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

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January 5, 2022

Administrator
Aftenro Home
510 West College Street
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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.

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

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

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

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 12/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/22/21, and 12/23/21, a standard abbreviated survey was conducted at your facility. 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 was found to be SUBSTANTIATED: HE355017C (MN79350), with deficiencies cited at F689. 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 regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a comprehensive	F 689	R1 has been discharged from this facility.	1/24/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 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.

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F 689

Continued From page 1

assessment of medical status to identify a change in condition was completed, following of physician orders, and notification of the physician was made regarding a change in condition at the time of a fall to prevent further falls for 1 of 3 residents (R1), reviewed for accidents.

Findings include:

R1's Admission Record printed 12/23/21, indicated R1's diagnoses included seizures, hypertension, chronic kidney disease, and age-related cognitive decline.

R1's Minimum Data Set (MDS) assessment dated 11/15/21, indicated R1 was cognitively intact and had no symptoms of delirium, psychosis, behaviors or mood concerns. R1's MDS further indicated R1 was independent with ambulation and transfers, was not steady but was able to stabilize self, and used a walker or a wheelchair. R1 was frequently incontinent of urine, had a history of falls prior to admission, had no fall at the facility between admission on 11/2/21 and 11/8/21, which was the assessment period for the MDS.

R1's Morse Fall Scale assessment, dated 11/2/21, indicated R1 was at high risk for falling.

R1's care plan initiated 11/3/21, indicated R1 was at risk for falls related to gait and balance problems and weakness and indicated R1 had a fall in her room on 12/13/21, which led to R1 being evaluated in the emergency room. R1's care plan directed staff to ensure interventions to prevent falls as listed were provided or in place. In addition, R1's care plan directed staff to complete a head-to-toe assessment every shift

F 689

All residents have the potential to be affected by this practice.

All licensed staff have been educated on the comprehensive assessment of medical status to identify a change in condition. Licensed staff have been educated on following physician orders, and of notifying the physician regarding a change in condition and to complete the procedure for a comprehensive fall assessment. All resident care plans have been reviewed. All blood pressures have been reviewed by DON, ADON, or designee. The Resident healthcare providers have been notified of elevated results as appropriate.

The facility will update its blood pressure policy and procedure. This will include parameters for abnormal results and when to notify the resident’s primary healthcare provider. Education will be for all nursing staff. Non-licensed staff will report all blood pressures taken during their shift to the charge nurse. The resident’s primary healthcare provider will be updated of abnormal values.

The facility will also update its nurse-to-nurse change-of-shift report policy to reflect the following change; the outgoing charge nurse will provide the oncoming nursing staff a verbal report. The oncoming nursing staff will be required to participate and provide a signature acknowledging that they were present.
The Director of Nursing, ADON, or

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F 689	Continued From page 2 for 48 hours, document assessments and notify the physician and responsible party of the fall and update as necessary, investigate the cause of R1's falls, review possible risk factors, and implement measures as indicated to prevent further falls. R1's care plan indicated R1 required set-up assistance by one staff to move safely between surfaces as necessary. A review of R1's incident reports and facility 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 to pick something up off the floor and slid down the door when her legs became weak. R1's blood pressure was 168/95 at the time of the incident. R1 had no orthostatic hypotension (drops in blood pressure with position changes, such as sitting to	F 689	designee will audit all neurological assessments to include monitoring blood pressures for all falls for a total of 90 days. The DON, ADON, or designee will monitor 5 residents per week for blood pressures values x 30 days, 3 residents per week x 30 days, and 2 residents per month x 30 days for a total of 90 days. The DON, ADON, or designee will audit and maintain all shift-to-shift report sheets for a period of 90 days. Shift-to-Shift report sheets will be maintained by the facility for a period of 90 days. Results of the all audits will be reported at the monthly QAPI meetings for the 90-day period.	

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standing or lying to sitting). R1's incident report indicated there was nothing on the floor for R1 to pick up. R1's incident report and progress notes indicated R1 was evaluated for a urinary tract infection, though indicated there was no change in R1's medical status.

R1's Home Health Certification and Plan of Care signed and dated 11/17/21, indicated R1 was receiving home health services for prevention of UTI's and falls, among other areas of concern. R1 was receiving skilled nursing, physical therapy, and occupational therapy services certified from 11/5/21 through 1/3/22.

-FALL-11/22/21, at 9:30 p.m. R1 got tangled up in her bedding and slid out of bed while reaching for something. R1's blood pressure was 136/84, no orthostatic blood pressure was recorded, and her incident report indicated R1 had no recent change in medical status. R1's neurological status assessment sheet indicated R1 had intermittent blood pressure elevations up to 172/80.

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.

R1's physician rounding form dated 11/26/21, indicated R1's blood pressure was 119/74 and the nurse summary of any changes since last rounds was left blank. The nurse report of any new concerns was left blank. R1's rounding form indicated there were no new physician orders.

R1's nurse practitioner (NP) visit notes dated 11/26/21, indicated R1 had frequent falls and was working with PT and OT. NP documentation

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F 689	Continued From page 4	F 689		

indicated R1 continued to have frequent falls, and denied dizziness, lightheadedness, or loss of consciousness. R1 was also noted to have labile hypertension (when a person's blood pressure frequently fluctuates between normal and high). R1 was alert and oriented. R1's Keppra (medication for seizures) level was within normal limits.

R1's physician rounding form dated 11/30/21, indicated R1's blood pressure was 154/94, and R1's physician changed R1's blood pressure medications.

R1's physician visit notes dated 11/30/21, indicated R1 had a couple of falls without injury, due to her knee buckling. R1 reported at that time that she felt fine with no particular symptoms. R1's urinary urgency and occasional incontinence had been stable at the facility. R1's daughter had mentioned that increased confusion previously indicated R1 had a bladder infection. R1's blood pressures and medications were reviewed and noted R1's blood pressure medications had been changed upon admission. R1's blood pressures were noted to range between 130-167/74-90, and R1's physician documented that R1 did not have satisfactory control of her blood pressure and her physician changed her blood pressure medications, and indicated her response would be monitored.

R1's home health communication tool dated 12/7/21, indicated R1 was discharged from physical therapy and had met her goals, was able to walk to and form meals, and transfer in room with her walker independently.

-FALL- 12/12/21, at 9:00 a.m. R1 was found on

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the floor by her nightstand in her room and appeared to have hit her face on the nightstand or the floor. R1's incident report indicated R1's blood pressure at the time of her fall was elevated at 205/112. R1's Fall Review progress note dated 12/13/21, at 10:30 a.m. and entered on 12/17/21, at 7:30 a.m. indicated R1 was more confused at the time of her fall, and her neurological checks were normal. R1's Fall Review progress note lacked indication of R1's elevated blood pressures. R1's progress notes indicated R1 was more confused related to a history of urinary tract infections, and an order had been obtained to check a urinalysis (UA) and urine culture (UC). R1's neurological flow sheet R1's blood pressure slowly came down, and then was rising again before her fall on 12/13/21. The last reading of her blood pressure at 3:30 p.m. on 12/13/21, was 184/72. R1's progress notes lacked documentation indicating R1's physician/provider was notified of R1's elevated blood pressures, though they indicated R1's provider was notified that R1's neurological checks were normal.

A Resident Fax Letter to R1's physician dated 12/12/21, indicated R1's physician was notified R1 had bitten her bottom lip and had a large bruise around her mouth and had sustained a 4 centimeter (cm) by 3 cm skin tear and bruise on her left elbow, and requested a treatment for that. R1's fax form lacked any indication of R1's elevated blood pressure.

-FALL-12/13/21, at 11:00 p.m. R1 had fallen in the bathroom, and had possible stroke symptoms with left-sided weakness and drooping of the face. R1 was incoherent. R1's incident report indicated R1's blood pressure was 215/102. R1 was sent to the emergency room for evaluation

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F 689	Continued From page 6	F 689		

and was admitted to the hospital with a subdural hematoma (a buildup of blood on the surface of the brain).

R1's progress notes dated 12/12/21, through 12/13/21, lacked indication that a UA/UC had been obtained.

R1's hospital admission history and physical dated 12/13/21, indicated R1 was admitted with an altered mental status and neurologic symptoms, and was determined to have a subdural hematoma. R1's blood pressure was noted to be quite elevated at 184/89, at the time of admission, which the physician suspected was related to a subdural hematoma or possible seizure. R1 and family chose to initiate comfort cares.

On 12/22/21, at 1:49 p.m. the director of nursing (DON) stated R1 had worked with therapies and become independent in her room, and they were going to get a UA. The DON stated the wellness department had looked at her, she was close to the nurses station due to her fall risk, and staff were checking on her. The DON stated they tried to find the root cause of the fall and put interventions in place. The DON stated they had gotten a UA sample, but R1 had not told them she had gone and it sat too long.

On 12/23/21, at 11:02 a.m. nursing assistant (NA)-A stated R1 was alert in the morning when he gave her medications, but was confused when she fell on 12/12/21, and had bit her lip.

On 12/23/21, at 11:15 p.m. licensed practical nurse (LPN)-A stated when a resident falls, they assess them, ask how they feel, how did they fall,

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F 689	Continued From page 7 do vital signs, and ask them questions. LPN-A stated they do a neurological check form, do a fall report, and huddle to discuss the fall. LPN-A stated they do regular blood pressures after they fall, but will do orthostatic blood pressures if the resident said they were dizzy. LPN-A stated she was working when R1 fell on 12/13/21. LPN-A stated R1 denied hitting her head, and said she was getting ready for bed. LPN-A stated she had talked to R1 about asking for help to get ready for bed before she fell, as R1 had told her she gets tired around bedtime. R1 was assisted to the toilet after her fall, and then was staring, and they noticed a droop of her face and she had weakness on her left side. LPN-A stated they did 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	F 689		

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F 689	Continued From page 8	F 689		

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 R1 was functionally declining. The NP stated she 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.

On 12/23/21, at 12:40 p.m. the DON stated he was not aware that R1's blood pressures were 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 stated they should investigate abnormal results or 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.

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 12/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9 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 there are specific instructions to notify the physician of changes in the resident's condition.	F 689		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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 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
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

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 12/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments	2 000		

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

NH LICENSING CORRECTION ORDER

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

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

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

INITIAL COMMENTS:
On 12/22/21 and 12/23/21, a complaint 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: HE355017C (MN79350), with a licensing order issued at 0830. 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 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 surveyor ' s 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 14-01, available at <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 Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure a comprehensive assessment of medical status to identify a change in condition was completed, following of physician orders, and notification of the physician was made regarding a change in condition at the time of a fall to prevent further falls for 1 of 3 residents (R1), reviewed for accidents. Findings include:	2 830	N/A	1/24/22

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2 830	Continued From page 3	2 830		

R1's Admission Record printed 12/23/21, indicated R1's diagnoses included seizures, hypertension, chronic kidney disease, and age-related cognitive decline.

R1's Minimum Data Set (MDS) assessment dated 11/15/21, indicated R1 was cognitively intact and had no symptoms of delirium, psychosis, behaviors or mood concerns. R1's MDS further indicated R1 was independent with ambulation and transfers, was not steady but was able to stabilize self, and used a walker or a wheelchair. R1 was frequently incontinent of urine, had a history of falls prior to admission, had no fall at the facility between admission on 11/2/21 and 11/8/21, which was the assessment period for the MDS.

R1's Morse Fall Scale assessment, dated 11/2/21, indicated R1 was at high risk for falling.

R1's care plan initiated 11/3/21, indicated R1 was at risk for falls related to gait and balance problems and weakness and indicated R1 had a fall in her room on 12/13/21, which led to R1 being evaluated in the emergency room. R1's care plan directed staff to ensure interventions to prevent falls as listed were provided or in place. In addition, R1's care plan directed staff to complete a head-to-toe assessment every shift for 48 hours, document assessments and notify the physician and responsible party of the fall and update as necessary, investigate the cause of R1's falls, review possible risk factors, and implement measures as indicated to prevent further falls. R1's care plan indicated R1 required set-up assistance by one staff to move safely between surfaces as necessary.

A review of R1's incident reports and facility

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2 830	Continued From page 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 to pick something up off the floor and slid down the door when her legs became weak. R1's blood pressure was 168/95 at the time of the incident. R1 had no orthostatic hypotension (drops in blood pressure with position changes, such as sitting to standing or lying to sitting). R1's incident report indicated there was nothing on the floor for R1 to pick up. R1's incident report and progress notes indicated R1 was evaluated for a urinary tract infection, though indicated there was no change in R1's medical status.

R1's Home Health Certification and Plan of Care signed and dated 11/17/21, indicated R1 was receiving home health services for prevention of UTI's and falls, among other areas of concern.

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2 830	Continued From page 5	2 830		

Continued From page 5

R1 was receiving skilled nursing, physical therapy, and occupational therapy services certified from 11/5/21 through 1/3/22.

-FALL-11/22/21, at 9:30 p.m. R1 got tangled up in her bedding and slid out of bed while reaching for something. R1's blood pressure was 136/84, no orthostatic blood pressure was recorded, and her incident report indicated R1 had no recent change in medical status. R1's neurological status assessment sheet indicated R1 had intermittent blood pressure elevations up to 172/80.

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.

R1's physician rounding form dated 11/26/21, indicated R1's blood pressure was 119/74 and the nurse summary of any changes since last rounds was left blank. The nurse report of any new concerns was left blank. R1's rounding form indicated there were no new physician orders.

R1's nurse practitioner (NP) visit notes dated 11/26/21, indicated R1 had frequent falls and was working with PT and OT. NP documentation indicated R1 continued to have frequent falls, and denied dizziness, lightheadedness, or loss of consciousness. R1 was also noted to have labile hypertension (when a person's blood pressure frequently fluctuates between normal and high). R1 was alert and oriented. R1's Keppra (medication for seizures) level was within normal limits.

R1's physician rounding form dated 11/30/21, indicated R1's blood pressure was 154/94, and R1's physician changed R1's blood pressure

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2 830	Continued From page 6	2 830		

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medications.

R1's physician visit notes dated 11/30/21, indicated R1 had a couple of falls without injury, due to her knee buckling. R1 reported at that time that she felt fine with no particular symptoms. R1's urinary urgency and occasional incontinence had been stable at the facility. R1's daughter had mentioned that increased confusion previously indicated R1 had a bladder infection. R1's blood pressures and medications were reviewed and noted R1's blood pressure medications had been changed upon admission. R1's blood pressures were noted to range betweeen 130-167/74-90, and R1's physician documented that R1 did not have satisfactory control of her blood pressure and her physician changed her blood pressure medications, and indicated her response would be monitored.

R1's home health communication tool dated 12/7/21, indicated R1 was discharged from physical therapy and had met her goals, was able to walk to and form meals, and transfer in room with her walker independently.

-FALL- 12/12/21, at 9:00 a.m. R1 was found on the floor by her nightstand in her room and appeared to have hit her face on the nightstand or the floor. R1's incident report indicated R1's blood pressure at the time of her fall was elevated at 205/112. R1's Fall Review progress note dated 12/13/21, at 10:30 a.m. and entered on 12/17/21, at 7:30 a.m. indicated R1 was more confused at the time of her fall, and her neurological checks were normal. R1's Fall Review progress note lacked indication of R1's elevated blood pressures. R1's progress notes indicated R1 was more confused related to a history of urinary tract infections, and an order had been obtained to

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2 830	Continued From page 7	2 830		

check a urinalysis (UA) and urine culture (UC). R1's neurological flow sheet R1's blood pressure slowly came down, and then was rising again before her fall on 12/13/21. The last reading of her blood pressure at 3:30 p.m. on 12/13/21, was 184/72. R1's progress notes lacked documentation indicating R1's physician/provider was notified of R1's elevated blood pressures, though they indicated R1's provider was notified that R1's neurological checks were normal.

A Resident Fax Letter to R1's physician dated 12/12/21, indicated R1's physician was notified R1 had bitten her bottom lip and had a large bruise around her mouth and had sustained a 4 centimeter (cm) by 3 cm skin tear and bruise on her left elbow, and requested a treatment for that. R1's fax form lacked any indication of R1's elevated blood pressure.

-FALL-12/13/21, at 11:00 p.m. R1 had fallen in the bathroom, and had possible stroke symptoms with left-sided weakness and drooping of the face. R1 was incoherent. R1's incident report indicated R1's blood pressure was 215/102. R1 was sent to the emergency room for evaluation and was admitted to the hospital with a subdural hematoma (a buildup of blood on the surface of the brain).

R1's progress notes dated 12/12/21, through 12/13/21, lacked indication that a UA/UC had been obtained.

R1's hospital admission history and physical dated 12/13/21, indicated R1 was admitted with an altered mental status and neurologic symptoms, and was determined to have a subdural hematoma. R1's blood pressure was noted to be quite elevated at 184/89, at the time

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2 830	Continued From page 8	2 830		

of admission, which the physician suspected was related to a subdural hematoma or possible seizure. R1 and family chose to initiate comfort cares.

On 12/22/21, at 1:49 p.m. the director of nursing (DON) stated R1 had worked with therapies and become independent in her room, and they were going to get a UA. The DON stated the wellness department had looked at her, she was close to the nurses station due to her fall risk, and staff were checking on her. The DON stated they tried to find the root cause of the fall and put interventions in place. The DON stated they had gotten a UA sample, but R1 had not told them she had gone and it sat too long.

On 12/23/21, at 11:02 a.m. nursing assistant (NA)-A stated R1 was alert in the morning when he gave her medications, but was confused when she fell on 12/12/21, and had bit her lip.

On 12/23/21, at 11:15 p.m. licensed practical nurse (LPN)-A stated when a resident falls, they assess them, ask how they feel, how did they fall, do vital signs, and ask them questions. LPN-A stated they do a neurological check form, do a fall report, and huddle to discuss the fall. LPN-A stated they do regular blood pressures after they fall, but will do orthostatic blood pressures if the resident said they were dizzy. LPN-A stated she was working when R1 fell on 12/13/21. LPN-A stated R1 denied hitting her head, and said she was getting ready for bed. LPN-A stated she had talked to R1 about asking for help to get ready for bed before she fell, as R1 had told her she gets tired around bedtime. R1 was assisted to the toilet after her fall, and then was staring, and they noticed a droop of her face and she had weakness on her left side. LPN-A stated they did

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2 830	Continued From page 9	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 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 R1 was functionally declining. The NP stated she 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.

On 12/23/21, at 12:40 p.m. the DON stated he was not aware that R1's blood pressures were

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 12/23/2021

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
2 830	Continued From page 10	2 830		

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 stated they should investigate abnormal results or 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

Minnesota Department of Health

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2 830	Continued From page 11 there are specific instructions to notify the physician of changes in the resident's condition. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop/review the facility policy on comprehensive nursing assessment and notification of physician following fallsm then inservice staff regarding ensuring a comprehensive nursing assessment is completed with any change in condition and medical staff are consulted timely to implement treatment following falls. The DON could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		