospice services and started to decline in April or May. TMA-A stated it was "impossible" to administer R1's medications. TMA-A stated R1 was terminally ill and did not understand what was being said. TMA-A stated towards the end of R1's life she would use the call light, however, sometimes she forgot she had it. TMA-A stated, at times, R1 would use her call light and informed staff there was a man in her closet. TMA-A stated R1 was unable to verbalize what she needed. TMA-A stated R1 required the assistance of one staff, with a gait belt, for transfers and toileting. TMA-A stated she did not recall R1 being "badly" incontinent or wearing a brief for very long. TMA-A stated R1 was known to get up and toilet herself, especially towards the end of her life. TMA-A stated toileting was an additional source of falls for R1. TMA-A stated R1 frequently leaned in her wheelchair "like she was too tired to sit up." TMA-A stated R1 spent a

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lot of time leaning against things and slid out of her wheelchair a couple of times. TMA-A stated "everyone" had a concern regarding R1's wheelchair, however, she did not believe anyone had assessed it. TMA-A stated facility administration was aware of the wheelchair concern; however, it was not "high on their priority list." TMA-A stated R1's fall interventions included a room close to the nurses' station, two-hour safety checks/toileting schedule, supportive shoes, and a silent pressure alarm. TMA-A stated she worked when R1 fell on 7/5/20, however, she only provided medications to the resident. TMA-A stated she was unsure if R1's silent alarm alerted staff when the R1 got up. TMA-A stated staff had "some issues" with the silent alarm not alerting staff previously. TMA-A stated the alarm had to be reset when moved from the bed to the wheelchair and it was a "hassle."

On 1/19/21, at 1:18 p.m. an interview was conducted with the interim director of nursing (DON). The DON stated R1 had poor cognition/memory and had a history of delusions/hallucinations. The DON stated R1's cognition had progressively declined prior to being admitted to hospice. The DON stated R1 was on an ambulation program and did well. The DON stated R1 was able to self-propel her wheelchair, however, towards the end of R1's life it was easier for R1 to propel her wheelchair backwards rather than forward. The DON stated R1 was able to use her call light, and for the most part, used it appropriately. The DON stated, at times, R1 would ask for items which were in front of her. The DON stated "towards the end" she believed R1 used her call light a "little less" when she faded physically and mentally. The DON stated R1 was initially able to toilet herself,

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	00581	A. BUILDING: ______ B. WING ______	C 01/19/2021

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

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however, she required assistance of one staff towards the end of her life. The DON stated R1 was occasionally incontinent of bladder. The DON stated R1 told staff when she needed use the bathroom, however, R1 would use the bathroom without staff assistance, at times. The DON confirmed R1 was known to self-transfer and stated it was concerning as R1 had oxygen tubing. The DON stated, at the end, she did not know if a toileting plan would had benefited R1, however, stated a toileting plan may had benefited R1 prior to the last month of her life. The DON confirmed a toileting schedule was not part of R1's care plan. The DON stated she did not recall if R1 leaned to the side of her wheelchair and remembered R1 sliding out of her wheelchair. The DON stated R1 would "slump" forward in her wheelchair. The DON stated R1 was in a "standard" wheelchair and verbalized R1 had the capability to get up and out of her wheelchair. The DON stated she did not believe the facility considered auto-lock brakes as part of the root cause analysis. The DON stated R1 received hospice services and had CHF with significant heart issues. The DON stated R1 was showing signs of terminal restlessness and anxiety towards the end of her life. The DON stated R1's fall interventions included a room near the second-floor nurses' station, increased safety checks, a silent pressure alarm, and scheduled bedtime cares. The DON stated she did not feel R1's behaviors changed. The DON stated as part of a root cause analysis the facility evaluates factors which are noted at the time of the fall, medication changes, and medical diagnoses. The DON stated on 7/5/20, R1 was found on the floor in her room. The DON stated a blood spot was toward the center of R1's room near the television. The DON stated she did not believe R1 was attempting to the use the

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bathroom. The DON stated it was hard to figure out what the root cause of the fall was, but there was a thought process that R1 may had went towards her wheelchair. The DON stated R1 hit her head and needed 16 staples to repair a laceration. The DON confirmed R1's silent pressure alarm did not alert staff when R1 had changed position. The DON stated the facility was unable to determine if the device was not plugged in, had malfunctioned, or failed due to user error. The DON stated the silent pressure alarm was tested and determined to be functional. The DON stated she was not in her role when the investigation was conducted. The DON stated, prior to the incident on 7/5/20, staff needed to move the silent pressure alarm back and forth from the bed to wheelchair. The DON added, after the incident, a second silent pressure alarm was added to R1's room so staff did not need to move the alarm back and forth. The DON stated NAs were also provided education. The DON stated the facility used silent pressure alarms for approximately one year and did not have any similar issues.

Two attempts were made to interview NA-C, however, contact was unable to be established.

R4

R4's Admission Record dated 1/20/21, indicated R4's diagnoses included Parkinson's disease, and abnormalities of gait and mobility.

R4's quarterly MDS dated 12/9/20, indicated R5 had intact cognition. R4 required extensive assistance with bed mobility, transfers, walking, and toilet use. R4 was not steady moving from a seated to standing position and used a walker and wheelchair. R4 was frequently incontinent of

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bladder and had one fall without injury.

R4's Falls CAA dated 6/11/20, indicated R4 had difficulty maintaining sitting balance and impaired balance during transitions. R4's CAA further indicated R4 had a cognitive impairment, cardiac dysrhythmias, and the overall objective of the care plan was to minimize risks.

R4's care plan lacked indication of fall risk factors and associated interventions.

An incident report dated 12/10/20, at 4:45 p.m. indicated R4 was found sitting upright near his bathroom door. R4 stated he was coming out of the bathroom, bent over to pick up a "grabber," and fell.

An incident report dated 12/2/20, at 11:45 p.m. indicated R4 was found on the floor in his room. R4 was naked from the waist down and his legs were towards the bathroom. R4 stated he got out of bed, headed for the bathroom, and his legs gave out.

An incident report dated 1/8/21, at 6:19 p.m. indicated R4 was found on the floor near his bathroom doorway. R4 stated he was reaching downward, grabbed the doorway, and fell.

On 1/19/21, at 3:48 p.m. an interview was conducted with R4. R4 stated he used a walker to get to the bathroom. R4 stated at times, he will take himself to the bathroom without assistance. R4 stated he had previously fallen when trying to go to the bathroom independently as he lost his balance. R4 stated staff has told him not to bother them and he does not get "any answers" when he pushes his call light.

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On 1/19/21, at 3:56 p.m. an interview was conducted with TMA-B. TMA-B stated R4 was cognitively intact and used a walker to ambulate. TMA-B stated R4 kept a urinal on his walker and usually would urinate while sitting in his chair. TMA-B stated R4 needed assistance of one staff to use the toilet and he frequently called for help. TMA-B stated a care plan was located at the third-floor nurses' station regarding fall interventions and toileting needs. At 4:02 p.m. TMA-B went to the third-floor nurses' station and confirmed he was unable to locate R4's care plan.

On 1/19/21, at 4:09 p.m. an interview was conducted with the DON. The DON stated R4 was cognitively intact, however, could get "a little" confused. The DON confirmed R4's care plan did not address fall risks and interventions, nor information regarding R4's bowel and bladder. The DON stated the resident's care plan should be reviewed and updated quarterly.

An untitled, undated facility policy directed, "The Interdisciplinary Plan of Care (IPOC) team will meet within the same time period of time and discuss the causative factors, interventions to prevent another fall, make therapy referral as necessary and revise the care plan if necessary."

SUGGESTED METHOD OF CORRECTION:
The DON or designee could develop, review, and/or revise policies and procedures related to performing fall risk assessments and comprehensive root cause analysis. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance.

Minnesota Department of Health

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2 830	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		