

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered January 27, 2022

Administrator Aftenro Home 510 West College Street Duluth, MN 55811

RE: CCN: 24E355

Cycle Start Date: December 23, 2021

Dear Administrator:

On January 27, 2022, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 5, 2022

Administrator Aftenro Home 510 West College Street Duluth, MN 55811

RE: CCN: 24E355

Cycle Start Date: January 5, 2022

Dear Administrator:

On December 23, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

Aftenro Home January 5, 2022 Page 2

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900

Email: susan.frericks@state.mn.us

Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Aftenro Home January 5, 2022 Page 3

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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 23, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 23, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

Aftenro Home
January 5, 2022
Page 4
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

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

PRINTED: 01/20/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		24E355	B. WING _		C 12/23/2021	
NAME OF F	PROVIDER OR SUPPLIER O HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		TION
F 000	INITIAL COMMENT		F 00	00		
	abbreviated survey Your facility was fou with the requiremen	12/23/21, a standard was conducted at your facility. Ind to be NOT in compliance hts of 42 CFR 483, Subpart B, ong Term Care Facilities.				
		laints was found to be HE355017C (MN79350), with t F689.				
	as your allegation of Departments acception enrolled in ePOC, yat the bottom of the	f correction (POC) will serve f compliance upon the stance. Because you are our signature is not required first page of the CMS-2567 c submission of the POC will ion of compliance.				
F 689 SS=D	onsite revisit of you validate that substa regulations has bee Free of Accident Ha	azards/Supervision/Devices	F 68	39	1/24/22	2
	supervision and assaccidents. This REQUIREMENT by:	resident receives adequate sistance devices to prevent		D1 has been discharged from this	fooility	
	facility failed to ens	and document review the ure a comprehensive	IATURE	R1 has been discharged from this	(X6) DATE	

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

(X6) DATE

Electronically Signed

01/14/2022

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED	
		24E355	B. WING			C 23/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		23/2021	
				510 WEST COLLEGE STREET			
AFTENR	O HOME			DULUTH, MN 55811			
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F 689	689 Continued From page 1		F 689	9			
	change in condition physician orders, a was made regardin time of a fall to prev	dical status to identify a was completed, following of and notification of the physician g a change in condition at the vent further falls for 1 of 3 ewed for accidents.		All residents have the poter affected by this practice. All licensed staff have been the comprehensive assessmedical status to identify a condition. Licensed staff has	educated on nent of change in		
	indicated R1's diag hypertension, chror age-related cognitiv R1's Minimum Data	a Set (MDS) assessment		condition. Licensed staff had educated on following physical and of notifying the physicial change in condition and to oppose the procedure for a comprehen assessment. All resident can been reviewed. All blood probeen reviewed by DON, AD designee. The Resident her	ng physician orders, physician regarding a and to complete the nprehensive fall sident care plans have blood pressures have DON, ADON, or		
	intact and had no s psychosis, behavio MDS further indicat ambulation and trail able to stabilize sel wheelchair. R1 wa urine, had a history no fall at the facility 11/2/21 and 11/8/22 period for the MDS			providers have been notified results as appropriate. The facility will update its blacking policy and procedure. This parameters for abnormal rewhen to notify the resident's healthcare provider. Educate all nursing staff. Non-license report all blood pressures to their shift to the charge nursing resident's primary healthcar	its blood pressure This will include nal results and dent's primary ducation will be for censed staff will res taken during e nurse. The		
	11/2/21, indicated F R1's care plan initia at risk for falls relat problems and weak fall in her room on being evaluated in care plan directed s prevent falls as liste In addition, R1's ca	ale assessment, dated R1 was at high risk for falling. ated 11/3/21, indicated R1 was ed to gait and balance kness and indicated R1 had a 12/13/21, which led to R1 the emergency room. R1's staff to ensure interventions to ed were provided or in place. re plan directed staff to e-toe assessment every shift		be updated of abnormal val The facility will also update nurse-to-nurse change-of-s policy to reflect the following outgoing charge nurse will poncoming nursing staff a verthe oncoming nursing staff required to participate and posignature acknowledging the present. The Director of Nursing, AD	its hift report g change; the provide the erbal report. will be provide a at they were		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDII			c	
		24E355	B. WING _			23/2021	
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
AFTENRO	HOME			510 WEST COLLEGE STREET			
AFTENRO	HOWE			DULUTH, MN 55811			
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for the control of th	the physician and respondent as necessary falls, review por mplement measure urther falls. R1's caret-up assistance between surfaces at review of R1's incorporess notes sincorporess notes sincorporess notes sincorporess notes sincorporess notes sincorporess notes sincorporess notes at 196 pressure (a blood pressure (ment assessments and notify esponsible party of the fall and ry, investigate the cause of ossible risk factors, and es as indicated to prevent are plan indicated R1 required by one staff to move safely as necessary. Cident reports and facility be R1's admission on 11/2/21 andicated R1 had the following 1:00 p.m. fell while getting off ot locked her wheelchair pressure at the time of the fall 8/104, and an orthostatic blood pressure reading in a sitting nother reading in the standing he if the blood pressure was ng unsteadiness or dizziness es) was not completed, ted on the incident report.	F 68	designee will audit all neurole assessments to include mon pressures for all falls for a to 90 days. The DON, ADON, owill monitor 5 residents per wellood pressures values x 30 residents per week x 30 days residents per month x 30 days of 90 days. The DON, ADON designee will audit and main shift-to-shift report sheets for of 90 days. Shift-to-Shift report be maintained by the facility period of 90 days. Results of will be reported at the month QAPI meetings for the 90-days.	itoring blood tal of or designee veek for days, 3 s, and 2 ys for a total I, or tain all ort sheets will for a it the all audits ly		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			510	EET ADDRESS, CITY, STATE, ZIP CODE WEST COLLEGE STREET .UTH, MN 55811	<u> 12/</u>	23/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	standing or lying to indicated there was pick up. R1's incide indicated R1 was e infection, though in in R1's medical state. R1's Home Health signed and dated 1 receiving home heat UTI's and falls, amount of the indicate o	sitting). R1's incident report to nothing on the floor for R1 to ent report and progress notes valuated for a urinary tract dicated there was no change tus. Certification and Plan of Care 1/17/21, indicated R1 was alth services for prevention of ong other areas of concern. killed nursing, physical ational therapy services	F6	89			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER O HOME			510 V	EET ADDRESS, CITY, STATE, ZIP CODE NEST COLLEGE STREET UTH, MN 55811	1 12/	20/2021
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F 689	indicated R1 continued denied dizziness, ligonsciousness. R1 hypertension (where frequently fluctuate R1 was alert and or (medication for seizlimits. R1's physician rour indicated R1's blood R1's physician charmedications. R1's physician visit indicated R1 had a due to her knee but that she felt fine wit R1's urinary urgenchad been stable at mentioned that incrindicated R1 had a pressures and medicated R1 had a pressures and medicated R1's blood prochanged upon adminimed R1's physician have satisfactory or and R1's physician comedications, and in the monitored. R1's home health or 12/7/21, indicated R1 physical therapy and medications and the physical therapy and medications and the physical therapy and medications are satisfacted R1.	ued to have frequent falls, and ghtheadedness, or loss of was also noted to have labile a a person's blood pressure is between normal and high). Tiented. R1's Keppra cures) level was within normal adding form dated 11/30/21, digressure was 154/94, and niged R1's blood pressure in notes dated 11/30/21, couple of falls without injury, ckling. R1 reported at that time in no particular symptoms. Ty and occasional incontinence the facility. R1's daughter had eased confusion previously bladder infection. R1's blood ications were reviewed and ressure medications had been ission. R1's blood pressures between 130-167/74-90, documented that R1 did not ontrol of her blood pressure thanged her blood pressure dicated her response would ommunication tool dated R1 was discharged from d had met her goals, was able meals, and transfer in room	F 6	89			
	-FALL- 12/12/21. at	9:00 a.m. R1 was found on					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
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NAME OF F	PROVIDER OR SUPPLIER O HOME			STREET ADDRESS, CITY, STATE, ZIP 510 WEST COLLEGE STREET DULUTH, MN 55811		
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F 689	the floor by her niglappeared to have hor the floor. R1's in blood pressure at the tat 205/112. R1's F12/13/21, at 10:30 at 7:30 a.m. indicate the time of her fall, were normal. R1's lacked indication of pressures. R1's promore confused relainfections, and an ocheck a urinalysis (R1's neurological fl slowly came down, before her fall on 1 her blood pressure 184/72. R1's progradocumentation indiwas notified of R1's though they indicate that R1's neurological floor and the slood pressure 184/72. R1's progradocumentation indiwas notified of R1's though they indicate that R1's neurological floor and the slood pressure 184/72. R1's progradocumentation individuals notified of R1's though they indicate that R1's neurological floor and the sloop indicate that R1's neurological floor and the sloo	htstand in her room and hit her face on the nightstand holden report indicated R1's he time of her fall was elevated all Review progress note dated a.m. and entered on 12/17/21, red R1 was more confused at and her neurological checks Fall Review progress note fR1's elevated blood ogress notes indicated R1 was reded to a history of urinary tract order had been obtained to (UA) and urine culture (UC). ow sheet R1's blood pressure and then was rising again 2/13/21. The last reading of at 3:30 p.m. on 12/13/21, was	F 68	9		
	R1 had bitten her b bruise around her r centimeter (cm) by her left elbow, and	nottom lip and had a large mouth and had sustained a 4 3 cm skin tear and bruise on requested a treatment for that.				
	the bathroom, and with left-sided weal face. R1 was incoh indicated R1's bloo	11:00 p.m. R1 had fallen in had possible stroke symptoms kness and drooping of the lerent. R1's incident report d pressure was 215/102. R1 ergency room for evaluation				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E355	B. WING				C 23/2021
NAME OF PROV	VIDER OR SUPPLIER	•		51	TREET ADDRESS, CITY, STATE, ZIP CODE TO WEST COLLEGE STREET ULUTH, MN 55811	,,	20,2021
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ann hee the R1 12 bee R1 da ann sy su no of rel se ca Or (D bee go de the we to int go sh Or (N hee sh	ematoma (a builde brain). I's progress note 1/13/21, lacked in the nobtained. I's hospital administed 12/13/21, incompleted to a subdural hematom of the department of the admission, which lated to a subdurizure. R1 and faires. In 12/22/21, at 1:40 (CN) stated R1 hematom independent of the partment had long the nurses station of the root causerventions in played and 12/23/21, at 11 (A)-A stated R1 was gave her medicine fell on 12/12/2 (In 12/23/21, at 11 (In 1	to the hospital with a subdural lup of blood on the surface of lup of l	F	689			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		24E355	B. WING		12	C :/23/2021	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (510 WEST COLLEGE STREET DULUTH, MN 55811	•		
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F 689	do vital signs, and stated they do a not report, and huddle stated they do regifall, but will do orthresident said they was working when stated R1 denied has getting ready talked to R1 about bed before she fel tired around bedtir toilet after her fall, noticed a droop of weakness on her laneurological che sent her in to the she had not been signs of a stroke b LPN-A stated they R1, but had not be to her fall. LPN-A condition changes the resident needer communicated at a urinary collection sits on the lower rithe urine sample) On 12/23/21, at 12 (NP), stated she diphysician was notipressures, though on-call provider. To notified her throug for her to review with NP stated she would blood pressure to	ask them questions. LPN-A eurological check form, do a fall to discuss the fall. LPN-A ular blood pressures after they nostatic blood pressures if the were dizzy. LPN-A stated she R1 fell on 12/13/21. LPN-A nitting her head, and said she for bed. LPN-A stated she had asking for help to get ready for I, as R1 had told her she gets me. R1 was assisted to the and then was staring, and they her face and she had eft side. LPN-A stated they did ck, called R1's daughter and emergency room. LPN-A stated confused and did not have refore the fall on 12/13/21. Were unable to get a UA on retain the told she needed a UA prior stated they hear about in shift change report, and if red a UA, it would be that time. LPN-A did not recall a hat" (a plastic container that m, under the toilet seat to catch in R1's toilet that night. 2:09 p.m. nurse practitioner id not recall if she or R1's fied of R1's elevated blood the facility could have called an He NP stated the facility usually han note in the rounding folder then she visited the facility. The all have attributed R1's high her fall and would have asked and call her back after a couple and call her back after a couple and call her back after a couple and call her back after a couple.	F6	i89			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED	
		24E355	B. WING _			C / 23/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 510 WEST COLLEGE STREET DULUTH, MN 55811			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 689	of hours if it had no R1 had symptoms treated her without would not have ma her fall that soon af dose of antibiotics if allen then, and had high blood pressure other falls. The NP declining. The NP sexpected the facility the norm, such as symptoms of a UTI On 12/23/21, at 12 was not aware that that high. The DON had not been that h 12/12/21. The DON physician or provide blood pressures, and documentation to in notified. The DON notified of abnormal stated they should symptoms for the reprovider. The DON it should be docum log and be passed nodded his head in high blood pressure fallen so close to the occurrences of her On 12/23/21, at 1:3	of a UTI, she would have the UA or culture, and said it de a difference in preventing iter the order, with only one in her system. If R1 had not deen treated for a UTI or exit could have prevented stated R1 was functionally stated she would have you notify her if R1 was out of with high blood pressures or with high blood pressures were I stated R1's blood pressures high earlier in the day on I stated he was not sure if the er was notified of the high and agreed there was no indicate the provider had been verified the provider should be all blood pressure reading and investigate abnormal results or esident, and then notify the stated if a UA was to be done, ented in the communication on shift to shift. The DON agreement that treatment of each of the provider of alls for R1, had not the resident we episodes of initial symptoms.	F 68	39			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E355	B. WING		42	C / 23/2021
NAME OF F	PROVIDER OR SUPPLIER O HOME	272000		STREET ADDRESS, CITY, STATE, ZIP 510 WEST COLLEGE STREET DULUTH, MN 55811		123/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	The facility policy are Protocol dated 2/16 for vital signs, include assess neurological primary care provide directed staff to repfacility policy and prograding obtaining and reporting abnormal symptoms to the protocological primary care provided in the protocological protoc	and procedure for Fall Clinical 1/21, directed nursing to check ding a blood pressure and I symptoms, and notify the er. The facility procedure ort to the oncoming shift. The rocedure lacked direction orthostatic blood pressures smal vitals or sings and hysician. Independent of Change in a nor Status revised 5/17, notify the resident's physician when there has been a	F6	89		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 5, 2022

Administrator Aftenro Home 510 West College Street Duluth, MN 55811

Re: State Nursing Home Licensing Orders

Event ID: XOFD11

Dear Administrator:

The above facility was surveyed on December 22, 2021 through December 23, 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Aftenro Home January 5, 2022 Page 2

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

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

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

Susan Frericks, Unit Supervisor Metro D District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health PO Box 64990 St. Paul MN 55164-0900

Email: susan.frericks@state.mn.us

Mobile: (218) 368-4467

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

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

PRINTED: 01/20/2022 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00504	B. WING		C	
		00581	B. WINO		12/2	3/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AFTENR	AFTENRO HOME DULUT			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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficition herein are not corrected shall I	Minnesota Statute, section order has been issued y. If, upon reinspection, it is iency or deficiencies cited octed, a fine for each violation oe assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of tlack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. It is several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	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 nin 15 days of receipt of a nt for non-compliance.				
	was conducted at y the Minnesota Depa facility was found N State Licensure. Pla plan of correction yo	TS: 2/23/21, a complaint survey our facility by surveyors from artment of Health (MDH). Your OT in compliance with the MN ease indicate in your electronic ou have reviewed these orders e when they will be completed.				

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

Electronically Signed 01/14/22

TITLE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00581	B. WING		12/2	23/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AFTENR	О НОМЕ		T COLLEGE MN 55811	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	0 Continued From page 1		2 000			
	The following comp SUBSTANTIATED: with a licensing ord The Minnesota Dep documenting the St Orders using Feder have been assigned statutes/rules for N tag number appear "ID Prefix Tag." The compliance is listed of Deficiencies" collowed Comply" portion of column also include violation of the state "This Rule is not me the surveyor's find Method of Correction.	plaint was found to be HE355017C (MN79350), er issued at 0830. partment of Health is tate Licensing Correction ral software. Tag numbers d to Minnesota state ursing Homes. The assigned s in the far-left column entitled e state statute/rule out of d in the "Summary Statement umn and replaces the "To the correction order. This es the findings which are in e statute after the statement, et as evidence by." Following lings are the Suggested on and Time Period for				
	receipt of State lice the Minnesota Dep. Informational Bullet https://www.health on/infobulletins/ib14 orders are delineate Department of Hea you electronically, is necessary for State enter the word "CO available for text. Ye electronic State lice heading completion be corrected prior to the Minnesota Dep. is enrolled in ePOC	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at n.state.mn.us/facilities/regulati 4_1.html> The State licensing ed on the attached Minnesota lth orders being submitted to Although no plan of correction ate Statutes/Rules, please RRECTED" in the box ou must then indicate in the ensure process, under the n date, the date your orders will o electronically submitting to artment of Health. The facility and therefore a signature is bottom of the first page of				

Minnesota Department of Health

STATE FORM KOFD11 If continuation sheet 2 of 12

			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00594				2/2024
NAME OF I		00581			12/2	3/2021
	PROVIDER OR SUPPLIER		COLLEGE	STATE, ZIP CODE STREET		
AFTENR	О НОМЕ	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	state form.					
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			1/24/22
	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.					
	by: Based on interview facility failed to ens assessment of med change in condition physician orders, at was made regardin	and document review the ure a comprehensive dical status to identify a was completed, following of and notification of the physician g a change in condition at the vent further falls for 1 of 3 ewed for accidents.		N/A		

6899

Minnesota Department of Health STATE FORM

XOFD11 If continuation sheet 3 of 12

Minnesota Department of Health						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		00504	B. WING			
		00581	B. WIIVO		12/2	3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		510 WFS	COLLEGE	STREET		
AFTENR	O HOME		MN 55811	OTREET		
			WIN 33011			
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		DATE
IAO		,	IAG	DEFICIENCY)		
2 830	Continued From pa	ge 3	2 830			
	R1's Admission Re	cord printed 12/23/21,				
		noses included seizures,				
		nic kidney disease, and				
	age-related cognitive	/e decline.				
	Dala Minimorum Data	Cat (MDC) accomment				
		a Set (MDS) assessment				
	· ·	icated R1 was cognitively				
		ymptoms of delirium,				
		rs or mood concerns. R1's				
		ed R1 was independent with				
		nsfers, was not steady but was				
		f, and used a walker or a				
		s frequently incontinent of				
		of falls prior to admission, had				
	no fall at the facility	between admission on				
	11/2/21 and 11/8/21	I, which was the assessment				
	period for the MDS					
	R1's Morse Fall Sc	ale assessment, dated				
	11/2/21, indicated F	R1 was at high risk for falling.				
	R1's care plan initia	ated 11/3/21, indicated R1 was				
	at risk for falls relat	ed to gait and balance				
		ness and indicated R1 had a				
	fall in her room on	12/13/21, which led to R1				
		the emergency room. R1's				
		staff to ensure interventions to				
		ed were provided or in place.				
		re plan directed staff to				
		-toe assessment every shift				
		nent assessments and notify				
		esponsible party of the fall and				
		ry, investigate the cause of				
		ossible risk factors, and				
		es as indicated to prevent				
		are plan indicated R1 required				
		y one staff to move safely				
	between surfaces a	as necessary.				
	A mandany of DAIs in	sident nements and for all to				
	A review of R1's inc	cident reports and facility				

Minnesota Department of Health STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					С	
		00581	B. WING		12/2	3/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AFTENR	O HOME		MN 55811	STREET		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
2 830	Continued From pa	ge 4	2 830			
	progress notes since R1's admission on 11/2/21 through 12/14/21, indicated R1 had the following falls: -FALL-11/10/21, at 1:00 p.m. fell while getting off the toilet and had not locked her wheelchair brakes. R1's blood pressure at the time of the fall was elevated at 198/104, and an orthostatic blood pressure (a blood pressure reading in a sitting position and then another reading in the standing position to determine if the blood pressure was dropping and causing unsteadiness or dizziness with position changes) was not completed, though was prompted on the incident report. R1's blood pressures ranged from 146-200/92-122, with the highest being 200/122. R1's root cause analysis lacked identification of high blood pressures and review of orthostatic blood pressures. R1's incident report and progress notes lacked documentation to indicate the physician had been notified of R1's high blood pressures. -FALL-11/14/21, at 2:00 p.m. R1 fell while trying					
	the door when her I pressure was 168/S R1 had no orthosta pressure with positi standing or lying to indicated there was pick up. R1's incide indicated R1 was einfection, though in R1's medical state					
	signed and dated 1 receiving home hea	Certification and Plan of Care 1/17/21, indicated R1 was alth services for prevention of ong other areas of concern.				

Minnesota Department of Health

STATE FORM KOFD11 If continuation sheet 5 of 12

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					С	
00581			B. WING		12/2	3/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AFTENR	O HOME		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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 5	2 830			
		killed nursing, physical ational therapy services 21 through 1/3/22.				
	her bedding and sli something. R1's blo orthostatic blood princident report indic change in medical s status assessment	9:30 p.m. R1 got tangled up in dout of bed while reaching for bod pressure was 136/84, no essure was recorded, and her lated R1 had no recent status. R1's neurological sheet indicated R1 had ressure elevations up to				
	R1's home health communication toll dated 11/24/21, indicated R1 was able to walk to meals with her four-wheeled walker and standby assist.					
	indicated R1's blood nurse summary of a was left blank. The concerns was left b	ding form dated 11/26/21, d pressure was 119/74 and the any changes since last rounds nurse report of any new lank. R1's rounding form e no new physician orders.				
	11/26/21, indicated working with PT and indicated R1 continued dizziness, liquid consciousness. R1 hypertension (when frequently fluctuates R1 was alert and or	ner (NP) visit notes dated R1 had frequent falls and was d OT. NP documentation ued to have frequent falls, and ghtheadedness, or loss of was also noted to have labile a person's blood pressure is between normal and high). riented. R1's Keppra				
	indicated R1's blood	ding form dated 11/30/21, d pressure was 154/94, and nged R1's blood pressure				

Minnesota Department of Health

STATE FORM KOFD11 If continuation sheet 6 of 12

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.		С	
		00581	B. WING		1	3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ΔFTFNR	O HOME	510 WEST	COLLEGE	STREET		
ALIENIN	O TIOME	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
	medications.					
	indicated R1 had a due to her knee but that she felt fine wit R1's urinary urgenchad been stable at mentioned that incrindicated R1 had a pressures and med noted R1's blood prochanged upon admixer enoted to range and R1's physician have satisfactory cound her physician of the state of the s	notes dated 11/30/21, couple of falls without injury, ckling. R1 reported at that time th no particular symptoms. Ey and occasional incontinence the facility. R1's daughter had eased confusion previously bladder infection. R1's blood dications were reviewed and ressure medications had been ission. R1's blood pressures to between 130-167/74-90, documented that R1 did not control of her blood pressure thanged her blood pressure edicated her response would				
	12/7/21, indicated F physical therapy an	ommunication tool dated R1 was discharged from d had met her goals, was able meals, and transfer in room ependently.				
	the floor by her night appeared to have hor the floor. R1's in blood pressure at that 205/112. R1's Faratrian 12/13/21, at 10:30 at 7:30 a.m. indicate the time of her fall, were normal. R1's lacked indication of pressures. R1's promore confused relations.	9:00 a.m. R1 was found on intstand in her room and lit her face on the nightstand incident report indicated R1's the time of her fall was elevated all Review progress note dated a.m. and entered on 12/17/21, ed R1 was more confused at and her neurological checks Fall Review progress note R1's elevated blood ogress notes indicated R1 was uted to a history of urinary tractorder had been obtained to				

Minnesota Department of Health

STATE FORM 6899 XOFD11 If continuation sheet 7 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION		E SURVEY PLETED	
		00581	B. WING			C 23/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
AFTENR	O HOME		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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	check a urinalysis (R1's neurological flus slowly came down, before her fall on 12 her blood pressure 184/72. R1's progradocumentation indiction was notified of R1's though they indicated that R1's neurological A Resident Fax Let 12/12/21, indicated R1 had bitten her burise around her recentimeter (cm) by her left elbow, and R1's fax form lacked elevated blood pressure 12/13/21, at the bathroom, and with left-sided weak face. R1 was incohindicated R1's blood was sent to the emand was admitted to hematoma (a builded the brain). R1's progress notes 12/13/21, lacked incoher obtained. R1's hospital admiss dated 12/13/21, indicated mental symptoms, and was subdural hematoma.	UA) and urine culture (UC). ow sheet R1's blood pressure and then was rising again 2/13/21. The last reading of at 3:30 p.m. on 12/13/21, was ess notes lacked cating R1's physician/provider selevated blood pressures, ed R1's provider was notified cal checks were normal. ter to R1's physician dated R1's physician was notified ottom lip and had a large nouth and had sustained a 4 3 cm skin tear and bruise on requested a treatment for that. d any indication of R1's				

Minnesota Department of Health

STATE FORM 6899 XOFD11 If continuation sheet 8 of 12

AND DIAN OF CORRECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00581	B. WING			C 23/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
AFTENR	O HOME		T COLLEGE S	STREET		
0(1) 15	CLIMMA DV CTA		, MN 55811		DDDECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 8	2 830			
	related to a subdura	n the physician suspected was al hematoma or possible mily chose to initiate comfort				
	(DON) stated R1 had become independe going to get a UA. department had loo the nurses station of were checking on his to find the root cause interventions in place.	9 p.m. the director of nursing ad worked with therapies and nt in her room, and they were The DON stated the wellness oked at her, she was close to due to her fall risk, and staff her. The DON stated they tried se of the fall and put ce. The DON stated they had e, but R1 had not told them t sat too long.				
	(NA)-A stated R1 w he gave her medica	02 a.m. nursing assistant ras alert in the morning when ations, but was confused when I, and had bit her lip.				
	nurse (LPN)-A state assess them, ask h do vital signs, and a stated they do a ne report, and huddle stated they do regulated they do orthoresident said they was working when stated R1 denied his was getting ready for talked to R1 about a bed before she fell, tired around bedtim toilet after her fall, a noticed a droop of h	15 p.m. licensed practical ed when a resident falls, they now they feel, how did they fall, ask them questions. LPN-A urological check form, do a fall to discuss the fall. LPN-A lar blood pressures after they estatic blood pressures if the vere dizzy. LPN-A stated she R1 fell on 12/13/21. LPN-A itting her head, and said she or bed. LPN-A stated she had asking for help to get ready for as R1 had told her she gets are. R1 was assisted to the and then was staring, and they her face and she had eft side. LPN-A stated they did				

Minnesota Department of Health

STATE FORM KOFD11 If continuation sheet 9 of 12

PRINTED: 01/20/2022 FORM APPROVED

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE \$10 WEST COLLEGE STREET DULLITH, NN 55811 CX4) ID PREFIX REACH DEPRICIENCY MUST BE PRECEDED BY PILL PREFIX TAG CONTINUED FROM THE PROVIDER'S ACTION SHOULD BE PROVIDER'S ACTION SHOULD BE PREFIX TAG CONTINUED FROM THE PROVIDER'S ACTION SHOULD BE PROVIDER'S ACTION SHOULD BE PREFIX TAG CONTINUED FROM THE PROVIDER'S ACTION SHOULD BE PROVIDER'S ACTION SHOULD BE PREFIX TAG 2 830 Continued From page 9 a neurological check, called R1's daughter and sent her in to the emergency room. LPN-A stated she had not been confused and did not have signs of a stroke before the fall on 12/13/21. LPN-A stated they were unable to get a UA on R1, but had not been told she needed a UA prior to her fall. LPN-A did not recall a urinary collection "hat" (a plastic container that sits on the lower rim, under the tollet seat to catch the urine sample) in R1's tollet that right. On 12/23/21, at 12:09 p.m. nurse practitioner (NP), stated she did not recall if she or R1's physician was notified of R1's elevated blood pressures, though the facility could have called an on-call provider. The NP stated the facility usually notified her through a note in the rounding folder for her to review when she visited the facility. The NP stated she would have asked them to monitor and call her back after a couple of hour's fit had not come down. The NP stated if R1 had symptoms of a UTI, she would have treated her without the UA or culture, and said it would not have made a difference in preventing her fall that soon after the order, with only one dose of antibiotics in her system. If R1 had not fallen then, and had been treated for a UTI or high blood pressure, it could have prevented other falls. The NP stated SH would have expected the facility to notify her if R1 was out of the norm, such as with high blood pressures or symptoms of a UTI.		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE \$10 WEST COLLEGE STREET DULUTH, MN 55811 (EACH DEPICIENCY MUST BE PRECEDED BY FULL PREFIX TAG. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG. 2 830 Continued From page 9 a neurological check, called R1's daughter and sent her in to the emergency room. LPN-A stated she had not been confused and did not have signs of a stroke before the fall on 12/13/21. LPN-A stated they were unable to get a UA on R1, but had not been told she needed a UA prior to her fall. LPN-A stated they her about condition changes in shift change report, and if the resident needed a UA, it would be communicated at that time. LPN-A did not recall a urinary collection "hat" (a plastic container that sits on the lower rim, under the tollet seat to catch the urine sample) in R1's tollet that right. On 12/23/21, at 12:09 p.m. nurse practitioner (NP), stated she did not recall fish er R1's physician was notified of R1's elevated blood pressures, though the facility could have called an on-call provider. The NP stated the facility. The NP stated she would have attributed R1's high blood pressure to her fall and would have asked them to monitor and call her back after a couple of hours if it had not come down. The NP stated if R1 had symptoms of a UTI, she would have treated her without the UA or culture, and said it would not have made a difference in preventing her fall that soon after the order, with only one dose of antibiotics in her system. If R1 had not fallen then, and had been treated for a UTI or high blood pressure is would have expected the facility to notify her if R1 was out of the norm, such as with high blood pressures or symptoms of a UTI.				7 5 5		C	
AFTENRO HOME X(A) ID PREFIX (EACH LEGERICENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (EACH LEGERICENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (EACH LEGERICENCY MUST BE PRECEDED BY FULL TAG ID PREFIX TAG			00581	B. WING		12/2	3/2021
CALL	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 9 a neurological check, called R1's daughter and sent her in to the emergency room. LPN-A stated she had not been confused and did not have signs of a stroke before the fall on 12/13/21. LPN-A stated they were unable to get a UA on R1, but had not been been been been dead a UA prior to her fall. LPN-A stated they hear about condition changes in shift change report, and if the resident needed a UA, it would be communicated at that time. LPN-A did not recall a urinary collection 'hat' (a plastic container that sits on the lower rim, under the toilet seat to catch the urine sample) in R1's toilet that night. On 12/23/21, at 12:09 p.m. nurse practitioner (INP), stated she did not recall facility could have called an on-call provider. THe NP stated the facility usually notified her through a note in the rounding folder for her to review when she visited the facility usually notified her through a note in the rounding folder for her to review when she visited the facility. The NP stated she would have attributed R1's high blood pressure to her fall and would have asked them to monitor and call her back after a couple of hours if it had not come down. The NP stated if R1 had symptoms of a UTI, she would have treated her without the UA or culture, and said it would not have made a difference in preventing her fall that soon after the order, with only one dose of antibiotics in her system. If R1 had not fallen then, and had been treated for a UTI or high blood pressure, it could have expected the facility to notify her if R1 was out of the norm, such as with high blood pressures or symptoms of a UTI.	AFTENR	О НОМЕ			STREET		
a neurological check, called R1's daughter and sent her in to the emergency room. LPN-A stated she had not been confused and did not have signs of a stroke before the fall on 12/13/21. LPN-A stated they were unable to get a UA on R1, but had not been told she needed a UA prior to her fall. LPN-A stated they hear about condition changes in shift change report, and if the resident needed a UA, it would be communicated at that time. LPN-A did not recall a urinary collection 'hat' (a plastic container that sits on the lower rim, under the toilet seat to catch the urine sample) in R1's toilet that night. On 12/23/21, at 12:09 p.m. nurse practitioner (NP), stated she did not recall if she or R1's physician was notified of R1's elevated blood pressures, though the facility could have called an on-call provider. THe NP stated the facility usually notified her through a note in the rounding folder for her to review when she visited the facility. The NP stated she would have attributed R1's high blood pressure to her fall and would have asked them to monitor and call her back after a couple of hours if it had not come down. The NP stated if R1 had symptoms of a UTI, she would have treated her without the UA or culture, and said it would not have made a difference in preventing her fall that soon after the order, with only one dose of antibiotics in her system. If R1 had not fallen then, and had been treated for a UTI or high blood pressure, it could have prevented other falls. The NP stated she would have expected the facility to notify the rif R1 was out of the norm, such as with high blood pressures or symptoms of a UTI.	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
On 12/23/21, at 12:40 p.m. the DON stated he	2 830	a neurological checksent her in to the ershe had not been of signs of a stroke be LPN-A stated they on R1, but had not beet to her fall. LPN-A scondition changes if the resident needed communicated at the urinary collection "hists on the lower ring the urine sample) if the urine sample on 12/23/21, at 12: (NP), stated she did physician was notificated her through for her to review who NP stated she would blood pressure to he them to monitor and of hours if it had no R1 had symptoms of the treated her without would not have man her fall that soon af dose of antibiotics if allen then, and had high blood pressure other falls. The NP declining. The NP sexpected the facility the norm, such as a symptoms of a UTI	ck, called R1's daughter and mergency room. LPN-A stated confused and did not have effore the fall on 12/13/21. Were unable to get a UA on en told she needed a UA prior stated they hear about in shift change report, and if d a UA, it would be not time. LPN-A did not recall a not" (a plastic container that in, under the toilet seat to catch in R1's toilet that night. 109 p.m. nurse practitioner d not recall if she or R1's ited of R1's elevated blood the facility could have called an in the rounding folder in the rounding folder in she visited the facility. The lid have attributed R1's high interfall and would have asked d call her back after a couple of come down. The NP stated if of a UTI, she would have the UA or culture, and said it de a difference in preventing for the order, with only one in her system. If R1 had not dispersive the unit of a UTI or entity in the could have prevented stated R1 was functionally stated she would have you notify her if R1 was out of with high blood pressures or .	2 830			

Minnesota Department of Health STATE FORM

KOFD11 If continuation sheet 10 of 12

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ### STEET ADDRESS ### STEET ADDRESS, CITY, STATE, ZIP CODE ### STEET ADDRESS ### STATE ### STATE ### STATE ### STATE ### STATE ### STATE ### SUMMARY STATEMENT OF CORRECTION ### CACH C		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE S10 WEST COLLEGE STREET DULUTH, MN 55811 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 10 that high. The DON stated R1's blood pressures had not been that high earlier in the day on 12/12/21. The DON stated he was not sure if the physician or provider was notified of the high blood pressures, and agreed there was no documentation to indicate the provider had been notified. The DON verified the provider should be notified of abnormal blood pressure reading and				71. 501251110.		C	
AFTENRO HOME SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY			00581	B. WING			
AFTENRO HOME DULUTH, MN 55811 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 10 that high. The DON stated R1's blood pressures had not been that high earlier in the day on 12/12/21. The DON stated he was not sure if the physician or provider was notified of the high blood pressures, and agreed there was no documentation to indicate the provider should be notified. The DON verified the provider should be notified of abnormal blood pressure reading and X4 ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) X5 COMPLETE DATE DATE	NAME OF	PROVIDER OR SUPPLIER					
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that high. The DON stated R1's blood pressures had not been that high earlier in the day on 12/12/21. The DON stated he was not sure if the physician or provider was notified of the high blood pressures, and agreed there was no documentation to indicate the provider had been notified. The DON verified the provider should be notified of abnormal blood pressure reading and	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
symptoms for the resident, and then notify the provider. The DON stated if a UA was to be done, it should be documented in the communication log and be passed on shift to shift. The DON nodded his head in agreement that treatment of high blood pressures or a UTI could have prevented further falls for R1, had not the resident fallen so close to the episodes of initial occurrences of her symptoms. On 12/23/21, at 1:30 p.m. the DON stated the facility did not have a policy and procedure for shift to shift communication logs. The facility policy and procedure for Fall Clinical Protocol dated 2/16/21, directed nursing to check for vital signs, including a blood pressure and assess neurological symptoms, and notify the primary care provider. The facility procedure directed staff to report to the oncoming shift. The facility policy and procedure lacked direction regarding obtaining orthostatic blood pressures and reporting abnormal vitals or sings and symptoms to the physician. The facility policy and procedure for Change in a Resident's Condition or Status revised 5/17, directed nursing to notify the resident's physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition, or when	2 830	that high. The DON had not been that h 12/12/21. The DON physician or provide blood pressures, ard documentation to in notified. The DON notified of abnorma stated they should is symptoms for the reprovider. The DON it should be docume log and be passed nodded his head in high blood pressure prevented further fa fallen so close to th occurrences of her On 12/23/21, at 1:3 facility did not have shift to shift community to shift to shift community to shift to shift community assess neurological primary care provided directed staff to repfacility policy and pregarding obtaining and reporting abnorsymptoms to the promote or physician on call significant change in the staff to represent the provided in the provide	I stated R1's blood pressures igh earlier in the day on I stated he was not sure if the er was notified of the high ad agreed there was no ndicate the provider had been werified the provider should be all blood pressure reading and investigate abnormal results or esident, and then notify the stated if a UA was to be done, ented in the communication on shift to shift. The DON agreement that treatment of es or a UTI could have alls for R1, had not the resident e episodes of initial symptoms. O p.m. the DON stated the a policy and procedure for inication logs. Indiprocedure for Fall Clinical id/21, directed nursing to check ding a blood pressure and all symptoms, and notify the er. The facility procedure ort to the oncoming shift. The rocedure lacked direction orthostatic blood pressures rmal vitals or sings and hysician. Indiprocedure for Change in a en or Status revised 5/17, notify the resident's physician when there has been a nother resident's	2 830			

Minnesota Department of Health

STATE FORM KOFD11 If continuation sheet 11 of 12

AND DUAN OF CODDECTION DENTIFICATION NUMBER.					DATE SURVEY COMPLETED	
		00581	B. WING			C 23/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1	
AFTENR	O HOME		COLLEGE MN 55811	STREET		
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2 830	there are specific in physician of change SUGGESTED MET The DON or design facility policy on cor assessment and not fallsm then inservic comprehensive nur with any change in consulted timely to falls. The DON coulcompliance.	ge 11 Instructions to notify the est in the resident's condition. IHOD OF CORRECTION: eee could develop/review the imprehensive nursing stiffication of physician following estaff regarding ensuring a sing assessment is completed condition and medical staff are implement treatment following in the implement treatment following in the implement treatment following in the surface of the implement treatment following in the surface of the implement treatment following in the implement following in the implement following in th	2 830			

Minnesota Department of Health STATE FORM

M Solution Sheet 12 of 12