Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 23, 2022

Administrator
Aftenro Home
510 West College Street
Duluth, MN 55811

RE: CCN: 24E355
Cycle Start Date: December 1, 2022

Dear Administrator:

On December 1, 2022, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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.

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
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: 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

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 1, 2023 (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 1, 2023 (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

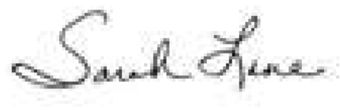
dates specified for compliance or the imposition of remedies.

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 22, 2023

Administrator
Aftenro Home
510 West College Street
Duluth, MN 55811

RE: CCN: 24E355
Cycle Start Date: December 1, 2022

Dear Administrator:

On January 20, 2023, the Minnesota Department(s) of Health and Public Safety, 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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 11/28/22, - 12/1/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/28/22, - 12/1/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: HE3556096C (MN84026); HE3556097C (MN85168); HE3556098C (MN83952); and HE3556350C (MN88908/MN88818). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/30/2022

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.

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 583 SS=F	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced	F 583		1/20/23

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F 583	Continued From page 2 by: Based on observation, interview and document review, the facility failed to safeguard personal and medical information contained in the Electronic Medical Record (EMR) when the EMR was left accessible for any staff, visitor or resident to view on two sperate occasions. This deficient practice affected all 48 residents who resided in the facility. Findings include: On 11/29/22, at 2:51 p.m. Point Click Care (PCC), the facility's EMR program was left open on one of the medication carts. The cart was parked across from the elevator doors along a guard rail on the second floor. The screen displayed a list of resident names and pictures. There were not any staff present at the cart or in the hallway. On 12/1/22, at 12:43 p.m. the nurse medication cart was parked in front of the second floor nurses station in the hallway. There were not any staff at the cart. The EMR was open and accesible for anyone to view or access. On 12/1/22, at 12:44 p.m. registered nurse (RN)-A returned to the medication cart and locked the screen. RN-A confirmed she had left the EMR open while she left the cart to obtain a blood sugar and stated she should have locked the screen before leaving her medication cart. On 12/1/22, at 2:30 p.m. the director of nursing (DON) stated before staff leave the medication cart he would expect them to lock the cart, clear the top of the cart of medications and/or anything a resident could hurt themselves with, and then make sure the EMR was closed so it could not be	F 583	F583 The facility□s Personal Privacy/Confidentiality/HIPPA policy was reviewed. The two staff assigned to the Medication Carts/Laptop on the two occurrences identified did not follow the facility□s policy of protecting the screen by using the internal system in Point Click Care or closing the laptop screen. All residents have the potential to be affected by this practice. All licensed staff and TMAs assigned to work the medication carts and laptops will be re-educated by the DON, ADON, or designee on the Policy for the Resident□s Electronic Medical Record. This measure, a systemic change, will ensure that the deficient practice will not reoccur. The Director of Nursing, ADON, or designee will audit 5 medication carts and interview 5 staff member's to ensure that laptops are secure from revealing resident Privacy/Confidentiality information each week x 30 days. Then audit 3 medication carts and interview 3 staff each week x 30 days. Then audit 2 medication carts and interview 2 staff each week x 30 days for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period. The DON, ADON, or designee is responsible for compliance	

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F 583	Continued From page 3 viewed or accessed. The facility policy Electronic Medical Record dated March 2014, indicated that only authorized persons would have access to the EMR. The policy reference list included The Health Insurance Portability and Accountability Act (HIPAA). The HIPAA Privacy Rule established national standards to protect individual's medical records and other individually identifiable health information.	F 583		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		1/20/23

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F 732	Continued From page 4 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to post the current nurse staffing daily. This had the potential to affect all 48 residents residing in the facility and/or visitors who may wish to view the information. Findings include: On 11/28/22, at 2:12 p.m. the facility nurse staffing posting was observed posted on a bulletin board located by the second-floor nursing station. The nurse staff posting was dated 11/27/22. On 11/29/22, at 8:50 a.m. the facility nurse staffing was not posted. On 12/1/22, at 2:35 p.m. the facility nurse staffing was posted on the bulletin board by the second-floor nurse's station. The report was dated 11/30/22. During an interview on 12/01/22, at 2:35 p.m. the director of nursing (DON) stated the purpose of posting staffing levels each day was so that	F 732	F732 The facility did not have the correct date on the Posted Nurse Staffing Information when identified on 11/28/2022, was not posted on 11/29/2022, and an incorrect date on 12/1/2022 All residents have the potential to be affected by this practice. Licensed Staff will be educated on the proper procedures for the Posted of Nurse Staffing Information. The form will be changed out at midnight to ensure the correct date, staffing, and hours are accounted for. Licensed staff will also be educated that this form must be updated throughout the day to ensure the information is current and correct. This measure, a systematic change, will ensure that the deficient practice will not reoccur. The DON, ADON, or designee will audit 5 Posted Nurse Staffing Forms per week x	

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F 732	Continued From page 5 residents could see the current staffing for the day. The DON stated they also post current staffing levels because it was a regulatory requirement. The DON confirmed the facility staffing data posted on 12/1/22, was staffing data from 11/30/22, which was from the day before and indicated this was wrong. The DON stated the current staff for 12/1/22, should have been posted that morning, not the data from 11/30/22. The DON acknowledged that the facility had not been posting current nurse staffing information. The facility policy titled Posting Direct Care Daily Staffing Numbers dated 8/2022, indicated within two hours of the beginning of each shift, either the charge nurse or designee should post the number of licensed staff in the building (RNs, LPNs, and LVNs) and the number of unlicensed nursing personal (CNAs and NAs) directly responsible for resident care in a prominent location accessible to residents and visitors in a clear and readable format.	F 732	30 days, 3 forms per week x 30 days, and 2 forms per week for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		1/20/23

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F 761	Continued From page 6 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were properly labeled with current medication orders for one of seven residents (R9) observed for medication administration. In addition, the facility failed to ensure medication fridge temperatures were monitored to ensure safe medication storage and that the emergency kit (e-kit) did not have expired insulin. This deficient practice had the potential to impact any residents that required emergency insulin and or received medications stored in the fridge. Findings included: Labeling R9's Face Sheet provided 12/1/22, indicated he had diagnosis that included Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Hypertenson, and unspecified peripheral vascular disease. On 11/30/22, at 1:30 p.m. trained medication adminstartion (TMA)-A stated R9's Medication	F 761	F761 1) Labeling of Medication Containers: The facility□s Labeling of Medication Container policy was not up to date. Our policy has been updated adding a label change sticker when orders are changed. There was no harm caused to the resident. This measure, a systemic change, will ensure that the deficient practice will not reoccur. 2) Medication Refrigeration Temperatures: The facility has defrosted the freezer and a daily temperature log has been added to the refrigerator to be checked daily by the NOC nurse. This systemic change, will ensure that the deficient practice will not reoccur. 3) E Kit expired medications: The facility□s policy titled Pharmacy Services, Emergency Pharmacy Service and Emergency Kits was not being followed. Reeducation will be provided to the licensed nursing staff to ensure the policy	

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F 761	Continued From page 7 Administration Record (MAR) for Albuterol did not match the pharmacy sticker on the inhaler: Proventil HFA 90 mcg one puff every four hours as needed. TMA-A clarified the order with the assistant director of nursing (ADON) before administering the medication. During an interview with the director of nursing (DON) on 12/1/22, at 10:41 a.m. the DON confirmed R9's Inhaler label read: Ventolin one puff every four hours as needed for shortness of breath. The DON further stated when the order changed, staff should have put a label on the medication to indicate the MAR and medication label did not match. On 12/01/22, at 12:05 p.m. the consultant pharmacist (CP) stated it was okay to use the proventil inhaler because albuterol and proventil are the same drug. The CP stated when the inhaler dose changed, the facility should have placed a sticker on the inhaler to indicate that the label did not match the order. The facility policy Labeling of Medication Containers dated April 2019, indicated that medication labels should include the name, strength, and directions for use. The policy did not address placing a sticker on the medication card/bottle/inhaler to indicate the order changed, but it did direct nursing staff to notify the pharmacist of provider ordered changes to medications. Medication Refridgeration Temperatures At approximately 10:35 a.m. on 11/30/22, during the medication storage review, it was noted the facility's medication fridge did not have a	F 761	is followed. The insulin E-Kit was sent back to the pharmacy and resupplied with expiration dates in compliance. All residents have the potential to be affected by these practices. All Aftenro licensed staff will be educated on the above-mentioned deficiencies. This will be completed no later than 1/13/2023. 1) The Director of Nursing, ADON, or designee will audit medication carts to ensure that labels match (for medication containers) the EMR or that a label change sticker has been placed to alert the TMA/Licensed Staff. 3 carts per week x 30 days, 2 carts per week x 30 days, and 1 cart per week x 30 days for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period. 2) The facility will audit the medication refrigerator logs to ensure temperatures are recorded daily that the freezer door is closed and has a minimal ice build-up. 5x per week x 30 days, 3x per week x 30 days, and 2x per week for 30 days for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period. 3) The E-kits will be audited by the NOC nurse for expiration dates on the 1st of each month. The DON, ADON, or designee will also complete an audit 1x per month x 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	

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	24E355	A. BUILDING _____ B. WING _____	C 12/01/2022

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AFTENRO HOME	510 WEST COLLEGE STREET DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 8 temperature log on the front of the fridge. On 12/1/22, at approximately 10:35 a.m. the director of nursing (DON) confirmed the facility did not have a formal process for monitoring medication fridge temperatures. The DON verified the thermometer located in the fridge door was at 32 degrees Fahrenheit. On 12/1/22, at 12:46 p.m. the medication fridge was reviewed with registered nurse (RN)-A. Bottles of liquid suspension medication, suppositories, and eye drops were stored in the fridge door compartments. A thermometer was stored in the top left compartment of the fridge door which aligned with the freezer compartment when closed. The freezer compartment was open and full of frosted ice. The fridge shelf directly below the freezer compartment had two bins of boxed insulin pens. One of the boxes was touching the bottom of the freezer compartment. Additional shelves contained bins of resident medication. The CP stated, "the policy Thrifty White shares with all facilities states that medication fridge temperatures should be monitored daily." CP stated he planned to follow-up with the facility because they needed to be checking and recording temperatures daily to ensure the fridge temperatures were safe for medication storage. The facility provided an inventory list with each drug and quantity stored in the fridge. Five out of 20 medication manufacturer instructions were reviewed. As listed below, all instructions indicated a storage temperature range greater than 32 degrees F. -Tresiba Flex Pen: between 36 degrees to 46	F 761	1/13/2023	

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F 761	Continued From page 9 degrees Fahrenheit (F) -Levemir insulin pen: between 36 degrees F and 46 degrees F -Trulicity pen: between 36 degrees F to 38 degrees F -Immunization, boostrix: between 36 degrees F and 46 degrees F and should be discarded if frozen. The facility policy Storage of Medications dated November 2020 indicated, "Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls." The policy did not address how the facility ensured the medications were stored at proper temperature. E Kits expirated medications On 12/1/22, at 12:46 p.m., the Emergency Kit (E-kit) containing three vials of insulin was stored in the medication fridge in a plastic box with a zip tag lock numbered 3730017. The sticker on the outside of the plastic box read: First Drug to Expire: 9/30/22, Date last checked: 12/28/21. RN-A verified the label indicated a medication inside the box was expired. RN-A stated the crash cart was checked one time a week, but she wasn't sure if the insulin E-Kit was included. On 12/1/22, 12:57 p.m. the DON confirmed the sticker on Insulin E-Kit read: First Drug to Expire: 9/30/22. The DON read dates for each of the three vials and confirmed that the Novolog insulin was expired. The DON stated that he did not think they checked the E-kit for expiration dates daily, and then pulled the ADON into the medication room for clarification.	F 761		

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F 761	Continued From page 10 On 12/1/22 at 1:00 p.m. the ADON stated as part of their service, the pharmacist should be reviewing dates of e kits to ensure they are not expired; staff do not do this. The facility policy titled Pharmacy Services, Emergency Pharmacy Service and Emergency Kits dated January 2020, indicated that facility staff would check the emergency medication kit(s) at least once a month to make sure it was properly stored, sealed, and medications were not outdated. The policy indicated a pharmacist designee would also do the same checks once a month.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		1/20/23

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F 812	Continued From page 11 Based on observation, interview, and document review the facility failed to ensure opened foods were dated and free from ice particles; food was stored off the floor; clean dishware was not exposed to contamination; and food temperatures were maintained according to standards. This had the potential to affect all 48 residents who consumed food from the kitchen. Findings include: During the initial kitchen tour with the dietary manager (DM)-B on 11/28/22, at 1:55 p.m. the following was observed: -Dijon mustard had a date 8/19, and a "best by" date of 11/2/21, on the shelf. DM-B confirmed this should not be used. -A box with seven packages of beef and packages of tator tots were on the floor of the freezer. DM-B confirmed these should not be on the floor but should be on a shelf. -A package of opened peas, carrots, and lima beans with no "opened by" date was in the freezer. -An opened bag of waffles was unsealed in the freezer with ice particles forming in the bag. DM-B confirmed these should not be used. -One bucket of vanilla frosting was located on the floor and DM-B stated foods should not be stored on the floor. During interview and observation on 11/28/22, at 2:21 p.m. cook (C)-A pushed a rack of clean dishes out of the dish washer using the tray of dirty dishes he pushed into the dishwasher. The DM-B stated clean dishes should not be pushed out of the dish washer by using the dirty dish tray going into the dishwasher.	F 812	Plan of Corrections for tag F812 On 11/28/22 Findings during walkthrough of kitchen yielded outdated and undated products, packages of food on freezer and walk-in cooler floor. Plan of corrections moving forward will be to: " Hold an in-service on 1/4/23 to review survey findings for all staff and educate on proper food handling " Audit for packages on floors in freezer, cooler, and dry storage daily for one month, 3 times a week for one month, and 2 time per week for one month, for a total of 90 days. " Audit cooler, freezer, and dry storage for outdated and undated products 5 x a week for one month, 3 times per week for one month, 2 times a week for one month, for a total of 90 days. On 11/28/22 surveyor observed cook pushing rack of clean dishes out of the dishwasher using the tray of dirty dishes. Plan of corrections moving forward will be: " Hold an in-service on 1/4/23 to educate all employees on proper dishwasher use, cleanliness, and sanitation. " Audit dishwashing during a meal to observe, correct, and educate staff. Audits will be completed 3 times per week for one month, 2 times a week for one month, and 1 time per week for one month, for a total of 90 days.	

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F 812	Continued From page 12 During interview on 11/29/22, at 2:13 p.m. dietary aide (DA)-A stated breakfast started at 7:30 a.m., lunch was at 11:30 a.m., and supper was at 5:00 p.m. During interview and observation on 11/30/22, at 8:15 a.m. C-A checked the temperature of the eggs in the food warmer and stated the temperature was 123 degrees Fahrenheit and stated the eggs were very cold. The temperature of the French toast was taken and was 104 degrees. C-A stated the eggs were supposed to be 150 degrees and thought something was wrong with their vent. On 11/30/22, at 8:20 a.m. C-A dished up a plate with eggs, oatmeal, and toast from the warmers. C-A was asked to check the temperature of the eggs; DA-A asked DM-B to heat the plate up. At 8:22 a.m., the temperature of the eggs in the warmer was at 120 degrees. During interview and observation on 11/30/22, at 8:27 a.m. DM-B stated the oatmeal was not warm enough and stated it should be at least 160 degrees. During interview 11/30/22, at 9:01 a.m. maintenance (M)-A stated a reheat coil valve failed 11/26/22, and would be repaired 12/1/22, but stated this would not affect the warmers. During interview on 11/30/22, at 10:20 a.m. R28 stated he did not eat his breakfast because the butter was sitting on top of his toast and when he picked up his toast, it was cold and stated that was why the butter had not melted. R28 stated the eggs were also cold. During observation and interview on 11/30/22, at	F 812	On 11/30/22 surveyor observed breakfast. Findings concluded warmer was not keeping eggs at proper temp. Upon further investigation the heater core had gone out and was not able to keep items in that compartment hot. Plan of correction moving forward will be: " Heating core was replaced on 11/31/22 and after replacing food was able to stay at proper temps. " Hold an in-service on 1/4/23 to educate all employees on proper food temps. " Audit food temps before meal, during meals, and at the end of meal to verify steady and correct serving temp 3 times per week for one month, 2 times a week for one month, and 1 time per week for one month, for a total of 90 days. The Dietary Manager or designee is responsible for monitoring and findings will be reviewed and overseen by the QAPI committee.	

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F 812	Continued From page 13 10:44 a.m. licensed practical nurse (LPN)-A stated the small refrigerator on the second floor was for the residents and stated that maintenance or housekeeping checked the refrigerator temperatures daily and would defrost them if needed. The small refrigerator had an unlabeled chicken pot pie in the freezer and the freezer had a buildup of ice. During interview on 11/30/22, at 10:48 a.m. the director of nursing (DON) verified there was a buildup of ice in the freezer, but did not know who was responsible for defrosting the freezer. During interview on 11/30/22, at 10:51 a.m. housekeeper (H)-A stated maintenance was responsible to defrost the freezers, and housekeeping would complete the task if asked. H-A stated it looked like it had been a while since the freezer had been defrosted. During interview on 11/30/22, at 1:18 p.m. the administrator stated she expected food to be stored on shelves, not on the floor; foods should be hot; foods should be dated; and freezers should not have ice buildup. During interview on 12/1/22, at 10:24 a.m. DM-B stated temperature standards for reheating foods used to be160 degrees, but stated it changed to 165 degrees. Facility policy Food Temperatures dated 2013, indicated all hot food items must be served at a temperature of a least 135 degrees Fahrenheit. Hot food items cannot fall below 135 degrees Fahrenheit and need to be reheated to at least 165 degrees Fahrenheit prior to serving.	F 812		

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F 812	Continued From page 14 Facility policy Food Storage dated 2013, indicated food items were to be stored on shelves, food was to be dated when placed on shelves, date marking was to include the date by which food was to be consumed, or discarded, and food was to be stored a minimum of six inches above the floor. Additionally, the policy indicated freezer units were kept clean and in good working condition at all times and all foods were to be covered, labeled, and dated.	F 812		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 23, 2022

Administrator
Aftenro Home
510 West College Street
Duluth, MN 55811

Re: State Nursing Home Licensing Orders
Event ID: PJEK11

Dear Administrator:

The above facility was surveyed on November 28, 2022 through December 1, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

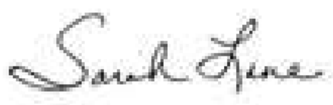
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Susan Frericks, 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: 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 feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00581	A. BUILDING: _____ B. WING _____	C 12/01/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/28/22 - 12/1/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were found to be UNSUBSTANTIATED: HE3556096C (MN84026); HE3556097C (MN85168); HE3556098C (MN83952); and HE3556350C (MN88908/MN88818). 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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	2 000		

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2 000	Continued From page 2 Minnesota Department of Health. 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.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with	2 302		1/20/23

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2 302	Continued From page 3 this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure consumers were provided a description of the Alzheimer's disease or related disorder training in a written or electronic form. Findings include: The facility admit packet lacked written information to consumers regarding information on Alzheimer's or dementia training. During interview on 12/1/22, at 2:15 p.m. assistant director of nursing (ADON)-A stated they had not provided consumers information on their training program. On 12/1/22, at 4:15 p.m. the administrator confirmed the facility did not have, and had not provided consumers with a written or electronic form of a description of the Alzheimer's training program, the categories of employees trained, the frequency of training, and the basic topics covered. Suggested Methods of Correction: The administrator or designee could add information describing the staff training program, categories of employees trained and the frequency training. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	corrected	

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21095	Continued From page 4	21095		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure opened foods were dated and free from ice particles; food was stored off the floor; clean dishware was not exposed to contamination; and food temperatures were maintained according to standards. This had the potential to affect all 48 residents who consumed food from the kitchen. Findings include: During the initial kitchen tour with the dietary manager (DM)-B on 11/28/22, at 1:55 p.m. the following was observed: -Dijon mustard had a date 8/19, and a "best by" date of 11/2/21, on the shelf. DM-B confirmed this should not be used. -A box with seven packages of beef and	21095	Corrected	1/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00581	A. BUILDING: _____ B. WING _____	C 12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21095	Continued From page 5 packages of tator tots were on the floor of the freezer. DM-B confirmed these should not be on the floor but should be on a shelf. -A package of opened peas, carrots, and lima beans with no "opened by" date was in the freezer. -An opened bag of waffles was unsealed in the freezer with ice particles forming in the bag. DM-B confirmed these should not be used. -One bucket of vanilla frosting was located on the floor and DM-B stated foods should not be stored on the floor. During interview and observation on 11/28/22, at 2:21 p.m. cook (C)-A pushed a rack of clean dishes out of the dish washer using the tray of dirty dishes he pushed into the dishwasher. The DM-B stated clean dishes should not be pushed out of the dish washer by using the dirty dish tray going into the dishwasher. During interview on 11/29/22, at 2:13 p.m. dietary aide (DA)-A stated breakfast started at 7:30 a.m., lunch was at 11:30 a.m., and supper was at 5:00 p.m. During interview and observation on 11/30/22, at 8:15 a.m. C-A checked the temperature of the eggs in the food warmer and stated the temperature was 123 degrees Fahrenheit and stated the eggs were very cold. The temperature of the French toast was taken and was 104 degrees. C-A stated the eggs were supposed to be 150 degrees and thought something was wrong with their vent. On 11/30/22, at 8:20 a.m. C-A dished up a plate with eggs, oatmeal, and toast from the warmers. C-A was asked to check the temperature of the eggs; DA-A asked DM-B to heat the plate up. At 8:22 a.m., the temperature of the eggs in the warmer was at	21095		

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21095	Continued From page 6 120 degrees. During interview and observation on 11/30/22, at 8:27 a.m. DM-B stated the oatmeal was not warm enough and stated it should be at least 160 degrees. During interview 11/30/22, at 9:01 a.m. maintenance (M)-A stated a reheat coil valve failed 11/26/22, and would be repaired 12/1/22, but stated this would not affect the warmers. During interview on 11/30/22, at 10:20 a.m. R28 stated he did not eat his breakfast because the butter was sitting on top of his toast and when he picked up his toast, it was cold and stated that was why the butter had not melted. R28 stated the eggs were also cold. During observation and interview on 11/30/22, at 10:44 a.m. licensed practical nurse (LPN)-A stated the small refrigerator on the second floor was for the residents and stated that maintenance or housekeeping checked the refrigerator temperatures daily and would defrost them if needed. The small refrigerator had an unlabeled chicken pot pie in the freezer and the freezer had a buildup of ice. During interview on 11/30/22, at 10:48 a.m. the director of nursing (DON) verified there was a buildup of ice in the freezer, but did not know who was responsible for defrosting the freezer. During interview on 11/30/22, at 10:51 a.m. housekeeper (H)-A stated maintenance was responsible to defrost the freezers, and housekeeping would complete the task if asked. H-A stated it looked like it had been a while since the freezer had been defrosted.	21095		

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21095	Continued From page 7 During interview on 11/30/22, at 1:18 p.m. the administrator stated she expected food to be stored on shelves, not on the floor; foods should be hot; foods should be dated; and freezers should not have ice buildup. During interview on 12/1/22, at 10:24 a.m. DM-B stated temperature standards for reheating foods used to be160 degrees, but stated it changed to 165 degrees. Facility policy Food Temperatures dated 2013, indicated all hot food items must be served at a temperature of a least 135 degrees Fahrenheit. Hot food items cannot fall below 135 degrees Fahrenheit and need to be reheated to at least 165 degrees Fahrenheit prior to serving. Facility policy Food Storage dated 2013, indicated food items were to be stored on shelves, food was to be dated when placed on shelves, date marking was to include the date by which food was to be consumed, or discarded, and food was to be stored a minimum of six inches above the floor. Additionally, the policy indicated freezer units were kept clean and in good working condition at all times and all foods were to be covered, labeled, and dated. SUGGESTED METHOD OF CORRECTION: The Dietary Manager or designee could develop, review, and/or revise policies and procedures to ensure food is stored appropriately. The Dietary Manager or designee could educate all appropriate staff on the policies and procedures. The Dietary Manager or designee could develop monitoring systems to ensure ongoing compliance.	21095		

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21095	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21095		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and documentation review, the facility failed to ensure employee evaluations for tuberculosis (TB) included all the required components for implementation of a two-step tuberculin skin test (TST), for 3 of 5 new employees (nursing assistant (NA)-A, registered nurse (RN)-A, and RN-B). This had the potential	21426	Corrected	1/20/23

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21426	Continued From page 9 to affect all 48 residents residing in the facility. Findings include: The Tuberculosis Screening - Administration and Interpretation of Tuberculin Skin Test (TST) policy revised October 2019, indicated interpretation of the TST would be completed 48 to 72 hours after administration, and the date and time the TST was administered, the date and time the TST results were interpreted, and the interpreted size of the induration would be indicated in the employee medical record. NA-A was hired 8/2/22, had a tuberculosis symptomology screen and step-one TST completed. The step-two TST was administered 9/8/22, however the administration time was not indicated. The step-two TST interpretation was completed 9/10/22, however the interpretation time was not indicated. RN-A was hired 9/1/22, had a tuberculosis symptomology screen and step-one TST administered on 9/1/22, at 11:45 a.m. However, the step-one TST interpretation completed 9/3/22, at 4:00 p.m. did not include the induration size. The step-two TST was administered 10/2/22, at 9:00 p.m. and interpretation was completed 10/5/22, however the time was not indicated. RN-B was hired 10/27/22, had a tuberculosis symptomology screen and step-one TST administered on 10/27/22, however the administration time was not indicated. The step-one TST interpretation was completed 10/30/22; however, the interpretation time was not indicated. Additionally, RN-B's record lacked evidence that a step-two TST was administered and interpreted.	21426		

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21426	Continued From page 10 On 12/1/22, at 4:28 p.m. assistant director of nursing (ADON) confirmed employee records lacked evidence of complete baseline TB screening for NA-A, RN-A, and RN-B. The ADON stated TST documentation education was needed. The facility Tuberculosis Infection Control Program policy, revised August 2019, indicated the facility recognized that TB transmission had been identified as a risk in healthcare settings and to prevent nosocomial transmission of TB, the facility instituted a TB infection control program. A component of the program included screening and surveillance of employees for latent tuberculosis infection (LTBI) and active TB. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review and revise policies and procedures to ensure tuberculosis screening and testing was done on all employees according to regulations. The (DON) or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have	21610		1/20/23

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21610	Continued From page 11 access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were properly labeled with current medication orders for one of seven residents (R9) observed for medication administration. In addition, the facility failed to ensure medication fridge temperatures were monitored to ensure safe medication storage and that the emergency kit (e-kit) did not have expired insulin. This deficient practice had the potential to impact any residents that required emergency insulin and or received medications stored in the fridge. Findings included: Labeling R9's Face Sheet provided 12/1/22, indicated he had diagnosis that included Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Hypertenson, and unspecified peripheral vascular disease. On 11/30/22, at 1:30 p.m. trained medication adminstartion (TMA)-A stated R9's Medication Administration Record (MAR) for Albuterol did not match the pharmacy sticker on the inhaler: Proventil HFA 90 mcg one puff every four hours as needed. TMA-A clarified the order with the assistant director of nursing (ADON) before administering the medication. During an interview with the director of nursing (DON) on 12/1/22, at 10:41 a.m. the DON confirmed R9's Inhaler label read: Ventolin one puff every four hours as needed for shortness of	21610	Corrected	

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21610	Continued From page 12 breath. The DON further stated when the order changed, staff should have put a label on the medication to indicate the MAR and medication label did not match. On 12/01/22, at 12:05 p.m. the consultant pharmacist (CP) stated it was okay to use the proventil inhaler because albuterol and proventil are the same drug. The CP stated when the inhaler dose changed, the facility should have placed a sticker on the inhaler to indicate that the label did not match the order. The facility policy Labeling of Medication Containers dated April 2019, indicated that medication labels should include the name, strength, and directions for use. The policy did not address placing a sticker on the medication card/bottle/inhaler to indicate the order changed, but it did direct nursing staff to notify the pharmacist of provider ordered changes to medications. Medication Refridgeration Temperatures At approximately 10:35 a.m. on 11/30/22, during the medication storage review, it was noted the facility's medication fridge did not have a temperature log on the front of the fridge. On 12/1/22, at approximately 10:35 a.m. the director of nursing (DON) confirmed the facility did not have a formal process for monitoring medication fridge temperatures. The DON verified the thermometer located in the fridge door was at 32 degrees Fahrenheit. On 12/1/22, at 12:46 p.m. the medication fridge was reviewed with registered nurse (RN)-A. Bottles of liquid suspension medication,	21610		

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21610	Continued From page 13 suppositories, and eye drops were stored in the fridge door compartments. A thermometer was stored in the top left compartment of the fridge door which aligned with the freezer compartment when closed. The freezer compartment was open and full of frosted ice. The fridge shelf directly below the freezer compartment had two bins of boxed insulin pens. One of the boxes was touching the bottom of the freezer compartment. Additional shelves contained bins of resident medication. The CP stated, "the policy Thrifty White shares with all facilities states that medication fridge temperatures should be monitored daily." CP stated he planned to follow-up with the facility because they needed to be checking and recording temperatures daily to ensure the fridge temperatures were safe for medication storage. The facility provided an inventory list with each drug and quantity stored in the fridge. Five out of 20 medication manufacturer instructions were reviewed. As listed below, all instructions indicated a storage temperature range greater than 32 degrees F. -Tresiba Flex Pen: between 36 degrees to 46 degrees Fahrenheit (F) -Levemir insulin pen: between 36 degrees F and 46 degrees F -Trulicity pen: between 36 degrees F to 38 degrees F -Immunization, boostrix: between 36 degrees F and 46 degrees F and should be discarded if frozen. The facility policy Storage of Medications dated November 2020 indicated, "Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light	21610		

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21610	Continued From page 14 and humidity controls." The policy did not address how the facility ensured the medications were stored at proper temperature. E Kits expirated medications On 12/1/22, at 12:46 p.m., the Emergency Kit (E-kit) containing three vials of insulin was stored in the medication fridge in a plastic box with a zip tag lock numbered 3730017. The sticker on the outside of the plastic box read: First Drug to Expire: 9/30/22, Date last checked: 12/28/21. RN-A verified the label indicated a medication inside the box was expired. RN-A stated the crash cart was checked one time a week, but she wasn't sure if the insulin E-Kit was included. On 12/1/22, 12:57 p.m. the DON confirmed the sticker on Insulin E-Kit read: First Drug to Expire: 9/30/22. The DON read dates for each of the three vials and confirmed that the Novolog insulin was expired. The DON stated that he did not think they checked the E-kit for expiration dates daily, and then pulled the ADON into the medication room for clarification. On 12/1/22 at 1:00 p.m. the ADON stated as part of their service, the pharmacist should be reviewing dates of e kits to ensure they are not expired; staff do not do this. The facility policy titled Pharmacy Services, Emergency Pharmacy Service and Emergency Kits dated January 2020, indicated that facility staff would check the emergency medication kit(s) at least once a month to make sure it was properly stored, sealed, and medications were not outdated. The policy indicated a pharmacist designee would also do the same checks once a month.	21610		

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21610	Continued From page 15 SUGGESTED METHOD OF CORRECTION: The director of nursing or their designee could development and implement policies and procedures to ensure that medications were stored appropriately. The director of nursing or their designee could then monitor the licensed staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty - one (21) days	21610		
21860	MN St. Statute 144.651 Subd. 16 Patients & Residents of HC Fac.Bill of Rights Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This MN Requirement is not met as evidenced by:	21860		1/20/23

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21860	Continued From page 16 Based on observation, interview and document review, the facility failed to safeguard personal and medical information contained in the Electronic Medical Record (EMR) when the EMR was left accessible for any staff, visitor or resident to view on two sperate occasions. This deficient practice affected all 48 residents who resided in the facility. Findings include: On 11/29/22, at 2:51 p.m. Point Click Care (PCC), the facility's EMR program was left open on one of the medication carts. The cart was parked across from the elevator doors along a guard rail on the second floor. The screen displayed a list of resident names and pictures. There were not any staff present at the cart or in the hallway. On 12/1/22, at 12:43 p.m. the nurse medication cart was parked in front of the second floor nurses station in the hallway. There were not any staff at the cart. The EMR was open and accesible for anyone to view or access. On 12/1/22, at 12:44 p.m. registered nurse (RN)-A returned to the medication cart and locked the screen. RN-A confirmed she had left the EMR open while she left the cart to obtain a blood sugar and stated she should have locked the screen before leaving her medication cart. On 12/1/22, at 2:30 p.m. the director of nursing (DON) stated before staff leave the medication cart he would expect them to lock the cart, clear the top of the cart of medications and/or anything a resident could hurt themselves with, and then make sure the EMR was closed so it could not be viewed or accessed.	21860	Corrected	

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21860	Continued From page 17 The facility policy Electronic Medical Record dated March 2014, indicated that only authorized persons would have access to the EMR. The policy reference list included The Health Insurance Portability and Accountability Act (HIPAA). The HIPAA Privacy Rule established national standards to protect individual's medical records and other individually identifiable health information. SUGGESTED METHOD OF CORRECTION: The DON could inservice staff regarding the importance of confidentiality and privacy of resident information displayed on the computer screen while staff were not present in the area and/or not utilizing the computer screen. An periodic audit could be conducted to ensure compliance and the findings could be communicated to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21860		

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	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/30/2022**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/30/2022. At the time of this survey, Aftenro Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/30/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Aftenro Home is a 3-story building with no basement. The building was constructed at 4 different times. The original 3 story building was constructed in 1921 and was determined to be of Type II(222) construction. In 1935, a 3 story addition was constructed to the North that was determined to be of Type II(222) construction. In 1990, a 2 story addition was constructed to the East that was determined to be of Type II(222) construction. In 2001, a 1 story addition was constructed above the 1990 East addition that	K 000		

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	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/30/2022**

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K 000	Continued From page 2 was determined to be of Type II(222) construction. Because the original building and the 3 additions are of the same type of construction, the facility was surveyed as one building. The facility has a capacity of 54 beds and had a census of 48 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012	K 353	K353 The 18 inch clearance will be clearly marked in all storage areas so that it will	1/20/23

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K 353	Continued From page 3 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 11/29/2022, between 11:00am and 2:00pm, it was revealed by observation that storage materials had been placed on a storage racks in storage rooms, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. An interview with maintenance personnel and Faculty Administrator verified this deficient finding at the time of discovery.	K 353	be obvious if supplies are stored in a manner inconsistent with the height requirement□s stated in the NFPA code book. Signage will also be provided in these storage areas to remind people of the importance of maintaining these clearances for fire protection. These areas will be checked 3 times a week for the first month, twice a week for the second month and once a week for the third month for a total of 90 days. The Maintenance Engineer or designee will be responsible for monitoring and compliance. All results are shared and overseen by the QAPI.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.	K 372		1/20/23

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K 372	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/30/2022 between 11:00am and 2:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors in main hallway Second Floor East corridor. An interview with maintenance personnel and Faculty Administrator verified this deficient finding at the time of discovery.	K 372	K372 A systematic check of all the rated walls will be done to ensure that any pipe chases used to permit wires to be pulled through door headers and other walls will be properly fire caulked, both the tube end as well as the wall penetration's will be addressed, caulking material will meet the current code requirements. The Maintenance Engineer is responsible for monitoring and compliance. The oversight and monitoring will be shared with the QAPI.	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 511	K511	1/20/23

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K 511	Continued From page 5 facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.2.2 and NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 11/30/2022, between 11:00am and 2:00pm, it was revealed by observation that the electrical panel #19 located in the corrador was not locked. An interview with maintenance personnel and Facilty Administrator verified this deficient finding at the time of discovery.	K 511	The electrical panels in resident accessible area will have the doors lock to prevent access to the circuit breakers. The Maintenance Engineer or designee is responsible for monitoring and compliance. All results will be shared with the QAPI.	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and	K 541		1/20/23

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K 541	Continued From page 6 protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect the existing laundry chute per NFPA 101 (2022 edition) Life Safety Code, section 19.5.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/30/2022, between 11:00 am and 2:00 pm, it was revealed by observation that fire protection was absent in the laundry chute that runs from the top floor to the lower level. An interview with maintenance personnel and the Facility Administrator verified this deficient finding at the time of discovery.	K 541	K541 A determination will be made by our fire protection company as to whether or not the current placement of the sprinkler head in the laundry chute will provide adequate protection for the laundry chute. This inspection will occur on 1/3/2023. If the current position is not effective the head will be relocated to a position that will provide proper fire protection for the laundry chute. The Maintenance Engineer or designee is responsible for compliance and monitoring. The results will be shared with the QAPI.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 22, 2023

Administrator
Aftenro Home
510 West College Street
Duluth, MN 55811

Re: Reinspection Results
Event ID: PJEK12

Dear Administrator:

On January 20, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 1, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us