DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 4, 2023

Administrator
Assumption Home
715 North First Street
Cold Spring, MN 56320

RE: CCN: 245446
Cycle Start Date: January 11, 2023

Dear Administrator:

On January 31, 2023, we notified you a remedy was imposed. On March 10, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 2, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 2, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 31, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 2, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 2, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 31, 2023

Administrator
Assumption Home
715 North First Street
Cold Spring, MN 56320

RE: CCN: 245446
Cycle Start Date: January 11, 2023

Dear Administrator:

On January 24, 2023, we informed you that we may impose enforcement remedies.

On January 19, 2023, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

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

- Directed plan of correction, Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 2, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 2, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 2, 2023.

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

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 2, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Assumption Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 2, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 11, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSUMPTION HOME	**715 NORTH FIRST STREET** **COLD SPRING, MN 56320**

(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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 01/18/2023, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Assumption 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/10/2023

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
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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. Assumption Home is a 1-story building with a partial basement. The building was constructed at three different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1988, an addition was added to the west of the original building and was determined to be of Type II (000) construction. In 1996 a kitchen addition was added to the northeast end of the 1963 building and was determined to be of Type II (000) construction. In 2009 two wings were constructed to the North of the 1988 addition. The	K 000		

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K 000	Continued From page 2 southwest wing is one-story with a basement, and the North Wing is two stories and was determined to be of Type II (000) construction. In 2010 a one-story addition with no basement was added to the south side of the facility and was determined to be of Type II (111) construction. The 1963 building is separated, by a 2-hour fire barrier, from an attached apartment building to the North, and the 1963 building is separated by a 2-hour fire barrier from an attached connecting link to an apartment building to the east. The facility is protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are centrally monitored. There is smoke detection in the resident sleeping rooms that is supervised by the nurse call system. The facility has a capacity of 76 beds and had a census of 56 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 131 SS=D	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by	K 131		2/1/23

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K 131	Continued From page 3 construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire barrier doors per NFPA 101 (2012 edition), Life Safety Code, section 8.3.3.1, and NFPA 80 (2010 edition), The Standard for Fire Doors and Other Opening Protectives, section 6.3.1.7.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/18/2023 at 11:50 AM, it was revealed by observation that the 90 minute fire rated double doors located in the two hour fire separation between the care center and the attached assisted living facility has a gap between the vertical edges of approximately ¼ of an inch. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 131	This plan of correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. K131 Multiple Occupancies SS=D CFR(s): NFPA 101 It is the practice of Assumption Home to ensure the maintenance of the fire doors, Per NFPA 101 & 80 Life safety code. CORRECTIVE ACTION TAKEN TO CORRECT DEFICIENCY Brush astragals were added to the fire doors to close the gap on the pair doors on 02-01-23 by Mid Central Door per	

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K 131	Continued From page 4	K 131	NFPA 101 (2012 edition), Life safety code section 8.3.3.1, and NFPA 80 (2010 edition). The doors were tested by Mid Central Door to verify proper latching and proper gap. MONITORING/AUDITING TO PREVENT REOCCURENCE AND ENSURE SUSTAINMENT Maintenance will do weekly inspections and documentation of the fire doors to assure proper gap, per NFPA 101 & 80 Life safety code and report findings to the QAPI committee RESPONSIBLE PARTY AND DATE OF SUBSTANTIAL COMPLIANCE Paul Stadler, Director of Environment Services is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training to ensure the solution is sustained. The facility alleges substantial compliance and completion of all action items as of 02-01-23.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and	K 901		2/6/23

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K 901	Continued From page 5 documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/18/2023, at 10:15 AM, it was revealed during a review of available documentation, that the utility risk assessment document provided at the time of the survey did not contain a complete list of the electrical and gaseous patients/residents care equipment and the associated risk categories for the patients/residents as outlined in 2012 edition of NFPA 99, The Health Care Facilities Code chapters 10 and 11. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 901	This plan of correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. K901 Building System Categories SS=F CFR(s): NFPA 101 It is the practice of Assumption Home to ensure the patient/resident care equipment is reviewed yearly or as often as needed per NFPA 99. The Don will relay to the Dir. of Environmental Services if any equipment is removed or added to the patient care equipment risk assessment. CORRECTIVE ACTION TAKEN TO CORRECT DEFICIENCY With the assistance of the DON, ADON, Dir. of Therapy (Adam Lubbers) and myself, the patient/resident care equipment risk assessment was reviewed	

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K 901	Continued From page 6	K 901	and completed on 02-06-23 per NFPA 99 chapters 10 and 11. Patient/resident care equipment will be reviewed yearly or as often as needed per NFPA 99. The DON will provide updates to the Director of Environment Services as equipment is added or removed to ensure that the risk assessment is accurate between yearly reviews. MONITORING/AUDITING TO PREVENT REOCCURENCE AND ENSURE SUSTAINMENT The Director of Environment Services will review the equipment risk assessment the DON weekly for 1 month and then monthly for 3 months and report findings to the QAPI committee. There after the risk assessment will be reviewed annually or as needed per NFPA 99. RESPONSIBLE PARTY AND DATE OF SUBSTANTIAL COMPLIANCE Paul Stadler, Director of Environment Services is responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training to ensure the solution is sustained. The facility alleges substantial compliance and completion of all action items as of 02-06-23.	

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ASSUMPTION HOME	715 NORTH FIRST STREET COLD SPRING, MN 56320

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F 000	INITIAL COMMENTS On 1/17/23-1/19/23, 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. In addition to the recertification survey, The following complaints were reviewed and unsubstantiated with no deficiency issued. H54467426C (MN89726) H54467414C (MN89871) H54467427C (MN90046) H54467412C (MN88857) H54467425C (MN89010) H54467411C (MN87412) H54467410C (MN87309) H54467413C (MN83286) 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 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care.	F 552		3/2/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/10/2023

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
	245446	A. BUILDING _____ B. WING _____	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSUMPTION HOME	715 NORTH FIRST STREET COLD SPRING, MN 56320

(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 552	Continued From page 1 The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to communicate changes in medication for 1 of 1 residents (R34) reviewed for notification of change in medications. Findings include: R34's diagnosis report printed 1/19/23, indicated R34's diagnoses included malignant neoplasm of the prostate (cancer). R34's admission Minimum Data Set (MDS) dated 11/28/22, indicated R34 was able to understand others and make himself understood. R34's cognition was moderately impaired. R34's provider note dated 12/5/22, noted urinary obstruction was controlled.	F 552	This plan of correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. F552 Right to be Informed/Make Treatment Decisions SS=D CFR(s): 483.10(c)(1)(4)(5) It is the practice of Assumption Home to update responsible parties with all changes to medication regimen.	

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F 552	Continued From page 2 R34's provider note dated 1/3/23, noted no difficulties with bladder. R34's provider order signed on 1/6/23, at the recommendation of the pharmacist, was to discontinue Flomax (medication used to treat an enlarged prostate). R34's medication administration record (MAR) printed 1/19/23, indicated Flomax was discontinued on 1/6/23. R34's nurse progress notes reviewed 1/1/23-1/17/23, failed to note the change in medication and failed to indicate if R34 or his family was notified of the medication change. When interviewed on 1/17/23, at 2:19 p.m. R34 reported his Flomax was stopped and he was not told about it. R34 did not know why the medication was stopped. R34 stated he has managed his medications for many years and it was important to him that he continue to have some level control over his medications. When interviewed on 1/18/23, at 10:21 a.m. R34's family member (FM)-D stated she was not aware of the medication change. R34 had always been aware of what medications he was taking and why. It would be important to R34's family and to R34 that he was told of any medication changes. When interviewed on 1/18/23, at 10:53 a.m. licensed practical nurse (LPN)-B stated changes to medications were communicated to family and to the resident if they were cognitively able to understand. LPN-B confirmed R34 was able understand and to communicate his needs.	F 552	CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED The resident (R34) and responsible party were updated on medication change and were given the opportunity to ask questions in regards to his medication regimen. Resident□s provider was also updated and has since restarted medication. All residents of Assumption Home have the potential to be affected by the deficient practice; however, no similar findings and/or negative effects have been identified by this alleged deficient practice. The facility□s corrective actions outlined below include policy, procedure and systemic changes; training and education; and monitoring and audits. POLICIES/PROCEDURES/SYSTEMIC CHANGES Utilizing an order template to ensure proper documentation of medication changes and family/resident notification of changes. Policy was reviewed and updated. TRAINING/EDUCATION Policy/process for Order Processing was printed for HIS, LPN, and RN to review and sign off that they understand the policy updates.	

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F 552	Continued From page 3 When interviewed on 1/18/23, at 4:36 p.m. registered nurse clinical manager (RN)-B confirmed R34's progress notes failed to note that R34 or his family was made aware of the medication change. RN-B stated R34 is aware of his medications and can understand and communicate his needs and he should have been made aware of the change to his medications. RN-B stated it was important to communicate medication changes to residents and their family to ensure they can actively participate in their care and in reporting changes. When interviewed on 1/19/23, at 10:07 a.m. director of nursing (DON) stated she expected residents and families were updated with all medication changes. Facility policy, Processing of Orders revision date 11/2014, instructed the person processing the order to call and update responsible party of all orders received.	F 552	Email communication sent on 1/27/23 to HIS, RNs, and LPNs on order processing and updating of resident and/or responsible party. MONITORING/AUDITING RNCC will conduct weekly audits for 1 month on all medication changes and updates to responsible parties/resident. Results will be reported to QA for ongoing determination. The Administrator and DON are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training. The facility alleges that it will be in substantial compliance and complete all action items by 3/2/2023.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a self administration assessment was completed for 1 of 1 residents (R4), who was observed with an open bottle of over the counter sinus spray on her bedside table.	F 554	This plan of correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set	3/2/23

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F 554	Continued From page 4 Findings include: R4's quarterly Minimum Data Set (MDS) dated 9/29/22, identified R4 was cognitively intact, and able to express needs. R4 was identified as receiving extensive assistance to complete activities of daily living (ADLs), however, was an active participant with cares. The following diagnoses were identified within the MDS: coronary artery disease, hypertension (high blood pressure), asthma/chronic obstructive pulmonary disease (COPD) or chronic lung disease (CLD) (all medical conditions which can impact breathing conditions). On 1/17/23, at 11:34 a.m. R4 was observed seated in her recliner in her room. R4 was noted to have a bottle of Sinex Severe (a nasal decongestant) on her bedside table. R4 stated she generally uses the nasal spray in the morning to help her nasal congestion and breathing. R4 stated she was short of breath at times related to her lung condition. During interview on 1/19/23, at 11:17 a.m., clinical manager registered nurse (RN)-C stated she was unaware of Vicks Sinus Severe on the bedside table in R4's room. RN-C stated R4 had not expressed desire to self administer any medications, so therefore had no self administration of medication (SAM) assessment completed. RN-C stated the SAM assessment was completed to assure the resident was physically and mentally able to self administer medication. Additionally, RN-C stated the SAM assessment was completed so any potential concerns with medication interactions and medical conditions could be identified and	F 554	forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. F554 Resident Self-Admin Meds-Clinically Appropriate SS=D CFR(s): 483.10(c)(7) It is the practice of Assumption Home to complete a Self-Administration of Medications for all residents with initial admission assessments. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED A Self- Administration of Medication Assessment was completed on resident, R4. If resident wishes to continue to self-administer medications, orders will be obtained by her provider. All residents of Assumption Home have the potential to be affected by the deficient practice; however, no similar findings and/or negative effects have been identified by this alleged deficient practice. The facility□s corrective actions outlined below include policy, procedure and systemic changes; training and education; and monitoring and audits. POLICIES/PROCEDURES/SYSTEMIC CHANGES Self-Administration of Medication Policy has been reviewed and updated.	

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F 554	Continued From page 5 appropriate interactions put in place. An undated document on the product website, vicks.com, advised potential users to ask a doctor before use if they had heart disease or high blood pressure. A review of R4's January 2023 medication administration record (MAR) indicated R4 routinely received the following medications for hypertension and coronary artery disease: Lisinopril, Aspirin (Aspirin) daily, Lasix, Isosorbide Mononitrate Extended Release 24 Hour, Lisinopril Tablet, Norvasc, Plavix, and Lopressor. Additionally, R4 received the following medications to improve her breathing status: Fluticasone Propionate Suspension nasal spray in each nostril daily, and Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3 ml per nebulization (breathing machine). The Self Administration of Medications policy, last reviewed February of 2020, identified all residents admitted to the facility were asked if they wished to self administer medications. If desired, the individual was to be assessed by the registered nurse/clinical coordinator to determine if the resident can self administer safely and if this was clinically appropriate. The policy identified if resident was able to do so, additional education was to be done which would identify proper storage, tracking of usage, and reviewing this process on an ongoing basis.	F 554	Self-Administration of Medication Assessment has been revamped. Further education was created for resident and responsible party to review and sign upon admission. This education includes the process the facility must take if a resident wishes to self-administer any medication. TRAINING/EDUCATION Policy and Procedure on Self Administration of Medications was printed and reviewed by all RN Management. RN Mangers were provided with the new admission acknowledgement of Self Administration of Medication Policy. Education was provided to floor staff to address steps to take if a resident has a medication in their rooms. MONITORING/AUDITING An audit of all residents will be completed to ensure they have an up-to-date Self Administration of Medication Assessment has been completed. Ongoing audits will be completed on any new admissions for the next month. Results will be communicated to QA for ongoing determination if audits need to continue.	

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F 554	Continued From page 6	F 554	The Administrator and DON are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training. The facility alleges that it will be in substantial compliance and complete all action items by 3/2/2023	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		3/2/23

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F 623	Continued From page 7 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part	F 623		

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F 623	Continued From page 8 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the state long-term care ombudsman was notified for 1 of 1 resident (R57) reviewed for discharge. Findings include: R57's discharge, return not anticipated Minimum Data Set dated 11/21/22, identified they had	F 623	This plan of correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by	

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F 623	Continued From page 9 discharged to the community which had been unplanned. R57's medical record did not identify the ombudsman had been notified of the unplanned discharge. During an interview on 01/19/23 at 12:13 PM, the admission coordinator confirmed the facility was currently not notifying the ombudsman's office when a resident is discharged or transferred. Review of facility policy titled, "Discharge of Resident," reviewed 04/28/22, indicated, "Notice of Resident Transfer or Discharge will be routed to Admission Nurse and will be sent to Ombudsman."	F 623	the provisions of federal and state law. F623 Notice Requirements Before Transfer/Discharge SS=D CFR(s): 483.15(c)(3)-(6)(8) It is the practice of Assumption Home that with all discharges or transfers a Singed Notice of Voluntary Resident Transfer or Discharge will be obtained. A copy will be sent with the discharging/transferring resident, another will be routed to Admission Nurse and will be sent to Ombudsman at the end of each month, and the final copy will be retained with their discharge records. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED A Notice of Voluntary Resident Transfer or Discharge was re-sent to Ombudsman and fax receipt retained. All residents of Assumption Home have the potential to be affected by the deficient practice; however, no similar findings and/or negative effects have been identified by this alleged deficient practice. The facility□s corrective actions outlined below include policy, procedure and systemic changes; training and education; and monitoring and audits. POLICIES/PROCEDURES/SYSTEMIC CHANGES	

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F 623	Continued From page 10	F 623	Policy was reviewed. Current policy remains appropriate and no changes were made. TRAINING/EDUCATION Policy was printed and reviewed by all Nurse Managers to ensure policy is properly followed with each discharge or transfer. MONITORING/AUDITING Due to sending document to Ombudsman monthly, all discharges and transfers will be audited monthly x3 months. The Administrator and DON are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training. The facility alleges that it will be in substantial compliance and complete all action items by 3/2/2023.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure the Minimum Data Set	F 641	This plan of correction is the facility□s credible allegation of compliance.	3/2/23

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F 641	Continued From page 11 (MDS) was accurate for 1 of 4 residents (R44) reviewed who received an antipsychotic medication. Findings include: R44's quarterly MDS dated 3/4/22, 6/3/22 and 9/2/22, did not identify R44 received an antipsychotic medication. R44's physician orders identified an order for Nuplazid (an antipsychotic medication) 10 milligrams and was ordered daily for delusions and hallucinations related to Parkinson's disease. The medication had been ordered since 12/30/21. During an interview on 01/18/23 at 10:39 AM, the MDS coordinator registered nurse (RN)-C stated she was unaware the Nuplazid was an antipsychotic. RN-C confirmed she made a coding error in the MDS assessments. During an interview on 01/19/23 at 1:09 PM, the interim director of nursing (DON) stated it was her expectation the MDS was to be correct. Review of the Resident Assessment Instrument (RAI) Manual," dated 10/01/19, indicated, ". . . It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. . ."	F 641	Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. F641 Accuracy of Assessments SS=D CFR(s): 483.20(g) It is the practice of Assumption Home to code correctly on the MDS the diagnosis and us of any psychotropic medication. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED MDS was modified to correct inaccurate documentation. All residents of Assumption Home have the potential to be affected by the deficient practice; however, no similar findings and/or negative effects have been identified by this alleged deficient practice. The facility's corrective actions outlined below include policy, procedure and systemic changes; training and education; and monitoring and audits. POLICIES/PROCEDURES/SYSTEMIC CHANGES Reviewed with MDS nurse the checklist that is utilized during all MDS	

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F 641	Continued From page 12	F 641	assessments. All continues to be appropriate with no changes needed at this time. Created a form to be filled out on admission that lists any medications used for anti-psychotic purposes, related diagnosis□, classification, and MD ordered. This form will be routed to RNCC, MDS Nurse, and Social Worker. TRAINING/EDUCATION Consulted with Consulting Pharmacists to provide an updated psychotropic medication list for use on MDS assessments. Updated Psychotropic medication list will be provided to all RN Managers to utilize as a reference for further assessments. Nurse Managers will be educated on the use of the new admission form that lists medications used for anti-psychotic purposes. MONITORING/AUDITING Auditing of MDS coding of psychotropic medications will be completed weekly x4 weeks. Will be reported to QA for further determination. The Administrator and DON are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI	

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	245446	A. BUILDING _____ B. WING _____	01/19/2023

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F 641	Continued From page 13	F 641	Committee will utilize audit data to guide future compliance monitoring and training. The facility alleges that it will be in substantial compliance and complete all action items by 3/2/2023.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to completely reassess a resident following a medication change for 1 of 1 residents (R34) reviewed for medication changes. Findings include: R34's diagnosis report printed 1/19/23, indicated R34's diagnoses included malignant neoplasm of the prostate (cancer). R34's admission Minimum Data Set (MDS) dated 11/28/22, indicated R34 was able to understand others and make himself understood. R34's cognition was moderately impaired. Provider order signed on 1/6/23, at the recommendation of the pharmacist, an order to	F 684	This plan of correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. F684 Quality of Care SS=D CFR(s): 483.25 It is the practice of Assumption Home is to inform the resident or resident representative and consult with the resident's physician when there is a need	3/2/23

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F 684	Continued From page 14 discontinue Flomax and to monitor post void residual (PVR) (check contents of bladder after voiding) three times each day for seven days. R34's medication administration record (MAR) printed 1/19/23, indicated Flomax (medication for urine retention) was discontinued on 1/6/23. PVR's were monitored as ordered. R34's nurse notes reviewed 1/1/23-1/17/23 failed to indicate that R34 was asked about his ability to fully empty his bladder and if he was having difficulty voiding. On 1/17/23, at 2:19 p.m. R34 reported his Flomax was stopped and he was not told about it. R34 did not know why the medication was stopped. R34 stated since the medication stopped, he felt he was not able to fully empty his bladder and was not able to maintain a urine stream after he started urinating. No staff have asked him if he was having difficulty with this or if he was able to maintain a urine stream once he started urinating. On 1/18/23, at 1:58 p.m. nursing assistant (NA)-D stated each time she has worked with R34 he was continent of bladder. On 1/18/23, at 3:17 p.m. NA-E stated R34 sits on the toilet and is continent of bladder. On 1/18/23, at 4:36 p.m. registered nurse clinical manager (RN)-B confirmed no nurse notes were found indicating R34 was monitored for quality of urine stream following medication change and R34 if able to effectively communicate his needs. RN-B stated she expected nurses would follow up with R34 following medication changes. RN-B stated it would be important to ask R34 about	F 684	to alter treatment/medication, a need to discontinue or change an existing form of treatment, or start a new medication treatment. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED R34 was affected by this deficient practice with no actual harm. Bladder assessment was completed for R34. Provider was updated with resident's complaints of urinary retention and made changes to medication regimen. Monitoring was implemented x1 week to assess effectiveness of medication change. All residents of Assumption Home have the potential to be affected by the deficient practice; however, no similar findings and/or negative effects have been identified by this alleged deficient practice. The facility's corrective actions outlined below include policy, procedure and systemic changes; training and education; and monitoring and audits. POLICIES/PROCEDURES/SYSTEMIC CHANGES Assessment and Monitoring After a Significant Medication Change Policy was created.	

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F 684	Continued From page 15 signs or symptoms following a medication change to ensure changes are reported to the provider and to prevent potentially serious outcomes. On 1/19/23, at 10:07 a.m. director of nursing (DON) stated she expected residents are monitored following changes to medications. Monitoring included verbal, visual and physical assessments. DON stated it is important to complete these assessments to prevent potentially serious outcomes. A facility policy regarding assessment and monitoring after medication changes was requested but was not received.	F 684	Template was created for nurses to monitor for symptoms related to significant medication changes. TRAINING/EDUCATION Policy was printed and reviewed by Nurse Managers. Medication Monitoring Template was printed and reviewed with Nurse Managers MONITORING/AUDITING DON will audit all new orders x1 month for adherence to new policy. Results will be presented at QA for determination of the need to complete further auditing. The Administrator and DON are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training. The facility alleges that it will be in substantial compliance and complete all action items by 3/2/2023	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		3/2/23

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F 686	Continued From page 16 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to consistently assess a pressure ulcer to determine if there was an improvement, decline or need need for change of treatment for 1 of 1 resident (R9) reviewed for pressure ulcers. Findings include: R9's admission Minimum Data Set (MDS) dated 10/24/22, identified cognitively intact with a diagnosis of paraplegia (paralysis of the lower body) due to a demyelinating disease of the central nervous system. R9 required extensive assistance for bed mobility and transfers. R9 was at risk for developing pressure ulcers, but did not have a current pressure ulcer. R9's pressure ulcer Care Area Assessment (CAA) identified a care plan would be developed to prevent pressure ulcer formation. R9's Braden Skin Risk/Tissue Tolerance Test dated 10/17/22, identified a moderate risk for developing a pressure ulcer. A GEO (pressure reducing) mattress and a ROHO (weight distributing) cushion for wheel chair were initiated. R9's Skin Observation form dated 10/8/22, did not identify a pressure ulcer on the right heel.	F 686	This plan of correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer SS=D CFR(s): 483.25(b)(1)(i)(ii) It is the practice of Assumption Home to provide registered nurse monitoring of current pressure-related dermal impairments and complicated dermal impairments on scheduled basis to assist in complication reduction and healing promotion. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED R9 was identified during the survey as	

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F 686	Continued From page 17 R9's Braden Skin Risk/Tissue Tolerance Test, dated 10/24/22, identified a moderate risk for pressure ulcer development. R9's progress note dated 10/26/22, identified a change in condition and was sent to the local hospital for evaluation and treatment. R9's hospital Orders Discharge Report, dated 10/31/22, identified a pressure ulcer on the right heel, and it was to be treated with Mepilex heel dressing using spandage/stretch stockinette to hold dressing in place and to change the Mepilex every five days and as needed. R9's Weekly Skin Inspection dated 10/31/22, indicated R9 had a new alteration noted upon readmission to his right heel. The description included an open area 2 x 0.9 centimeters (cm) and a non-blanchable area which measured 1 x 0.4 cm and to apply Mepilex to the heel. There was no staging of the right heel pressure ulcer on this document which was completed by clinical staff. R9's Treatment Administration Record (TAR) dated 11/1/22, indicated R9 was to have Mepilex applied every five days, or as needed to his right heel, and to use spandage/stretch stockinette to keep the dressing in place if needed. In addition, the TAR directed staff to lift/remove dressing for skin assessments. The TAR indicated the resident received wound treatment daily until it was discontinued on 11/11/22. The treatment was reordered on 11/12/22 until it was discontinued on 12/05/22. The TAR indicated the resident received treatment every five days.	F 686	being affected by this deficient practice. Resident is getting weekly wound assessments completed by an RN. Also has weekly skin observations completed by Licensed Floor Staff. Provider is consulting with wound nurse for appropriate treatment options. All residents of Assumption Home have the potential to be affected by the deficient practice; however, no similar findings and/or negative effects have been identified by this alleged deficient practice. The facility□s corrective actions outlined below include policy, procedure and systemic changes; training and education; and monitoring and audits. POLICIES/PROCEDURES/SYSTEMIC CHANGES Skin and Wound Protocol Policy was created and implemented. House-wide wound rounds will be completed every 7 days. Initiation of Wound Tracking Spreadsheet to monitor for changes in wounds. TRAINING/EDUCATION Education binder will be created for all Nurse Managers to assist with proper wound documentation and treatments. Skin and Wound Protocol Policy has been printed and reviewed by all Nurse Managers.	

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F 686	Continued From page 18 R9's care plan, undated, indicated the resident was at risk for dermal (skin) impairments. The goal for the resident's care plan was to maintain intact skin integrity. The interventions were to implement a pressure relieving cushion to the resident's wheelchair and to implement a pressure reliving mattress to the resident's bed. In addition, staff were to complete a head-to-toe skin assessment on a weekly basis. R9's Nutritional progress note dated 11/7/22, indicated R9 was provided supplements for wound healing twice a day. R9's Weekly Skin Inspection, dated 11/21/22, indicated R9 had a pressure ulcer on his right heel. Under the description column included, "On-going alteration noted to right heel. Non-blanchable area. Applied Mepilex to heel per orders." There was no stage of the pressure ulcer, no description, and there were no measurements identified. There were no prior weekly skin inspections completed prior to this assessment during the month of November 2022. R9's Weekly Skin Inspection dated 11/25/22, indicated R9 had an on-going right heel pressure ulcer. The note revealed the Mepilex was done since there was no dressing upon morning cares. The note indicated the right heel was blanchable and the wound measured 2 x 2 cm and the wound was not open nor was it draining. R9's Weekly Pressure Wound Evaluation, dated 11/28/22, indicated R9's right heel pressure ulcer was first identified on 11/21/22. The document revealed the resident's right heel wound had now deteriorated to an unstageable pressure ulcer which measured 2.5 cm x 2.4 cm with no depth.	F 686	Nurse Managers will be provided education regarding the implementation of Wound Tracking Spreadsheet. MONITORING/AUDITING RN will complete weekly wound round audits on all residents with pressure and non-pressure skin impairments x8 weeks. Results will be presented at QA for determination of the need to complete further auditing. The Administrator and DON are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training. The facility alleges that it will be in substantial compliance and complete all action items by 3/2/2023.	

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F 686	Continued From page 19 There was no specific information identified on this document which would reveal if there were any descriptors, such as the condition of the peri-wound and if there was drainage or odor present, since there were two other wounds present on the resident during this assessment. The document identified the resident's current treatment plan indicated the wound was noted upon admission from the hospital. The current orders from the hospital provider were to apply Mepilex to the resident's right heel and to hold the dressing in place with spandage/stretch stockinette. To remove/lift dressing for skin assessment and reapply and to change every five days or as needed. The document revealed the clinical manager registered nurse (RN)-A notified the wound nurse. There were no changes made to the wound care ordered from when the resident was readmitted from the hospital on 10/31/22. RN-A marked there were no changes in the resident's wound. R9's Weekly Pressure Wound Evaluation, dated 12/05/22, indicated R9 had an unstageable right heel wound and it now measured 2.7 cm x 4. There was no identified if the resident had any depth to this area. There was no specific information identified on this document which would reveal if there were any descriptors, such as the condition of the peri-wound and if there was drainage or odor present, since there were four other wounds present on the resident during this assessment. The clinical staff member identified the resident's wound had declined and the physician and responsible party were notified of the change in status. Review of a document provided by the facility titled, "Diagnosis, Assessment and Plan," dated	F 686		

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F 686	Continued From page 20 12/05/22, indicated R9 had an unstageable pressure ulcer. The document directed the clinical staff to continue to monitor. The document revealed there were interventions in place for offloading and to continue to encourage nutritional interventions. The medical provider continued the order of Mepilex to be applied to the resident's right heel every five days and as needed. During an interview on 1/19/23, at 8:41 a.m. the Interim director of nursing (DON) confirmed there were no weekly skin assessments completed from 11/01/22 through 11/20/22. The Interim DON B confirmed there were no weekly wound evaluations completed from 11/01/22 through 11/27/22. During this interview, the Interim DON went through R9's medical record and verified there were no progress notes which would reflect changes in the resident's skin. The Interim DON stated the nursing staff were to complete weekly skin assessments. During an interview on 1/19/23, at 9:35 a.m. RN-A confirmed she was the one who completed R9's 11/28/22 wound assessment. RN-A stated the resident was hospitalized early in his admission to the facility and never got to see his wounds, therefore, the admission MDS assessment did not reflect the resident's current wounds. CMA stated the resident was transferred to the hospital during this assessment period. RN-A stated the weekly skin assessments were to be completed by the floor nurses. RN-A stated the wound assessments were additional assessments and this was the one she completed on 11/28/22. The intention of the skin assessments were to observe all skin problems and document and measure all areas of concern. RN-A stated she	F 686		

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F 686	Continued From page 21 was not aware the weekly skin assessments were not completed from 11/01/22 through 11/20/22. CMA stated during this time, a new process was developed by the interim DON. The nursing staff were documenting the condition of residents' skin in different places. RN-A stated during this time, there was lots of education happening to get the nurses to move to the weekly skin assessments and to be consistent with their documentation. RN-A stated this was an adjustment period and stated the weekly skin assessments were in place now. R9 wears pressure relieving boots each day and they come off during morning and evening cares. RN-A was asked if there was a physician or Nurse Practitioner (NP) note, which was written in 11/22 which would indicate the resident's pressure ulcers were an expected decline. RN-A stated the resident's overall health had been declining. A request for a wound treatment observation was again requested and RN-A stated a nurse practitioner wrote an order today that there was not to be any wound care treatments until 01/20/23, therefore the surveyor could not visualize the pressure ulcer. An interview on 01/19/23, at 10:10 a.m. with the administrator and Interim DON. DON stated the skin assessments was a new process to streamline the documentation. DON stated currently there is better and more consistent documentation on the status of the resident's right heel pressure ulcer. During this interview, a request was made for a medical provider note which would indicate R9's heel pressure ulcer was unavoidable or not. This information was not provided by the end of the survey. During an interview on 01/19/23, at 11:49 a.m. R9's family member (FM)-F stated R9 was using	F 686		

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F 686	Continued From page 22 the pressure reducing boots prior to his admission to the facility. FM-F stated she was aware of the deterioration of the resident's pressure ulcer on his right heel. FM-F stated the resident's right heel initially had a small pressure ulcer and now it was, "really bad." During an interview on 01/19/23, at 11:55 the nurse practitioner (NP)-E stated she was familiar with R9's care and his pressure ulcer on the right heel. NP-E stated the wound was chronic and he was at risk for a decline in his status due to poor functional ability and lack of solid nutrition. NP-E confirmed the resident received nutritional supplements. During an interview on 01/19/23, at 1:09 p.m. the Interim DON stated it was her expectation nursing staff were to measure and provide descriptions of a resident's wound for consistency of care. The Interim DON B stated to measure and provide a description was to alert the clinical staff for improvement of a wound, deterioration, or identify a possible infection. Review of a document provided by the facility titled, "Skin and Wound Management," dated 01/17/23, ". . .The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s)...In addition, the nurse shall describe and document/report the following. . .Full assessment of the pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue. . .Pain assessment. . .Resident's mobility status...Current treatments, including	F 686		

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F 686	Continued From page 23 support services. . .and. . .All active diagnosis. . .The physician will help identify and define any complications related to pressure ulcers. . .The physician will help staff characterize the likelihood of wound healing, based on a review of pertinent factors. . .for example. . .Healing or Prevention Unlikely. . .The resident is likely to decline or die because of his/her overall medical instability. . .wounds reflect the individual's overall medical instability. . .an existing would is unlikely to improve significantly...additional wounds are likely to occur despite preventative efforts. . ."	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure there were orders and interventions in place for oxygen (O2) usage for 1 of 1 residents (R4) reviewed for oxygen therapy. Findings include: R4's quarterly Minimum Data Set (MDS) dated 12/27/22, identified R4 was cognitively intact, and able to express needs. R4 was identified as receiving extensive assistance to complete	F 695	This plan of correction is the facilities credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. F695 Respiratory/Tracheostomy Care	3/2/23

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F 695	Continued From page 24 activities of daily living (ADLs), however, was an active participant with cares. The following diagnoses were identified within the MDS: coronary artery disease, hypertension (high blood pressure), asthma/chronic obstructive pulmonary disease (COPD) or chronic lung disease (CLD) (all medical conditions which can impact breathing conditions). During interview on 1/17/23, at 11:41 a.m. R4 was observed in her recliner in an upright position, with no bed observed on her side of the room. R4 stated she has slept in the recliner for an extended period of time and no longer sleeps in her bed. R4 was noted to have an oxygen concentrator in the corner of the room by her recliner. R4 stated she uses oxygen at night routinely, at times during the day when she is feeling short of breath. R4 had a nebulizer set (an apparatus to give medication for improved breathing) sitting on the bedside stand next to her chair on the opposite side. R4 stated she wasn't sure what the exact medications were which helped her breathing, but was on some ordered by the doctor. R4 denied cough or fever at this time, however, stated she had experienced Covid since her admission. A review of R4's progress notes identified the following instances where oxygen therapy was provided and respiratory care was indicated: On 11/12/22, at 10:22 p.m. R4 was noted to be using oxygen at 2 liters (L) per nasal cannula (NC). On 12/31/22, at 5:08 p.m., R4 was identified as having oxygen saturation levels (the level of oxygen in the blood flow) at 89%, and a temperature of 100.1 degrees, with complaints of tightness and shortness of breath (SOB). The	F 695	and Suctioning SS=D CFR(s): 483.25(i) It is the practice of Assumption Home to assure there are orders and interventions in place for oxygen(02) usage when a standing order is needed beyond 7 days. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED R4 was identified during survey as affected by this deficient practice with no actual harm occurring. R4's provider was updated on resident's continued use of supplemental oxygen and order was obtained for ongoing use. All residents of Assumption Home have the potential to be affected by the deficient practice; however, no similar findings and/or negative effects have been identified by this alleged deficient practice. The facility□s corrective actions outlined below include policy, procedure and systemic changes; training and education; and monitoring and audits. POLICIES/PROCEDURES/SYSTEMIC CHANGES Standing Order Policy was reviewed and continues to be appropriate. IDT will monitor use of standing orders and discuss need for continued use and need to obtain an updated order from the	

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F 695	Continued From page 25 staff provided resident with Tylenol for fever and a nebulization treatment (a treatment to aide in breathing). The narrative note did not indicate use of oxygen at this time, however, the narrative note on 1/1/23 indicated R4 was receiving oxygen at 6:30 a.m. On 1/1/23, at 6:31 a.m. R4 was noted to be receiving oxygen at at 2 L/NC. On 1/1/23, at 2:40 p.m. R4's documentation regarding a fall identified R4 was found on the floor, with O2 tubing underneath her, which had been disconnected. The entry lacked flow rate in effect. On 1/2/23, at 6:05 a.m. R4 was noted to be on oxygen therapy at 2 L/NC. The narrative identified R4 was noted to have increased SOB with exertion. On 1/6/23, at 5:40 a.m. R4 was noted to be on oxygen at 2 L/NC. The documentation also reflected R4 was noted to have increased SOB after exertion and continued to be weak with transfers. On 1/18/23, at 3:17 p.m. a review of both the medication administration record (MAR) and treatment administration record (TAR) for January 2023 and both MAR/TAR lacked any indication of oxygen administration, dosage, and effectiveness prior to the date of 1/18/23. On 1/17/23, at 4:11 p.m. an order was entered to the electronic record for oxygen at 3 liters for comfort. In addition to the oxygen order, an entry was noted on the TAR per nursing order to perform tubing change weekly. This order was transcribed by licensed practical nurse (LPN)-E. A review of R4's care plan, initiated on 8/22/22, identified the following diagnoses: chronic obstructive pulmonary disease and unspecified	F 695	provider. TRAINING/EDUCATION Education will be created for all Licensed nurses to review current policy regarding standing order medication use. MONITORING/AUDITING RNCC will audit all resident orders weekly x4 weeks to ensure that all standing orders being utilized have an end date that does not exceed 7 days. The Administrator and DON are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training. The facility alleges that it will be in substantial compliance and complete all action items by 3/2/2023.	

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F 695	Continued From page 26 obstructive sleep apnea, however,the care plan lacked any potential concerns regarding these diagnoses. Although the oxygen use was clearly documented in the narrative notes, the careplan did not identify any concerns regarding R4's respiratory status. The care plan had identified the potential for COVID-19 related to recent pandemic with the following interventions were recommended; Monitor for signs/symptoms of COVID-19 per CDC guidelines; Limit group exposure or attempt to remain 6 feet from others. Although the resident identified having Covid-19, the care plan was not updated to reflect a change in interventions when diagnosed as positive. A review was completed of R4's medical record and it was noted R4 did have the Standing Orders for Assumption Home signed on 12/14/22 by the provider which identified staff may administer O2 at 2 L/NC or 5-6 per mask for respiratory difficulty, SOB or saturation levels less than 90%. The order for O2 at 3 liters per minute as needed for comfort was received on 1/17/23. During interview on 1/18/23, at 3:28 p.m. LPN-E stated the facility policy was to change the tubing weekly. LPN-E stated previously, staff had been standing orders for O2 use for R4. LPN-E stated R4 had been using O2 more frequently,and had used it greater than seven days, so an order was obtained. The facility policy Standing Orders, reviewed May 2021, indicated when the use of orders or treatments are done through the orders, the order was to be documented in the medication administration record directly as it is stated on the standing orders. The standing order is to be entered no longer than 7 days. If the order is	F 695		

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F 695	Continued From page 27 needed for greater than seven days, the primary provider is to be contacted for the appropriate order for the resident. The facility policy, titled Oxygen, reviewed July 2023, the policy directed residents on long term administration of supplemental oxygen are required to have an order by a physician. The policy directs staff to change the oxygen tubing, masks, and cannula's weekly and as needed to prevent overgrowth and bacteria.	F 695		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to ensure 1 of 1 resident (R44) reviewed for the provision of behavioral health services was evaluated and possibly treated for mental health services to meet his emotional needs. Findings include: R44's annual Minimum Data Set (MDS) dated 11/30/22, identified cognitively intact with a	F 742	F742 Treatment/Services Mental/Psychosocial Concerns SS=D CFR(s): 483.40(b)(1) It is the practice of Assumption Home, based on the comprehensive assessment of a resident to ensure that a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder,	3/2/23

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F 742	Continued From page 28 diagnosis of Parkinson's disease and did not have any hallucinations or delusions. R9's Encounter Note dated 1/18/22, indicated R44's family shared the resident was hallucinating which was distressing to him. The nurse practitioner (NP) progress note revealed the resident did not share the distressing hallucinations with staff since he was a private person. The resident was started on Nuplazid (an antipsychotic for treatment of hallucinations related to Parkinson's disease). The NP's progress notes revealed nursing staff questioned if a meeting with the resident's family to discuss care goals would be appropriate. The NP indicated in this document that she agreed this was a good idea and requested nursing check with the family to set this meeting up. A new diagnosis of psychotic disorder due to known physiological condition was added. R44's medical record for the months of November and December 2022, and January 2023 failed to monitor or provide interventions for any hallucinations or delusions. Review of R44's medical record failed to indicate a mental health referral was made or that a discussion was held with the resident and/or his family to discuss a mental health referral. Review of a document provided by the facility untitled, undated, and unsigned indicated the facility offered a mental health referral to family on behalf of R9 on 11/08/21 and the family has yet to respond. During an interview on 01/17/23, at 6:18 p.m. R44 confirmed he did see things that were not there.	F 742	receive appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED R44 has been referred for PASRR Level II-MI screening to determine the appropriate treatment and services to correct the assessed problem and/or to attain the highest practicable mental and psychosocial well-being. R44 continues to take Nuplazid 10mg one time a day for Parkinson□s Psychosis symptoms and now also takes Ativan for his anxiety. His care plan continues to include nonpharmacological intervention such as 1. Offer fluids 2. Offer snacks 3. 1:1 4. Ice/Heath 5 Deep breathing 6. Bring to a quiet area 7. Offer blanket 8. Guided imagery 9. Essential oils (lemon: improve clarity of thought, improve energy, improve memory, promotes a sense of well being and reduces stress. Oils can be uses topically per instructions or through a diffuser) 10. Remove from area 11. Offer books/magazines 12. Offer music 13. Walk. Every shift, staff monitor for targeted behaviors of: elevated mood/behavior that include: 1. Restlessness 2. Anxious thoughts/comments 3. Trouble falling asleep due to anxiety. License staff write progress notes if any targeted behaviors is observed. Interventions are used as needed. Progress notes are reviewed at	

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F 742	Continued From page 29 The resident stated many times it was a figure who would sit next to him, and realized the figure was not there. The resident stated he did get scared when he hallucinates, since the hallucination was realistic. On 01/18/23, at 9:13 a.m. R44 stated that he would like to have therapy to help with the hallucinations and he has brought it up to his primary care physician about the need to speak with a therapist. R44 reported no one had directly spoken with him about speaking with someone about the hallucinations. R44 stated, "I have had times with anxiety about the hallucinations. I had a dream last night and it was bad it was a tough dream; it might be good to speak with someone." During an interview on 01/17/23, at 6:24 a.m. licensed practical nurse (LPN)-A stated R44 typically would hallucinate on the night shift and was distressing to him. During an interview on 01/18/23, at 9:13 a.m. R44 stated he would like to have mental health services to help him with the hallucinations. The resident stated no staff from the facility has asked him if he was interested in meeting with a therapist. During an interview on 01/18/23, at 12:35 p.m. nursing assistant (NA)-B stated R44 hallucinates, and he reports these episodes to nursing when they happen. There is no where to document them and no interventions to help R9 with these. During an interview on 01/18/23, at 4:07 p.m. social services (SS)-A confirmed she has not been asked to make a mental health referral. SS-A stated the resident/family was asked about	F 742	the IDT meeting and concerns are discussed and addressed. R44 was assessed through the PHQ9 tool with improvement of 3 pts from 11/30/22 with score of 6 and on 2/1/23 with a score of 3. Mental health and psychosocial well-being are reviewed quarterly, annually and when symptoms and/or behaviors indicate that treatments, services and interventions may need to be adjusted to meet R44□s needs. Current residents who display or who are diagnosed with mental disorder or psychosocial adjustment difficulty, or who have a history of trauma and/or post-traumatic stress disorder have the potential to be affected by the deficient practice; however, no similar findings and/or negative effects have been identified by this alleged deficient practice. Audits of all other residents did not identify any residents who would benefit for referral for assessment to determine if the resident would benefit from mental health and psychosocial well-being treatment and services. The facility□s corrective actions outlined below include policy, procedure and systemic changes; training and education; and monitoring and audits. POLICIES/PROCEDURES/SYSTEMIC CHANGES Policies and Procedures related to identifying residents who would benefit from appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and	

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F 742	Continued From page 30 this a while back in 11/21 and there was no follow up made by the family or facility. During an interview on 01/18/23, at 4:44 p.m. NA-C stated R44 did hallucinate, and she alerts the nursing staff when this happens. NA-C stated R9 sees figures and the resident seemed aware when he hallucinates. Review of a document provided by the facility titled "Social Services," dated 11/05/14, indicated ,". . .It is the policy of Assumption Home that the Social Services staff has a consultant and coordinates the consulting Psychologist services within the home according to the service agreement. . ." There was no information in the facility policy which would reflect a process of referrals and coordination of mental health services for residents.	F 742	psychosocial well-being were reviewed by the DON, ADON and Social Services Director and were updated as necessary. The Assumption Home Care Conference Summary Form will be updated to include a section that documents resident specific information that informs the IDT on identifying residents who would benefit from a referral for assessment to determine if they would benefit from additional treatments and services to support mental and psychosocial well-being. The Social Services Initial Assessment Form will be added to the Admission packet for families/residents to complete. This new form gathers information regarding the residents mental and psychosocial health and well being as well as any history of trauma or PTSD. This information will be discussed during IDT and referrals will be made by the Social Services Director as required by state and federal regulations. The facility will continue it's practice of interviewing new admitted residents for history of mental illness, trauma, PTSD, difficulty with psychosocial adjustment, symptoms that would suggest the need for assessment. Residents who are flagged for needing assessment to determine the appropriate treatments and services are discussed by IDT and Social Services makes the appropriate referrals.	

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F 742	Continued From page 31	F 742	TRAINING/EDUCATION The Administrator and Social Services Director(SSD) will in-service leadership, nursing staff, and therapeutic recreation on identifying residents who are appropriate for assessment to determine if additional mental health treatment and/or psychosocial services would benefit the resident. This staff will also be trained on the Social Services Initial Assessment. MONITORING/AUDITING To verify continued compliance, the SSD and Administrator will monitor use of the modified forms for completion and review by IDT weekly X4 and then monthly X3. This data will be communicated to QAPI for review and guidance. The Administrator and DON are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training. The facility alleges that it will be in substantial compliance and complete all action items by March 2, 2023.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring.	F 867		3/2/23

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F 867	Continued From page 32 A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action.	F 867		

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F 867	Continued From page 33 §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance	F 867		

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F 867	Continued From page 34 improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement appropriate action plans to correct quality deficiencies identified during the survey that the facility was aware of or should have been aware of. This deficient practice had the potential to affect at 56 residents currently residing in the facility.	F 867	This plan of correction is the facilities credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or	

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F 867	Continued From page 35 Findings include: During an interview on 01/19/23 at 2:30 PM, the Infection Preventionist (IP) revealed there was no month to month tracking or line list surveillance for the residents to track any potential health care acquired infections. The only tracking being done was if residents had COVID-19. On 1/19/23, at a concurrent interview with the Administrator the director of nursing (DON) the Administrator stated, the infection preventionist (IP) was an active participant at the Quality Assurance and Performance improvement (QAPI) meetings and did review her findings regarding COVID-19 and antibiotic use in regards to urinary tract infections (UTI). The IP would also review concerns such as skin infections and other respiratory infections but only if she noted a group of residents in a specific area of the facility experienced the same concern. The Administrator and DON confirmed they were not aware the IP was not maintaining a line listing to consistently track each individual area of concern. During this same interview, review of the recertification survey on 3/10/22 when federal regulation F880 for surveillance was cited, was completed. It was unclear if either the Administrator or the DON were aware that the same concern being reviewed for the current recertification survey was also cited during the previous recertification survey. Both the Administrator and the DON indicated it is important for the IP to consistently monitor all infections, use of antibiotics and health concerns with the residents so trends can be reviewed during QAPI meetings.	F 867	executed solely because it is required by the provisions of federal and state law. F867 QAPI/QAA Improvement Activities SS=F CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) It is the practice of Assumption Home to develop and implement appropriate action plans to correct quality deficiencies identified during the survey that the facility was aware of or should have been aware of. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED The facility is developing and implementing action plans that reflect the deficiencies identified in the most recent annual survey along with findings from complaint surveys. Action items will remain on the action plan until the next annual survey or until the team is sufficiently satisfied that the deficiency has been corrected and is in a period of sustainment. The action plans will be kept up-to-date wand will be reviewed during QAPI/QAA to ensure the accuracy of the action plans. All residents of Assumption Home have the potential to be affected by the deficient practice; however, no residents were noted to be affected by the deficient practice. The facility's corrective actions outlined below include policy, procedure and	

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F 867	Continued From page 36	F 867	systemic changes; training and education; and monitoring and audits. POLICIES/PROCEDURES/SYSTEMIC CHANGES QAPI Plan, and QA policies and procedures are being reviewed and modified as necessary. Existing QAPI/QAA binders that house the QAPI plan, current list of action items/projects, and agendas and meeting minutes are being consolidated into a single binder(s) that are labeled with the corresponding year. Having well organized QAPI/QAA Binders will help new and interim administrators easily find and review the most up-to-date QAPI information. The QAPI/QAA agenda will be modified to include "Review of current action items including survey deficiency correction status" to ensure that corrections to deficient practices are appropriate and are sustained to avoid repeat citations for the same deficient practice from one survey to the next. TRAINING/EDUCATION The Administrator will educate the QAPI/QA committee during the next QAPI meeting on maintaining accurate action plans to include accurate status' for each project.	

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F 867	Continued From page 37	F 867	MONITORING/AUDITS The DON, Administrator and QAPI committee will monitor the action plan during each QAPI/QA meeting to ensure that no survey deficiencies are unresolved, have reoccurred or have failed to be sustained. Any item that reocccurs will be added back to the action plan. The Administrator and DON are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training. The facility alleges that it will be in substantial compliance and complete all action items by 3/2/2023	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		2/15/23

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F 880	Continued From page 38 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 39 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure the Infection Control policies were reviewed annually and failed to conduct ongoing surveillance for healthcare-associated infections (HAIs) in the facility. This had the potential to affect all 56 residents in the facility. Findings include: During an interview on 01/19/23, at 1:49 p.m. the Infection Preventionist (IP) revealed the overall infection control policies were not reviewed in the last year. During an interview on 01/19/23, at 3:29 p.m. the Interim administrator and the director of nursing (DON) explained the facility does not have a process in place to review the Infection Control Policies and were not aware they needed to be updated annually. During an interview on 01/19/23, at 2:30 p.m. the IP revealed there was no month to month tracking or line list surveillance for the residents, to track any potential HAIs.	F 880	This plan of correction is the facilities credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. F880 Infection Prevention & Control SS=F CFR(s): 483.80(a)(1)(2)(4)(e)(f) It is the practice of Assumption Home to ensure the Infection Control policies are reviewed annually, for the infection preventionist to conduct ongoing surveillance for healthcare-associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions, and to monitor, track, trend and analyze all	

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F 880	Continued From page 40 During an interview on 01/19/23, at 3:29 p.m. the Interim administrator and the DON explained they were not aware the IP was not using line listing for potential HAIs for resident surveillance and should be doing so. Review of facility policy titled, "Surveillance for Infections," revised 03/22, indicated "The infection preventionist will conduct ongoing surveillance for healthcare-associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions."	F 880	residents and staff for signs and symptoms of communicable, respiratory infections, according to CDC guidelines. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED The DON, ADON or RNCCs will review the progress notes for all 56 residents at the time of the survey for the period between admission and the last MDH recertification survey to identify entries with mentions of signs and symptoms of communicable, respiratory infection that would indicate any type of illness. This data will be added to appropriate Monthly Infection Control Log Line Listing. All 56 residents at the time of the survey had the potential to be affected by this deficient practice; however, no negatieeffects have been identified by this alleged deficient practice. The facility□s corrective actions outlined below include all necessary components of the Directed Plan of Correction (DPOC) as imposed in accordance with 42 CFR 488.424. POLICIES/PROCEDURES/SYSTEMIC CHANGES The facilities Quality Assurance and Performance Improvement Committee (QAPI) with assistance from the Infection Preventionist (IP), with Governing Body	

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F 880	Continued From page 41	F 880	oversight will conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence. The IP and DON will review and revise polices for infection surveillance as needed. The IP and DON will develop and implement an infection control program sign and symptom tracking tool to monitor all residents and staff for communicable, respiratory infection, according to the CDC guidelines. The IP and DON will ensure that the lead/charge nurse for each shift documents all resident and employee infections on the facility□s shared infection tracking log. The IP nurse will review the infection control log for compliance daily and the data will be analyzed for possible trends/outbreaks. The IP will investigate any potential outbreaks and follow-up as appropriate. The IP and DON will review infection prevention tracking and trending. Any unexpected increases in infection will be reported to the Medical Director, and/or Public Health Department, and the state survey agency in order to obtain guidance/assistance for infection control concerns. TRAINING/EDUCATION	

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F 880	Continued From page 42	F 880	The IP, DON, Nurse Mangers, and Administrator will complete training that utilizes online courses from the Centers of Disease Control and Preventions (CDC) and the Minnesota Department of Health (MDH) websites. The training will cover standard infection control practices, active surveillance, and tracking and trending for a comprehensive infection control program. Training will be completed by 2/15/2023 and will be verified with signature of completion. MONITORING/AUDITING Daily and more often as necessary, the IP and DON will review infection prevention tracking logs and analysis. Any unexpected increases in infection will be reported to the Medical Director, and/or Public Health Department, and the state survey agency to obtain further assistance for Infection control practices. The DON, IP, or Designee will review results of audits and monitoring with the QAPI program. The DON will audit IPs line listing weekly x2 weeks to be completed by 2/15/2023. The Administrator and DON are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training.	

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F 880	Continued From page 43	F 880	The facility alleges that it will be in substantial compliance and complete all action items by 2/15/2023	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to establish an antibiotic stewardship program to include protocols to monitor extended antibiotic use for residents reviewed use in a sample of 1 of 1 resident (R158). As a result of this deficient practice the residents had the potential for development of antibiotic resistant bacterial infections for residents on antibiotics. Findings include: Review of R158's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab, revealed an admission date of 01/04/23 with medical diagnoses that included infection and inflammatory reaction due to other internal joint prosthesis. R158 physician's order, dated 01/04/23 included, cephalexin (an antibiotic) Tablet 500 milligrams	F 881	This plan of correction is the facilities credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. F881 Antibiotic Stewardship Program SS=D CFR(s): 483.80(a)(3) It is the practice of Assumption Home to have an established antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use as prevention measures for the potential for development of antibiotic	3/2/23

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F 881	Continued From page 44 (mg) Give 500 mg by mouth, two times a day for infection associated with prosthesis of [left] shoulder joint with no end date. R158's January 2023, Medication Administration Record (MAR), documented administration of Cephalexin twice daily since admission. The physician's order on the MAR lacked a discontinue order date. Review of the resident medical record lacked any documentation for the reason for the extended use of the antibiotic. Review of the "Admission Orders" found in the hard chart for R158 revealed the list of medications including cephalexin 500 mg Cap (Commonly known as: KEFLEX) to take 1 Capsule (500 mg) by mouth in the morning and 'l Capsule (500 mg) in the evening. The associated diagnosis infection associated with prosthesis of left shoulder joint and a start date 07/26/22. During an interview on 01/19/23, at 2:08 p.m. the infection preventionist (IP) explained R158 had been on the antibiotic since admission and the facility did not have a protocol about physician ordered antibiotics having an end date when prescribed and was unaware of a reason R158 antibiotic order had no discontinue date. The IP verbalized the facility had no antibiotic protocol for prescribing antibiotics for the residents in the facility. Review of facility policy titled, "Antibiotic Stewardship Procedure," dated 09/2017, indicated, "Upon admission/ re-admission into the facility, the admission's Registered Nurse (RN) will complete the antibiotic form and alert the infection control nurse (who also serves on the	F 881	resistant bacterial infections for residents on antibiotics. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED R158 was identified during survey as being affected by this deficient practice. The resident's provider was contacted in regard to the appropriateness of the ongoing use of what was documented in admission paperwork as "lifelong" antibiotic use of Cephalexin. Provider response is still pending at time of submission of the Plan of Correction. All residents of Assumption Home who have orders for antibiotics have the potential to be affected by the deficient practice; however, no similar findings and/or negative effects have been identified by this alleged deficient practice. The facility's corrective actions outlined below include policy, procedure and systemic changes; training and education; and monitoring and audits. POLICIES/PROCEDURES/SYSTEMIC CHANGES The DON an ADON/IP nurse are reviewing and updating the Antibiotic Stewardship Policy and Procedure as necessary. Under the direction of the ADON/Infection Control (IC) Nurse, the RN Care	

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F 881	Continued From page 45 leadership and infection control teams) of what medication(s) the resident is admitting with. The infection control RN or member of the infection control team, will evaluate the appropriateness of the medication."	F 881	Coordinators will review all existing medication orders to determine whether the clinical assessment, prescription documentation and antibiotic selections are in accordance with facility antibiotic use polices and procedures for any current antibiotic order. This information will be documented on the facility created F881 Antibiotic Stewardship Program Medical Record Review Spreadsheet. Any situations of non-compliance discovered during the review will be addressed immediately until all of the orders are compliant with state and federal regulations. In accordance with the facility□s policies and procedures, upon admission and re-admission to the facility, the Admission□s Registered Nurse (RN) will complete the Admission/ In House Antibiotic Documentation form and alert the ADON/IC Nurse and the RN Care Coordinator to what medication(s) the resident is admitting with. The ADON/IC RN or designee will evaluate the appropriateness of the medication per the facilities antibiotic use protocols and will make sure, that appropriate monitoring is in place. At the morning stand-up meeting, the interdisciplinary team will review new and current antibiotic orders to monitor outcomes and continued appropriateness of the antibiotic order. This information will be reviewed at the daily shift to shift huddles.	

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F 881	Continued From page 46	F 881	TRAINING/EDUCATION Through interactive academic workshops, the ADON/IC Nurse and Staff Development Nurse will educate the Health Information Team and all licensed nurses, including the admission□s nurse, on the facility□s antibiotic stewardship program and the procedure for new and existing antibiotic orders. All licensed nurses will have additional education on how to review antibiotic orders to determine whether the clinical assessment, prescription documentation and antibiotic selection are in accordance with the facility□s antibiotic use polices and procedures and the procedure to utilize the facility□s antibiotic form for admissions having antibiotic orders. The DON or RN designee will schedule one-to-one time with clinicians and will utilize academic detailing to provide unbiased, non-commercial, evidence-based information regarding antibiotic use with the goal of improving resident care. During this time, the DON or RN designee will review the facilities current established antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use as prevention measures for the potential for development of antibiotic resistant bacterial infections for residents on antibiotics. MONITORING/AUDITING The IP nurse will monitor process	

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F 881	Continued From page 47	F 881	measures to assess whether antibiotic prescribing policies are being followed by staff and clinicians once a week for 4 weeks and once a months for 3 months. The DON and IC Nurse are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training. The facility alleges that it will be in substantial compliance and complete all action items by March 2, 2023	