

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.

Aftenro Home February 8, 2021 Page 2

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

Aftenro Home February 8, 2021 Page 3

(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.

Aftenro Home February 8, 2021 Page 4 **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 <u>Tamika.Brown@cms.hhs.gov.</u>

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:

Aftenro Home February 8, 2021 Page 5 <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			Сом	E SURVEY PLETED
		24E355	B. WING				C 19/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AFTENR	ОНОМЕ				10 WEST COLLEGE STREET ULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	00			
	survey was comple complaint investiga NOT to be in compl	h 1/19/21, an abbreviated ted at your facility to conduct tions. Your facility was found liance with 42 CFR Part 483, ong Term Care Facilities.					
		laint was found to be HE355007C with a deficiency					
	substantiated with	laint was found to be NO deficiencies cited due to ed by the facility prior to survey:					
	The following comp	laint was found to be ED: HE355008C.					
		f correction (POC) will serve f compliance upon the otance.					
	signature is not req						
	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with					
F 689 SS=G		azards/Supervision/Devices 1)(2)	F 6	89			2/23/21
	§483.25(d) Acciden	its.					
		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						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.

PRINTED: 02/17/2021

		AND HUMAN SERVICES			FORM	: 02/17/202 1 APPROVEI 0. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		COM	TE SURVEY MPLETED C
		24E355	B. WING	i		/ 19/2021
NAME OF F	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CI	· · · · · · · · · · · · · · · · · · ·	
AFTENR	OHOME			510 WEST COLLEGE DULUTH, MN 558	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREMEN by: Based on interview facility failed to perf cause analysis which factors to reduce the falls, and failed to of plan which identified implement resident reduce the risk of fa R4) reviewed for action actual harm for R1 injury which required Findings include: R1's Admission Rev R1's Admission Rev R1's significant chat dated 6/14/20, indic cognitive impairment required extensive transfers, and toilett identified she used frequently incontine symptoms were identified R1's Urinary Incont	resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced y and document review, the form a comprehensive root ch identified individualized risk he likelihood of subsequent levelop a comprehensive care d fall risk factors and/or centered interventions to alls for 2 of 4 residents (R1, coidents. This resulted in who fell and suffered a head ed medical intervention.	F	 Boyce was not DON will review education at the meeting to be an R1 expired on R4 s care plat identified fall ri- interventions. All resident s the potential to practice. The facility will Assessment of assessment with ADON, or desi adjusted based assessment. A on completing after each fall. The facility s f reflect changes include an upd Huddle form, V 	Medical Director, Dr. Mark ified of the deficiency. The w POC and employee ie next scheduled QAPI held in March 2021. 7/8/20. n will be corrected to have sk factors and associated that reside at Aftenro have be affected by this complete a Fall Risk n all Residents. Each ill be reviewed by the DON, gnee. Care plans will be d on the findings of the All nurses will be educated the Fall Risk Assessment fall policy will be updated to s. Fall paperwork will ated Incident Report, a Fall Vitness Statements from e on duty at the time of the	
	dated 6/14/20, indic cognitive impairment required extensive transfers, and toilet identified she used frequently incontine symptoms were ide R1's Urinary Incont	cated R1 had moderate nt. R1's MDS identified she assistance with bed mobility, use. R1's MDS further a wheelchair and was ent of bladder. No behavioral entified.		assessment. A on completing after each fall. The facility s f reflect changes include an upd Huddle form, V each employee	All nurses will be educated the Fall Risk Assessment fall policy will be updated to s. Fall paperwork will ated Incident Report, a Fall Vitness Statements from	

Facility ID: 00581

If continuation sheet Page 2 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES	T		FORM	02/17/2021 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	COM	E SURVEY PLETED C
		24E355	B. WING	i		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
AFTENR	ОНОМЕ			510 WEST COLLEGE STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DATE
F 689	mobility, and urinary R1's Falls CAA data received antipsycho (pain), and diuretic CAA further indicate impairment, anxiety cardiac dysrhythmia hospice agency. R1's care plan revis impaired cognitive f processes related to further indicated R1 (ADL) self-care defi intolerance, fatigue shortness of breath urinary leakage/blac diuretic use and imp identified R1 require surface-to-surface to assist R1 with toilet request." R1's care plan revis was at risk for falls gait/balance problet and hearing problet staff to perform caro (antipsychotic medi (created 7/10/20), s for functionality and (created 7/10/20), s	A1 had delirium, restricted y urgency. ed 6/17/20, indicated R1 btic, antidepressant, opioid (water pill) medication. The ed R1 had delirium, cognitive y disorder, incontinence, and as. R1 was referred to a sed 7/13/20, indicated R1 had function and thought o dementia. R1's care plan had an activity of daily living icit related to activity , impaired balance, and . R1 had the potential for dder incontinence related to paired mobility. The care plan ed assistance of one staff for transfers and directed staff to ing, as needed, per "resident ed on 7/13/20, indicated R1 related to weakness, ms, psychoactive drug use, ms. The care plan directed es, at bedtime, after Seroquel cation) was administered safety checks every two hours I placement of silent alarm islent pressure alarm to bed eated 6/30/20), and increased	F	 nurses will be educated on coupdated Incident Report, Fall Form, and Witness Statemer The facility will complete a Fall Management Root Cause An the Balance in Action: A Root Intervention Guide during the review. This will be included volucident Report. Interventions added to the resident scare DON or designee will summar at the conclusion of the IDT edocument in the resident spinotes. The DON, ADON, or designee each resident fall paperwork completed for a total time per days. Care plans will be audit week x 1 month, then 2 per womonth, then 1 per week x 1 m total of 90 days. Results will the at QAPI meetings. The facility will develop a mar all-staff in-service packet that reviewed and turned in by nu February 23rd, 20201. This work corrected items identified in the 02/23/21 	Huddle ht. alls alysis using Cause and IDT fall with the swill be plan. The irize all falls event and progress e will audit packet that is riod of 90 ted 3 per veek x 1 nonth for a pe reviewed hdatory t will be rsing staff by <i>i</i> ll include all	
		lated 4/11/20, at 11:50 p.m. bund on the floor in her room.				

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/17/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24E355	B. WING	i			C 19/2021
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
AFTENR	O HOME				510 WEST COLLEGE STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	R1 was dressed, bu was to her left side. towards the bathroo bathroom. R1 state oxygen tubing and blanket was observ was noted to be on analysis (RCA) date "poor safety awarer further indicated R1 get oxygen tubing, I fell to the floor as th unlocked. The RC/ R1 waited for her ca she needed to use interventions includ Seroquel administra socks. The facility of assessment for R1. An incident report of indicated R1 was for R1 was sitting with R1's wheelchair wa table. A telephone table. R1 stated sh toenails and slipped dated 4/21/20, indic awareness, cognitiv The RCA further ind and was not wearin Corrective actions i care." No new inter facility did not comp R1. An incident report of indicated R1 was for	at barefoot. R1's wheelchair The wheelchair backrest was om. R1 was half-way from the ed she was "going to get" 'slipped on a blanket." No ed near R1. R1's call light . The facility root cause ed 4/13/20, indicated R1 had ness and balance." The RCA walked through her room to eaned on her wheelchair, and ne wheelchair breaks were A lacked indication of how long all light to be answered, or if the bathroom. New ed assisting R1 to bed after ation, and applying gripper lid not complete a fall risk	F	689			

If continuation sheet Page 4 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/17/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMI	E SURVEY PLETED
		24E355	B. WING			(01/1) 19/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				5	10 WEST COLLEGE STREET		
AFTENR	O HOME			D	DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	of a bedside table. left of her. R1 state and the "next thing had a laceration, to measured 4 centim had a 5 cm. contus The facility RCA da sent to the emerger noted she had an e medication) level. If daily digoxin toxicity not complete a fall A progress note dat indicated R1 believe was attempting to s across the hall was representative expr Trazadone (antidep recently ordered. F rounds on 5/18/20. An incident report d indicated R1 was for R1's left arm was n she was halfway in was attempting to p the bathroom. R1's the floor, but not ne 6/2/20, indicated R2 safety awareness, w conditions, chronic cognitive impairment R1 toileted herself a up. R1 was not we interventions includ and "long-term" pla floor near the nurse	R1's wheelchair was to the ed she was sitting on her bed I knew I was on the floor." R1 the top of her head, which eters (cm.). Additionally, R1 ion (bruise) to her forehead. ted 5/4/20, indicated R1 was ney department and it was levated digoxin (cardiac New interventions included / monitoring. The facility did risk assessment for R1. ted 5/17/20, at 12:11 p.m. ed an individual across the hall leep in her bed. The room	F	689			

If continuation sheet Page 5 of 17

		AND HUMAN SERVICES				FORM	02/17/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COM	E SURVEY PLETED
		24E355	B. WING				C 19/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AFTENR	O HOME				510 WEST COLLEGE STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	The facility did not of assessment for R1. An incident report of indicated R1 was for in her room. R1's w R1's pants were arc she was going to he R1 was reminded to her pants. The facil indicated R1 had w awareness, cognitiv limitations, heart co failure, and history of indicated R1 toilete fell while in the bath included a hospice medication manage plan remained mov near the nurses' sta continue increased not complete an as needs. The facility of assessment for R1. A progress note dat indicated R1's represent agency. The progres would be screened health related to "ca decline, wt [weight] An incident report of indicated R1 was for was midway betwee R1 was dressed an her. The wheelcha R1 was incontinent	complete a fall risk complete a fall risk lated 6/4/20, at 12:00 p.m. bund sitting in front of the toilet vheelchair was near her bed. bund her knees. R1 stated er wheelchair from the toilet. b call for help when pulling up lity RCA dated 6/5/20, eakness, decreased safety ve impairment, visual unditions, chronic respiratory of falls. The RCA further d herself independently and proom. New interventions referral for care and ement. The facility long-term ing R1 to the second floor ation. The facility was to safety checks. The facility did sessment of R1's toileting did not complete a fall risk	Fé	389			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/17/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		24E355	B. WING				C 19/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AFTENR	O HOME				310 WEST COLLEGE STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	what had happened on floor" and R1 did was reminded to ca dated 6/9/20, indica decreased safety ar impairment, visual I history of falls, and The RCA further inde edge of her bed and in it. Additionally, it to hospice the previous very "cluttered." Ne room cleaning, R1's room change. The assessment of R1's did not complete a An incident report of indicated R1 was for table. R1's wheeld stated she was pick RCA dated 6/24/20 awareness, poor ba recent medication of was barefoot. The end-of-life restless interventions includ R1's bed and whee complete a fall risk An incident report of indicated R1 was for wheelchair near a to dated 6/24/20, indica awareness, poor ba recent hospice adm indicated R1 had re done by hospice, du	I. R1's room had "no clutter I not have her oxygen on. R1 Il for help. The facility RCA Ited R1 had weakness,	F	\$89			

Facility ID: 00581

If continuation sheet Page 7 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/17/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24E355	B. WING	·			C 19/2021
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
AFTENR	ОНОМЕ				510 WEST COLLEGE STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	agitation. New inter- silent pressure alarn Additionally, the fac- consult with hospice changes. The facilit assessment for R1. A progress note dat indicated R1 was for seated "opposite" of her head. R1's whe sent to the emerger An incident report d indicated R1 was for bleeding from the lessitting opposite of h have a 2-inch (in.) If head. R1 was sent The facility RCA dat poor safety awarent mental status, and RCA further indicate the pharmacist and medications to redu Additionally, the inclust assistants (NAs) we their next shift on si A "second" silent pr R1's wheelchair. Th fall risk assessment A progress note dat indicated R1 returned "confused and refus pressure alarm was R1 had a laceration were in-place. R1 was	rventions included adding a m to R1's bed and wheelchair. ility indicated they would e regarding medication y did not complete a fall risk and not complete a fall risk and not complete a fall risk and on the floor. R1 was f her chair and was holding eelchair was near her. R1 was ney department. ated 7/5/20, at 10:25 a.m. bund on the floor and was eff side of her head. R1 was eff side of her head to acceration to the side of her to the hospital for treatment. ted 7/5/20, indicated R1 had ess, poor balance, altered had declining health. The ed the facility reached out to hospice for guidance and ice anxiety and wandering. ident report indicated nursing ere to be educated prior to lent pressure alarm function. essure alarm was installed on he facility did not complete a	F	589			

If continuation sheet Page 8 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/17/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED C
		24E355	B. WING				_ 19/2021
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AFTENR	O HOME				10 WEST COLLEGE STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	provided to NAs on and expected respo- to ensure silent pre- initiated. An investigation sur R1 was noted to be maker" and had an injury related to cor 7/5/20, at 8:30 a.m. alarm sounded. R1 bed was made, and control box was pla R1 was seated, in to placed in front of he approximately 8:45 a.m. to 10:15 a.m. v staff walked past R sitting on the floor, if holding her head. F she was doing. R1 sound. R1 had a la of her head, was tra department, and hat the laceration. The undetermined if R1 unplugged or malfu was tested, and it w not complete a fall if An emergency depa 7/10/20, at 10:25 a. indicated R1 had ar impulsive. R1 was ringing staff." R1 hat which was stapled.	ge 8 the new silent pressure alarm onse. Two-hour safety checks, ssure alarm function, were mmary dated 7/5/20, indicated a "historically poor decision anoxic (lack of oxygen) brain onary bypass surgery. On R1's bed silent pressure was cleaned up, dressed, her the silent pressure alarm ced on R1's bedside stand. bed, and her breakfast was er. Staff left R1's room at a.m. R1's status from 8:45 was uncertain. At 10:15 a.m. 1's room and R1 was found near the room entry, and was R1 was unable to state what 's silent pressure alarm did not ceration to the back-left side ansferred to the emergency dd 16 staples placed to repair investigation indicated it was 's silent pressure alarm was nctioned. The silent alarm vas functional. The facility did risk assessment for R1.	Fθ	\$89			

If continuation sheet Page 9 of 17

							FORM	02/17/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION	0	(X3) DAT COM	E SURVEY PLETED
		24E355	B. WING					C 19/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZI	P CODE		
AFTENR	ОНОМЕ				0 WEST COLLEGE STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
F 689	indicated R1 attemp 11:30 p.m. R1 com restless, agitated, a Ativan and morphin sleep. At 4:45 a.m. "ouch, ouch." R1 w out of bed. Morphin slept since 5:15 a.m A progress note dat indicated hospice w medication review v indicated a nurse w Additionally, hospic wheelchair for R1. A progress note dat indicated R1 slept r noted to become re administered. R1 " administer oral sche A progress note dat indicated R1 slept r noted to become re administered. R1 " administer oral sche A progress note dat indicated R1 compl repositioning. R1 s grabbed for her hip look to her face and color was dusky. A progress note dat indicated R1 was has breathing) episodes Hospice was notifie	ted 7/6/20, at 5:19 a.m. pted to crawl out of bed at aplained of head pain, was and aggressive. R1 received be at 11:50 p.m. R1 went to ., R1 woke up and stated, vas again attempting to crawl ne was administered and R1 n. ted 7/6/20, at 10:36 a.m. vas updated of R1's fall. A was requested, and hospice vould evaluate R1 today. e ordered a different ted 7/6/20, at 3:47 p.m. most of the shift. R1 was also estless and Ativan was was not awake enough" to eduled medications. ted 7/7/20, at 2:36 a.m. ained of pain with tated "ouch, ouch" and s and legs. R1 had a "distant" d was unable to focus. R1's ted 7/7/20, at 3:49 p.m. aving apneic (period of not s lasting 20-30 seconds. ed. ted 7/8/20, at 4:28 p.m.	F	589				
	On 1/19/21, at 10:0	1 a.m. an interview was						

If continuation sheet Page 10 of 17

	MAN SERVICES CAID SERVICES				FORM	02/17/2021 APPROVED 0938-0391
	/IDER/SUPPLIER/CLIA 'IFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
	24E355	B. WING				_ 19/2021
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AFTENRO HOME				510 WEST COLLEGE STREET DULUTH, MN 55811		
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689 Continued From page 10 conducted with NA-A. NA-A R1's cognition was "skewed" a lot. NA-A stated R1 would request assistance, however NA-A stated R1 was "notoric thing." NA-A stated R1 was her wheelchair, however, lor difficult for her. NA-A stated independent with toileting, he assistance toileting around t admitted to hospice. NA-A s help pulling her pants up and care. NA-A stated she did n was on a toileting schedule a "probably was." NA-A stated interventions included freque pressure alarm, and R1 was second-floor nurses' station. worked on 7/5/20, and attem fell and hit her head. NA-A s yell for help and she respond NA-A stated R1 was on the f wheelchair, and R1's head w stated the silent pressure alar R1's bed. NA-A stated there pressure alarm on R1's whe R1's silent pressure alarm d had gotten up. NA-A stated staff-person for help, left the nurse. NA-A stated NA-C got R1 re NA-A stated NA-C got R1 re NA-A stated NA-C told her R bed, with a bedside table in t left the room. NA-A stated s silent pressure alarm and it ' stated she did not know why alarm did not alert staff R1 h	" and R1 hallucinated use her call light to r, it was "hit or miss." ous for doing her own able to self-propel og distances were R1 was historically owever, R1 required he time R1 was stated R1 needed d performing perineal ot remember if R1 and stated she d R1's fall ent checks, a silent moved closer to the NA-A stated she ded to R1 when she stated she heard R1 ded to R1's room. floor, near her vas bleeding. NA-A arm was located on e was not a silent elchair. NA-A stated id not alert staff R1 she asked another room, and found a assessed R1, called to the hospital. ady in the morning. R1 was seated on the front of R1, when she he did check R1's 'was working." NA-A	Fé	589			

Facility ID: 00581

If continuation sheet Page 11 of 17

		AND HUMAN SERVICES				FORM	02/17/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		24E355	B. WING				C 19/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AFTENR	O HOME				510 WEST COLLEGE STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	On 1/19/21, at 10:2 conducted with train (TMA)-A. TMA-A s "totally gone," and h long before R1 had received hospice se in April or May. TM to administer R1's r was terminally ill an was being said. TM R1's life she would sometimes she forg at times, R1 would staff there was a m stated R1 was unab needed. TMA-A sta assistance of one s transfers and toileti recall R1 being "bac brief for very long. to get up and toilet end of her life. TM/ additional source of R1 frequently leane was too tired to sit u lot of time leaning a her wheelchair a co "everyone" had a co wheelchair, however had assessed it. T administration was concern; however, f list." TMA-A stated included a room clo two-hour safety che supportive shoes, a TMA-A stated she w however, she only p	A a.m. an interview was ned medication assistant tated R1's cognition was nad progressively worsened died. TMA-A stated R1 ervices and started to decline IA-A stated it was "impossible" medications. TMA-A stated R1 ad did not understand what MA-A stated towards the end of use the call light, however, got she had it. TMA-A stated, use her call light and informed an in her closet. TMA-A ole to verbalize what she ated R1 required the staff, with a gait belt, for ng. TMA-A stated R1 was known herself, especially towards the A-A stated toileting was an f falls for R1. TMA-A stated ed in her wheelchair "like she up." TMA-A stated R1 spent a against things and slid out of ouple of times. TMA-A stated oncern regarding R1's er, she did not believe anyone	F	\$89			

Facility ID: 00581

If continuation sheet Page 12 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/17/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24E355	B. WING				C 19/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AFTENR	ОНОМЕ				10 WEST COLLEGE STREET DULUTH, MN 55811		
					·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 12	F6	89			
1 009	silent alarm alerted TMA-A stated staff silent alarm not aler stated the alarm ha from the bed to the "hassle." On 1/19/21, at 1:18 conducted with the (DON). The DON s cognition/memory a delusions/hallucinal cognition had progr being admitted to h was on an ambulati	staff when the R1 got up. had "some issues" with the rting staff previously. TMA-A d to be reset when moved wheelchair and it was a p.m. an interview was interim director of nursing stated R1 had poor and had a history of tions. The DON stated R1's essively declined prior to ospice. The DON stated R1 on program and did well. The		889			
	DON stated R1 was wheelchair, however it was easier for R1 backwards rather th R1 was able to use part, used it approp times, R1 would as of her. The DON st believed R1 used h she faded physicall stated R1 was initia	s able to self-propel her er, towards the end of R1's life to propel her wheelchair han forward. The DON stated her call light, and for the most riately. The DON stated, at k for items which were in front tated "towards the end" she er call light a "little less" when y and mentally. The DON illy able to toilet herself, red assistance of one staff					
	towards the end of was occasionally in DON stated R1 told the bathroom, howe bathroom without si DON confirmed R1 and stated it was co tubing. The DON si know if a toileting p however, stated a to benefited R1 prior to	red assistance of one staff her life. The DON stated R1 continent of bladder. The I staff when she needed use ever, R1 would use the taff assistance, at times. The was known to self-transfer oncerning as R1 had oxygen tated, at the end, she did not lan would had benefited R1, oileting plan may had o the last month of her life. d a toileting schedule was not					

If continuation sheet Page 13 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/17/2021 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		24E355	B. WING	i		(01/1) 19/2021
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	510 WEST COLLEGE STREET		
	OHOME			C	DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	part of R1's care planot recall if R1 lean wheelchair and rem wheelchair. The D0 forward in her wheel was in a "standard" had the capability to wheelchair. The D0 the facility consider the root cause anal received hospice se significant heart iss showing signs of te anxiety towards the stated R1's fall inter near the second-flo safety checks, a sile scheduled bedtime did not feel R1's be stated as part of a r evaluates factors w the fall, medication diagnoses. The D0 found on the floor in blood spot was tow near the television. believe R1 was atter bathroom. The D0 out what the root ca was a thought proc towards her wheelch her head and need laceration. The D0 pressure alarm did changed position. was unable to deter plugged in, had ma user error. The D0	ge 13 an. The DON stated she did ed to the side of her nembered R1 sliding out of her ON stated R1 would "slump" elchair. The DON stated R1 wheelchair and verbalized R1 o get up and out of her ON stated she did not believe ed auto-lock brakes as part of ysis. The DON stated R1 ervices and had CHF with ues. The DON stated R1 was rminal restlessness and end of her life. The DON rventions included a room or nurses' station, increased ent pressure alarm, and cares. The DON stated she haviors changed. The DON oot cause analysis the facility hich are noted at the time of changes, and medical ON stated on 7/5/20, R1 was n her room. The DON stated a ard the center of R1's room The DON stated she did not ompting to the use the N stated it was hard to figure ause of the fall was, but there ess that R1 may had went hair. The DON stated R1 hit ed 16 staples to repair a N confirmed R1's silent not alert staff when R1 had The DON stated the facility mine if the device was not functioned, or failed due to N stated the silent pressure and determined to be	F	689			

Facility ID: 00581

If continuation sheet Page 14 of 17

		AND HUMAN SERVICES				FORM	02/17/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		24E355	B. WING				C 19/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
AFTENR	O HOME				10 WEST COLLEGE STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	functional. The DC role when the invest DON stated, prior to needed to move the and forth from the b added, after the inco pressure alarm was did not need to move The DON stated NA education. The DC silent pressure alar and did not have ar Two attempts were however, contact we R4 R4's Admission Ree R4's diagnoses incl and abnormalities of R4's quarterly MDS had intact cognition assistance with bed and toilet use. R4 we seated to standing and wheelchair. R4 bladder and had on R4's Falls CAA date difficulty maintaining balance during tran- indicated R4 had a dysrhythmias, and to care plan was to mi	N stated she was not in her tigation was conducted. The o the incident on 7/5/20, staff e silent pressure alarm back bed to wheelchair. The DON ident, a second silent s added to R1's room so staff ve the alarm back and forth. As were also provided DN stated the facility used ms for approximately one year by similar issues. made to interview NA-C, as unable to be established. cord dated 1/20/21, indicated uded Parkinson's disease, of gait and mobility. dated 12/9/20, indicated R5 and the facility used R5 and the standy moving from a position and used a walker a was frequently incontinent of the fall without injury. ed 6/11/20, indicated R4 had g sitting balance and impaired sitions. R4's CAA further cognitive impairment, cardiac the overall objective of the inimize risks. ed indication of fall risk factors	F	\$89			

If continuation sheet Page 15 of 17

		AND HUMAN SERVICES				FORM	02/17/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		24E355	B. WING				C 19/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AFTENR	ОНОМЕ				10 WEST COLLEGE STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 15	F 6	89			
	indicated R4 was for bathroom door. R4	lated 12/10/20, at 4:45 p.m. ound sitting upright near his stated he was coming out of over to pick up a "grabber,"					
	indicated R4 was for R4 was naked from were towards the ba	lated 12/2/20, at 11:45 p.m. bund on the floor in his room. I the waist down and his legs athroom. R4 stated he got out the bathroom, and his legs					
	indicated R4 was for bathroom doorway.	lated 1/8/21, at 6:19 p.m. ound on the floor near his R4 stated he was reaching t the doorway, and fell.					
	conducted with R4. to get to the bathroot take himself to the R4 stated he had p go to the bathroom balance. R4 stated	p.m. an interview was R4 stated he used a walker om. R4 stated at times, he will bathroom without assistance. reviously fallen when trying to independently as he lost his I staff has told him not to a does not get "any answers" is call light.					
	conducted with TM, cognitively intact an TMA-B stated R4 k usually would urina TMA-B stated R4 n to use the toilet and TMA-B stated a car third-floor nurses' s	p.m. an interview was A-B. TMA-B stated R4 was d used a walker to ambulate. ept a urinal on his walker and te while sitting in his chair. eeded assistance of one staff the frequently called for help. re plan was located at the tation regarding fall pileting needs. At 4:02 p.m.					

		AND HUMAN SERVICES				FORM	02/17/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		24E355	B. WING	i			C 19/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
AFTENR	O HOME				310 WEST COLLEGE STREET DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	TMA-B went to the confirmed he was uplan. On 1/19/21, at 4:09 conducted with the was cognitively inta confused. The DO did not address fall information regardin The DON stated the be reviewed and up An untitled, undated Interdisciplinary Pla meet within the san discuss the causati prevent another fall	third-floor nurses' station and inable to locate R4's care p.m. an interview was DON. The DON stated R4 ct, however, could get "a little" N confirmed R4's care plan risks and interventions, nor ng R4's bowel and bladder. e resident's care plan should	F	589			

Facility ID: 00581

If continuation sheet Page 17 of 17



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 <u>only a suggestion</u> 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 <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. 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.

Aftenro Home February 8, 2021 Page 2

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

Minnesc	ta Department of He	alth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00581	B. WING		01/1) 9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AFTENR	ОНОМЕ		COLLEGE MN 55811	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	survey was conduct with State Licensure NOT in compliance Please indicate in y correction that you and identify the date	TS: n 1/19/21, an abbreviated ted to determine compliance e. Your facility was found to be with the MN State Licensure. our electronic plan of have reviewed these orders, e when they will be completed.				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 02/17/21

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 18

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00581	B. WING			19/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AFTENR	O HOME		T COLLEGE , MN 55811	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	The following comp SUBSTANTIATED: HE355007C HE355009C	laints were found to be				
	The following comp	laint was found to be ED: HE355008C.				
	5	ed in ePOC and therefore a uired at the bottom of the first				
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; General	2 830			2/23/21
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on interview facility failed to perf cause analysis whic factors to reduce th falls, and failed to d	ent is not met as evidenced and document review, the orm a comprehensive root ch identified individualized risk e likelihood of subsequent evelop a comprehensive care d fall risk factors and/or		The facility⊡s Medical Director Boyce was notified of the def DON will review POC and em education at the next schedu meeting to be held in March 2	iciency. The pployee led QAPI	

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		00581	B. WING		01/19/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
AFTENR	OHOME		F COLLEGE MN 55811	STREET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 830	Continued From pa	nge 2	2 830		
	reduce the risk of fa R4) reviewed for ac actual harm for R1	centered interventions to alls for 2 of 4 residents (R1, ccidents. This resulted in who fell and suffered a head ad medical intervention.		R1 expired on 7/8/20. R4□s care plan will be corrected to h identified fall risk factors and associa interventions. All resident□s that reside at Aftenro h	ited
	Findings include:			the potential to be affected by this practice.	lave
	R1's diagnoses incl of gait and mobility, (CHF), and general	cord printed 1/19/21, indicated luded weakness, abnormalities , congestive heart failure lized anxiety disorder. ange Minimum Data Set (MDS)		The facility will complete a Fall Risk Assessment on all Residents. Each assessment will be reviewed by the I ADON, or designee. Care plans will be adjusted based on the findings of the	be
	dated 6/14/20, indic cognitive impairment required extensive transfers, and toilet	cated R1 had moderate nt. R1's MDS identified she assistance with bed mobility, t use. R1's MDS further		assessment. All nurses will be educa on completing the Fall Risk Assessm after each fall.	ated ient
	frequently incontine symptoms were ide			The facility⊡s fall policy will be updat reflect changes. Fall paperwork will include an updated Incident Report, a Huddle form, Witness Statements fro	a Fall
	Catheter Care Area 6/17/20, indicated F mobility, and urinar			each employee on duty at the time of fall, and a Fall Risk Assessment. All nurses will be educated on completin updated Incident Report, Fall Huddle Form, and Witness Statement.	ng the
	received antipsycho (pain), and diuretic CAA further indicate impairment, anxiety	ed 6/17/20, indicated R1 otic, antidepressant, opioid (water pill) medication. The ed R1 had delirium, cognitive y disorder, incontinence, and as. R1 was referred to a		The facility will complete a Falls Management Root Cause Analysis u the Balance in Action: A Root Cause 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. T	and
	impaired cognitive processes related t further indicated R	sed 7/13/20, indicated R1 had function and thought to dementia. R1's care plan 1 had an activity of daily living icit related to activity		added to the resident is care plan. T DON or designee will summarize all at the conclusion of the IDT event an document in the resident is progress notes.	falls d

PRINTED: 02/17/2021 FORM APPROVED

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY _ETED
		00581	B. WING		01/1	; 9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		510 WES	T COLLEGE	STREET		
AFTENR	O HOME	DULUTH	MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 3	2 830			
	shortness of breath urinary leakage/blad diuretic use and im identified R1 require surface-to-surface	, impaired balance, and . R1 had the potential for dder incontinence related to paired mobility. The care plan ed assistance of one staff for transfers and directed staff to ing, as needed, per "resident		The DON, ADON, or design each resident fall paperwork completed for a total time days. Care plans will be a week x 1 month, then 2 per month, then 1 per week x total of 90 days. Results w at QAPI meetings.	ork packet that is period of 90 udited 3 per er week x 1 1 month for a	
	 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 wa 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 facility will develop a f all-staff in-service packet reviewed and turned in by February 23rd, 2021. This corrected items identified 02/23/21	that will be nursing staff by will include all		
		bund on the floor in her room. It barefoot. R1's wheelchair The wheelchair backrest was bom. R1 was half-way from the ed she was "going to get" "slipped on a blanket." No ed near R1. R1's call light . The facility root cause ed 4/13/20, indicated R1 had hess and balance." The RCA walked through her room to leaned on her wheelchair, and he wheelchair breaks were A lacked indication of how long all light to be answered, or if the bathroom. New				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						с
		00581	B. WING			19/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
AFTENR	О НОМЕ		T COLLEGE S MN 55811	TREET		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 4	2 830			
	socks. The facility of assessment for R1.	lid not complete a fall risk				
	indicated R1 was for R1 was sitting with R1's wheelchair wa table. A telephone table. R1 stated sh toenails and slipped dated 4/21/20, indic awareness, cognitiv The RCA further ind and was not wearin Corrective actions i care." No new inter	lated 4/21/20, at 11:45 p.m. bund on the floor in her room. her back up against her bed. s pushed to the side of a cord was wrapped around a the leaned forward to clip her d out of bed. The facility RCA cated R1 had, poor safety ve deficit, and poor balance. dicated R1 slipped off her bed g non-skid footwear. ncluded "continuing plan of ventions were identified. The blete a fall risk assessment for				
	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.					
	indicated R1 believe was attempting to s across the hall was	ed an individual across the hall leep in her bed. The room				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00581	B. WING			C 19/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
AFTENR	OHOME			STREET		
			MN 55811			()(=)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 5	2 830			
		ressant) medication R1 was 1 was scheduled for virtual				
	indicated R1 was for R1's left arm was n she was halfway in was attempting to p the bathroom. R1's the floor, but not ne 6/2/20, indicated R safety awareness, v conditions, chronic cognitive impairmen R1 toileted herself a up. R1 was not we interventions includ and "long-term" pla floor near the nurse					
	indicated R1 was for in her room. R1's w R1's pants were are she was going to he R1 was reminded to her pants. The faci indicated R1 had w awareness, cognitiv limitations, heart co	lated 6/4/20, at 12:00 p.m. bund sitting in front of the toilet wheelchair was near her bed. bund her knees. R1 stated er wheelchair from the toilet. b call for help when pulling up lity RCA dated 6/5/20, eakness, decreased safety //e impairment, visual inditions, chronic respiratory of falls. The RCA further				
	indicated R1 toilete fell while in the bath included a hospice medication manage	d herself independently and proom. New interventions referral for care and ement. The facility long-term ing R1 to the second floor				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
						с
		00581	B. WING			19/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
AFTENR	OHOME		ST COLLEGE S	TREET		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 6	2 830			
	continue increased not complete an as	ation. The facility was to safety checks. The facility did sessment of R1's toileting did not complete a fall risk				
	indicated R1's representation agency. The prograwould be screened health related to "ca	ted 6/5/20, at 11:59 a.m. esentative contacted a hospice ess note further indicated R1 for hospice due to failing ardiac issues, cognitive changes, and falls."	•			
	indicated R1 was for was midway betwee R1 was dressed an her. The wheelcha R1 was incontinent noted in R1's toilet. what had happened on floor" and R1 did was reminded to ca dated 6/9/20, indica decreased safety a impairment, visual I history of falls, and The RCA further ind edge of her bed and in it. Additionally, it to hospice the prev very "cluttered." Ne room cleaning, R1's room change. The assessment of R1's	lated 6/6/20, at 11:30 p.m. bund sitting on the floor, and en the bathroom and her bed. d a wheelchair was beside ir breaks were unlocked and of urine. Urine was also R1 was unable to explain d. R1's room had "no clutter d not have her oxygen on. R1 all for help. The facility RCA ated R1 had weakness, wareness, cognitive limitations, heart conditions, chronic respiratory failure. dicated R1 tried to sit on the d the bed mattress had a "dip" was noted R1 was admitted ious week and R1's room was ew interventions included a s mattress was turned, and a facility did not complete an s toileting needs. The facility fall risk assessment for R1.				
	indicated R1 was for	lated 6/23/20, at 7:15 a.m. ound laying under her bedside nair was near a closet. R1				

alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED	
00581	B. WING		01/19/202		
STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
		TREET			
TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	I SHOULD BE	(X5) COMPLET DATE	
RCA further indicated R1 had ess and impulsivity. New ed a silent pressure alarm to chair. The facility did not assessment for R1. ated 6/23/20, at 9:20 a.m. und sitting in front of her elevision. The facility RCA ated R1 had poor safety lance, weakness, fatigue, and ission. The RCA further cent medication changes ue to a decline in condition. I end-of-life restlessness and ventions included adding a m to R1's bed and wheelchair. ility indicated they would e regarding medication y did not complete a fall risk ed 7/5/20, at 11:02 a.m. und on the floor. R1 was f her chair and was holding eelchair was near her. R1 was ney department. ated 7/5/20, at 10:25 a.m. und on the floor and was off side of her head. R1 was er chair. R1 was noted to accration to the side of her to the hospital for treatment.					
	00581 STREET AI 510 WES DULUTH TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Ge 7 ing dandelions. The facility indicated R1 had poor safety lance, weakness, fatigue, hanges, cognitive impairment RCA further indicated R1 had ess and impulsivity. New ed a silent pressure alarm to chair. The facility did not assessment for R1. ated 6/23/20, at 9:20 a.m. und sitting in front of her elevision. The facility RCA ated R1 had poor safety lance, weakness, fatigue, and ission. The RCA further cent medication changes te to a decline in condition. end-of-life restlessness and ventions included adding a n to R1's bed and wheelchair. lity indicated they would a regarding medication y did not complete a fall risk ed 7/5/20, at 11:02 a.m. und on the floor. R1 was i her chair and was holding elchair was near her. R1 was i her chair and was holding the chair. R1 was noted to acceration to the side of her	IDENTIFICATION NUMBER: A. BUILDING: 00581 B. WING STREET ADDRESS, CITY, ST S10 WEST COLLEGES DULUTH, MN 55811 DULUTH, MN 55811 TEMENT OF DEFICIENCIES ID MUST BE PRECEDED BY FULL ID SCIDENTIFYING INFORMATION) PREFIX TAG JAG ge 7 2 830 ing dandelions. The facility indicated R1 had poor safety lance, weakness, fatigue, hanges, cognitive impairment, RCA further indicated R1 had ess and impulsivity. New ed a silent pressure alarm to chair. The facility did not chair. The facility RCA ated 6/23/20, at 9:20 a.m. und sitting in front of her elevision. The facility RCA ated R1 had poor safety lance, weakness, fatigue, and lance, weakness, fatigue, and ission. The RCA further cent medication changes et to a decline in condition. end-file restlessness and ventions included adding a n to R1's bed and wheelchair. lity indicated they would or regarding medication y did not complete a fall risk ed 7/5/20, at 11:02 a.m. und on the floor. R1 was	IDENTIFICATION NUMBER: A. BUILDING: 00581 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE STREET COLLEGE STREET DULUTH, NN 55811 PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION) TAG PREFIX CORRECTIVE ACTION (EACH CORRECTIVE ACTION) TAG DEPROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION) TAG OUTHER STREET DULUTH, NN 55811 TAG CORRECTIVE ACTION (EACH CORRECTIVE ACTION) TAG DEFICIENCIES IDE PRECEDED DY FULL CORRECTIVE ACTION TAG DEFICIENCIES IDE PRECEDED DY FULL CORRECTIVE ACTION CORRECTIVE ACTION TAG DEFICIENCIES <td col<="" td=""><td>IDENTIFICATION NUMBER: A BUILDING: COM 00581 B. WING 01/ STREET ADDRESS, CITY, STATE, ZIP CODE S10 WEST COLLEGE STREET DULUTH, MN 55811 PROVIDER'S PLAN OF CORRECTION WAST BE REPCEDED BY PLUL PREFIX INST BE REPCEDED BY PLUL PREFIX INST BE REPCEDED BY PLUL PREFIX ING CALCHOORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY ge 7 2 830 ID PROVIDER'S PLAN OF CORRECTION DEFICIENCY ge 7 2 830 Ing dandelions. The facility indicated R1 had poor safety lance, weakness, fatigue, hanges, cognitive impairment, RCA further indicated R1 had ess and impulsivity. New ad a silent pressure alarm to chair. The facility (id not assessment for R1. ated 6/23/20, at 9:20 a.m. und sitting in front of her levision. The facility RCA ated A fl had poor safety lance, weakness, fatigue, and ission. The RCA further cent medication changes te to a decline in condition. end-of-life restlessness and ventions included adding a n to R1's bed and wheelchair. lity indicated they would regraring medication y did not complete a fall risk ed 7/5/20, at 11:02 a.m. und on the floor. R1 was regraring medication y did not complete a fall risk ed 7/5/20, at 11:02 a.m. und on the floor and was ft side of her head. R1 was re chair. R1 was holding elchair was near her. R1 was re chair. R1 was noted to aceration to the side of her to the hospital for treatment. ed 7/5/20, indicated R1 had</td></td>	<td>IDENTIFICATION NUMBER: A BUILDING: COM 00581 B. WING 01/ STREET ADDRESS, CITY, STATE, ZIP CODE S10 WEST COLLEGE STREET DULUTH, MN 55811 PROVIDER'S PLAN OF CORRECTION WAST BE REPCEDED BY PLUL PREFIX INST BE REPCEDED BY PLUL PREFIX INST BE REPCEDED BY PLUL PREFIX ING CALCHOORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY ge 7 2 830 ID PROVIDER'S PLAN OF CORRECTION DEFICIENCY ge 7 2 830 Ing dandelions. The facility indicated R1 had poor safety lance, weakness, fatigue, hanges, cognitive impairment, RCA further indicated R1 had ess and impulsivity. New ad a silent pressure alarm to chair. The facility (id not assessment for R1. ated 6/23/20, at 9:20 a.m. und sitting in front of her levision. The facility RCA ated A fl had poor safety lance, weakness, fatigue, and ission. The RCA further cent medication changes te to a decline in condition. end-of-life restlessness and ventions included adding a n to R1's bed and wheelchair. lity indicated they would regraring medication y did not complete a fall risk ed 7/5/20, at 11:02 a.m. und on the floor. R1 was regraring medication y did not complete a fall risk ed 7/5/20, at 11:02 a.m. und on the floor and was ft side of her head. R1 was re chair. R1 was holding elchair was near her. R1 was re chair. R1 was noted to aceration to the side of her to the hospital for treatment. ed 7/5/20, indicated R1 had</td>	IDENTIFICATION NUMBER: A BUILDING: COM 00581 B. WING 01/ STREET ADDRESS, CITY, STATE, ZIP CODE S10 WEST COLLEGE STREET DULUTH, MN 55811 PROVIDER'S PLAN OF CORRECTION WAST BE REPCEDED BY PLUL PREFIX INST BE REPCEDED BY PLUL PREFIX INST BE REPCEDED BY PLUL PREFIX ING CALCHOORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY ge 7 2 830 ID PROVIDER'S PLAN OF CORRECTION DEFICIENCY ge 7 2 830 Ing dandelions. The facility indicated R1 had poor safety lance, weakness, fatigue, hanges, cognitive impairment, RCA further indicated R1 had ess and impulsivity. New ad a silent pressure alarm to chair. The facility (id not assessment for R1. ated 6/23/20, at 9:20 a.m. und sitting in front of her levision. The facility RCA ated A fl had poor safety lance, weakness, fatigue, and ission. The RCA further cent medication changes te to a decline in condition. end-of-life restlessness and ventions included adding a n to R1's bed and wheelchair. lity indicated they would regraring medication y did not complete a fall risk ed 7/5/20, at 11:02 a.m. und on the floor. R1 was regraring medication y did not complete a fall risk ed 7/5/20, at 11:02 a.m. und on the floor and was ft side of her head. R1 was re chair. R1 was holding elchair was near her. R1 was re chair. R1 was noted to aceration to the side of her to the hospital for treatment. ed 7/5/20, indicated R1 had

	NT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00581	B. WING			C 19/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
AFTENR	О НОМЕ		T COLLEGE S MN 55811	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	RCA further indicate the pharmacist and medications to redu Additionally, the inc assistants (NAs) we their next shift on si A "second" silent pr R1's wheelchair. Th fall risk assessmen A progress note dat indicated R1 returne "confused and refus pressure alarm was R1 had a laceration were in-place. R1 v on her left shoulder provided to NAs on and expected respon to ensure silent pre- initiated. An investigation sur R1 was noted to be maker" and had an injury related to corr 7/5/20, at 8:30 a.m. alarm sounded. R1 bed was made, and control box was pla R1 was seated, in the placed in front of he approximately 8:45 a.m. to 10:15 a.m. v staff walked past R sitting on the floor, in holding her head. F	had declining health. The ed the facility reached out to hospice for guidance and ice anxiety and wandering. ident report indicated nursing ere to be educated prior to lent pressure alarm function. essure alarm was installed on the facility did not complete a				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00581	B. WING			C 19/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
AFTENR	OHOME		T COLLEGE S , MN 55811	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	of her head, was tra department, and ha the laceration. The undetermined if R1' unplugged or malfu was tested, and it w not complete a fall r An emergency depa 7/10/20, at 10:25 a. indicated R1 had ar impulsive. R1 was ringing staff." R1 ha which was stapled. progressive decline been sleepy. A progress note dat indicated R1 attemp 11:30 p.m. R1 com restless, agitated, a Ativan and morphin sleep. At 4:45 a.m. "ouch, ouch." R1 w out of bed. Morphir slept since 5:15 a.m A progress note dat indicated hospice w medication review v indicated a nurse w Additionally, hospica wheelchair for R1. A progress note dat	ansferred to the emergency d 16 staples placed to repair investigation indicated it was s silent pressure alarm was nctioned. The silent alarm vas functional. The facility did risk assessment for R1. artment physician note signed m. for the ED visit on 7/5/20, n unwitnessed fall and was noted to "get up without ad a large left scalp laceration R1 was noted to have a , with minimal intake, and had ded 7/6/20, at 5:19 a.m. oted to crawl out of bed at plained of head pain, was nd aggressive. R1 received e at 11:50 p.m. R1 went to , R1 woke up and stated, ras again attempting to crawl ne was administered and R1				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ (°СОМ	E SURVEY PLETED
		00581	B. WING			<u>19/2021</u>
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
AFTENR	OHOME		T COLLEGE S , MN 55811	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 10	2 830			
	indicated R1 compl repositioning. R1 s grabbed for her hip look to her face and color was dusky. A progress note dat indicated R1 was ha	tated "ouch, ouch" and s and legs. R1 had a "distant" d was unable to focus. R1's ted 7/7/20, at 3:49 p.m. aving apneic (period of not s lasting 20-30 seconds.				
	A progress note dat indicated R1 died a	ted 7/8/20, at 4:28 p.m. t 11:31 a.m.				
	conducted with NA- R1's cognition was a lot. NA-A stated F request assistance, NA-A stated R1 was thing." NA-A stated her wheelchair, how difficult for her. NA independent with to assistance toileting admitted to hospice help pulling her par care. NA-A stated s was on a toileting s "probably was." NA interventions includ pressure alarm, and second-floor nurses worked on 7/5/20, a	ed frequent checks, a silent d R1 was moved closer to the s' station. NA-A stated she and attended to R1 when she				
	yell for help and she NA-A stated R1 was wheelchair, and R1	d. NA-A stated she heard R1 e responded to R1's room. s on the floor, near her 's head was bleeding. NA-A essure alarm was located on				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00581	B. WING			19/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
AFTENR	OHOME		T COLLEGE S MN 55811	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	pressure alarm on I R1's silent pressure had gotten up. NA- staff-person for help nurse. NA-A stated 911, and R1 was tra NA-A stated NA-C g NA-A stated NA-C g NA-A stated NA-C f bed, with a bedside left the room. NA-A silent pressure alar stated she did not k alarm did not alert s On 1/19/21, at 10:2 conducted with train (TMA)-A. TMA-A s "totally gone," and f long before R1 had received hospice se in April or May. TM to administer R1's r was terminally ill an was being said. TM R1's life she would sometimes she forg at times, R1 would staff there was a m stated R1 was unak needed. TMA-A sta assistance of one s transfers and toileti recall R1 being "bac brief for very long. to get up and toilet	ge 11 ated there was not a silent R1's wheelchair. NA-A stated e alarm did not alert staff R1 A stated she asked another p, left the room, and found a I a nurse assessed R1, called ansferred to the hospital. got R1 ready in the morning. told her R1 was seated on the table in front of R1, when she A stated she did check R1's m and it "was working." NA-A crow why R1's silent pressure staff R1 had gotten up. 1 a.m. an interview was ned medication assistant tated R1's cognition was nad progressively worsened died. TMA-A stated R1 ervices and started to decline A-A stated it was "impossible" medications. TMA-A stated R1 did not understand what MA-A stated towards the end of use the call light, however, got she had it. TMA-A stated, use her call light and informed an in her closet. TMA-A ole to verbalize what she ated R1 required the taff, with a gait belt, for ng. TMA-A stated R1 was known herself, especially towards the A-A stated toileting was an	2 830	DEFICIENC		
linnesota D	bed, with a bedside left the room. NA-A silent pressure alar stated she did not k alarm did not alert s On 1/19/21, at 10:2 conducted with train (TMA)-A. TMA-A s "totally gone," and h long before R1 had received hospice se in April or May. TM to administer R1's r was terminally ill an was being said. TM R1's life she would sometimes she forg at times, R1 would staff there was a m stated R1 was unab needed. TMA-A sta assistance of one s transfers and toileti recall R1 being "bac brief for very long. to get up and toilet end of her life. TM/ additional source of R1 frequently leane	table in front of R1, when she A stated she did check R1's m and it "was working." NA-A mow why R1's silent pressure staff R1 had gotten up. 1 a.m. an interview was hed medication assistant tated R1's cognition was had progressively worsened died. TMA-A stated R1 ervices and started to decline A-A stated it was "impossible" medications. TMA-A stated R1 did not understand what MA-A stated towards the end of use the call light, however, got she had it. TMA-A stated, use her call light and informed an in her closet. TMA-A ble to verbalize what she ated R1 required the taff, with a gait belt, for ng. TMA-A stated R1 was known herself, especially towards the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	СОМ	E SURVEY PLETED
		00581	B. WING			C 19/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
AFTENR	О НОМЕ		T COLLEGE S MN 55811	TREET		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 12	2 830			
	her wheelchair a co "everyone" had a co wheelchair, howeve had assessed it. Th administration was concern; however, i list." TMA-A stated included a room clo two-hour safety che supportive shoes, a TMA-A stated she w however, she only p resident. TMA-A st silent alarm alerted TMA-A stated staff silent alarm not aler stated the alarm ha from the bed to the "hassle."	aware of the wheelchair it was not "high on their priority R1's fall interventions ose to the nurses' station, ecks/toileting schedule, and a silent pressure alarm. worked when R1 fell on 7/5/20, provided medications to the ated she was unsure if R1's staff when the R1 got up. had "some issues" with the rting staff previously. TMA-A d to be reset when moved wheelchair and it was a				
	conducted with the (DON). The DON s cognition/memory a delusions/hallucinat cognition had progr being admitted to h was on an ambulati DON stated R1 was wheelchair, howeve it was easier for R1 backwards rather th R1 was able to use part, used it approp	tions. The DON stated R1's ressively declined prior to ospice. The DON stated R1 ion program and did well. The s able to self-propel her er, towards the end of R1's life to propel her wheelchair nan forward. The DON stated her call light, and for the most riately. The DON stated, at				
	of her. The DON sibelieved R1 used h she faded physicall	k for items which were in front tated "towards the end" she er call light a "little less" when y and mentally. The DON illy able to toilet herself,				

STATEMEI	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00581	B. WING			C 19/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	ATE, ZIP CODE		
		510 WES	T COLLEGE S	TREET		
AFIENR	OHOME	DULUTH	, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 13	2 830			
	towards the end of was occasionally in DON stated R1 told the bathroom, howe bathroom without si DON confirmed R1 and stated it was co tubing. The DON s know if a toileting p however, stated a to benefited R1 prior to The DON confirmed part of R1's care pla not recall if R1 lean wheelchair and rem wheelchair. The DO forward in her whee was in a "standard" had the capability to wheelchair. The DO the facility consident the root cause anall received hospice se significant heart iss showing signs of te anxiety towards the stated R1's fall inten near the second-flo safety checks, a sile scheduled bedtime did not feel R1's be stated as part of a r evaluates factors w the fall, medication diagnoses. The DO found on the floor in blood spot was towa	red assistance of one staff her life. The DON stated R1 continent of bladder. The staff when she needed use ever, R1 would use the taff assistance, at times. The was known to self-transfer oncerning as R1 had oxygen tated, at the end, she did not lan would had benefited R1, oileting plan may had o the last month of her life. d a toileting schedule was not an. The DON stated she did ed to the side of her tembered R1 sliding out of her ON stated R1 would "slump" elchair. The DON stated R1 wheelchair and verbalized R1 o get up and out of her ON stated she did not believe ed auto-lock brakes as part of ysis. The DON stated R1 envices and had CHF with ues. The DON stated R1 was rminal restlessness and end of her life. The DON rventions included a room or nurses' station, increased ent pressure alarm, and cares. The DON stated she haviors changed. The DON root cause analysis the facility hich are noted at the time of changes, and medical ON stated on 7/5/20, R1 was and the center of R1's room The DON stated she did not				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00581	B. WING			19/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
AFTENR	OHOME		ST COLLEGE S I, MN 55811	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ige 14 N stated it was hard to figure	2 830			
	was a thought proc towards her wheeld her head and need laceration. The DC pressure alarm did changed position. was unable to deter plugged in, had ma user error. The DC alarm was tested at functional. The DC role when the inves DON stated, prior to needed to move the and forth from the b added, after the inc pressure alarm was did not need to mov The DON stated N/ education. The DC silent pressure alar and did not have ar	ause of the fall was, but there ess that R1 may had went chair. The DON stated R1 hit ed 16 staples to repair a DN confirmed R1's silent not alert staff when R1 had The DON stated the facility rmine if the device was not lfunctioned, or failed due to DN stated the silent pressure nd determined to be DN stated she was not in her stigation was conducted. The o the incident on 7/5/20, staff e silent pressure alarm back bed to wheelchair. The DON sident, a second silent s added to R1's room so staff ve the alarm back and forth. As were also provided DN stated the facility used ms for approximately one year ny similar issues.	-			
		made to interview NA-C, as unable to be established.				
	R4's Admission Re	cord dated 1/20/21, indicated luded Parkinson's disease, of gait and mobility.				
	had intact cognition assistance with bec and toilet use. R4 seated to standing	dated 12/9/20, indicated R5 n. R4 required extensive d mobility, transfers, walking, was not steady moving from a position and used a walker 4 was frequently incontinent of				

STATEMEN	Ita Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00581	B. WING			19/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
AFTENR	О НОМЕ		T COLLEGE S , MN 55811	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 15	2 830			
	bladder and had on	e fall without injury.				
	difficulty maintaining balance during tran indicated R4 had a dysrhythmias, and t care plan was to mi R4's care plan lack and associated inte An incident report d	ed indication of fall risk factors rventions. lated 12/10/20, at 4:45 p.m.				
	bathroom door. R4	ound sitting upright near his stated he was coming out of over to pick up a "grabber,"				
	indicated R4 was for R4 was naked from were towards the ba	lated 12/2/20, at 11:45 p.m. bund on the floor in his room. the waist down and his legs athroom. R4 stated he got out the bathroom, and his legs				
	indicated R4 was for bathroom doorway.	lated 1/8/21, at 6:19 p.m. ound on the floor near his R4 stated he was reaching I the doorway, and fell.				
	conducted with R4. to get to the bathroot take himself to the l R4 stated he had pu go to the bathroom balance. R4 stated	p.m. an interview was R4 stated he used a walker om. R4 stated at times, he will bathroom without assistance. reviously fallen when trying to independently as he lost his staff has told him not to does not get "any answers" is call light.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMI	E SURVEY PLETED
		00581	B. WING			C 19/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
AFTENR	OHOME		COLLEGE S MN 55811	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	conducted with TM/ cognitively intact an TMA-B stated R4 ke usually would urinan TMA-B stated R4 ne to use the toilet and TMA-B stated a car third-floor nurses' si interventions and to TMA-B went to the confirmed he was up plan. On 1/19/21, at 4:09 conducted with the was cognitively inta confused. The DOI did not address fall information regardin The DON stated the be reviewed and up An untitled, undated Interdisciplinary Pla meet within the sam discuss the causativ prevent another fall necessary and revis SUGGESTED MET The DON or design and/or revise policie performing fall risk a comprehensive roo designee could edu the policies and pro	p.m. an interview was A-B. TMA-B stated R4 was d used a walker to ambulate. ept a urinal on his walker and te while sitting in his chair. eeded assistance of one staff I he frequently called for help. e plan was located at the tation regarding fall bileting needs. At 4:02 p.m. third-floor nurses' station and mable to locate R4's care p.m. an interview was DON. The DON stated R4 ct, however, could get "a little" N confirmed R4's care plan risks and interventions, nor ng R4's bowel and bladder. e resident's care plan should dated quarterly. d facility policy directed, "The n of Care (IPOC) team will ne time period of time and ve factors, interventions to , make therapy referral as see the care plan if necessary." THOD OF CORRECTION: ee could develop, review, es and procedures related to assessments and t cause analysis. The DON or cate all appropriate staff on cedures. The DON or elop monitoring systems to	2 830			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPF AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00581	B. WING			C 19/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
FTENR	ОНОМЕ		COLLEGE S MN 55811	TREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 17	2 830			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				

If continuation sheet 18 of 18