DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 5, 2022

CMS Certification Number (CCN): 245446

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 21, 2022 the above facility is certified for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 5, 2022

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

RE: CCN: 245446
Cycle Start Date: March 10, 2022

Dear Administrator:

On April 1, 2022, we notified you a remedy was imposed. On April 24, 2022 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 April 21, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 1, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 1, 2022, 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 May 1, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 21, 2022, 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
Minnesota Department of Health
Licensing and Certification Program

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

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Electronically delivered

May 5, 2022

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

Re: Reinspection Results
Event ID: FFOW12

Dear Administrator:

On April 24, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 10, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
April 1, 2022

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

RE: CCN: 245446
Cycle Start Date: March 10, 2022

Dear Administrator:

On March 10, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 1, 2022.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 1, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 1, 2022.

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

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 May 1, 2022, 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 May 1, 2022. 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 September 10, 2022 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:

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@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
Licensing and Certification Program

Program Assurance Unit
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 _____ B. WING _____	C 03/10/2022

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
E 000	Initial Comments On March 7th - 9th, 2022, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On March 7th - 9th, 2022, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5446032C (MN00080958) The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 656	Develop/Implement Comprehensive Care Plan	F 656		4/15/22

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

Electronically Signed | 04/11/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656 SS=D	Continued From page 1 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 2 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop the care plan to include monitoring for the use of anticoagulants, and to monitor for the potential signs and symptoms of bruising and bleeding for 1 of 1 residents (R38) who was prescribed Coumadin (and anticoagulant). Findings include: R38's Diagnosis Report (print date of 3/09/22) indicated the diagnoses of Alzheimer's disease, acute embolism and thrombosis of unspecified deep veins of right lower extremity, and tachycardia. R38's annual Minimum Data Set (MDS) dated 1/21/22, identified R38 was severely cognitively impaired and required extensive assistance with with all activities of daily living. R38's physician orders (print date of 03/09/2022) documented the following anticoagulant orders: > Coumadin tablet (Warfarin Sodium) Give 3 milligrams (mg) by mouth in the evening every [Wednesday] for Acute Saddle Embolism. > Coumadin tablet (Warfarin Sodium) Give 4 mg by mouth in the evening every [Monday, Tuesday, Thursday, Friday, Saturday, Sunday] for Acute Saddle Embolism. R38's care plan (undated) lacked acknowledgement R38 not only was prescribed	F 656	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: Reviewed all resident care plans/med lists, updated monitoring for nursing to document specific targeted symptoms related to anticoagulant medications. Monitoring was also added to PCC every shift (Observe for side effects of anticoagulation, if present, alert nurse for a focused assessment and to enter a progress note and update MD. Common Side effects: Black tarry stools, severe headache, stomachache, unusual or excessive bruising, nose or gum bleeding. Bleeding that is hard to control.) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents on anticoagulant medications could potentially be affected by this deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Nursing staff and Health Information staff	

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F 656	Continued From page 3 Coumadin, further lacked the reason why the medications was prescribed, and the need to observe of signs and symptoms of bruising and bleeding which could occur when Coumadin is prescribed. During interview on 03/08/22, at 1:53 p.m. registered nurse (RN)-A, after review of R38's care plan and medication administration record (MAR), verified resident's care plan did not address R38 was receiving Coumadin and both the care plan and MAR lacked documentation reminding nursing to monitor for sings and symptoms of bruising and bleeding. RN-A stated it was important for the staff to be aware of medication side effects so the physician could be updated and interventions / holding of medications could be done. A review of the facility policy, entitled: Care Plans (last revised January 10, 2022) indicated under the section of "Permanent Plan of Care" subpart b. 15 only: "Medication Administration Status" and under the section of : "[Care Plan] Implementation/Monitoring/Documentation" subpart 1d.: "A template will be added to [Point Click Care] under "Clinical Monitoring" indicating specific symptoms to monitor for related diagnosis or specific to that resident. This will flag for the floor [licensed practical nurse] or [registered nurse] for the unit."	F 656	being educated of the need to add monitoring for side effects related to anticoagulant medications. How the facility plans to monitor its performance to make sure that solutions are sustained: RN□s or designee will audit care plans and PCC for residents on anticoagulation therapy monthly for the next quarter. Results to be reviewed at QA. This plan will be implemented and the corrective action evaluated for its effectiveness. DON/RNCC	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		4/15/22

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F 761	Continued From page 4 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure an insulin KwikPen was kept locked or under direct observation of authorized staff in an area where residents and visitors could access the medication. This deficient practice had the potential to affect 16 residents who resided on the Cobblestone unit. Findings include: During a continuous observation on 3/8/22, from 1:25 p.m. to 1:51 p.m. the Cobblestone medication cart was observed. There was an insulin KwikPen (a disposable pre-filled pen containing 3 milliliter of insulin) with a needle	F 761	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: Updated medication storage policy. Providing education to all TMAs, RNs and LPNs on medication storage and administration. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents receiving medications could potentially be affected by this deficient practice.	

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F 761	Continued From page 5 attached to the KwikPen and dialed up for the number of units to give to a resident, sitting unsecured on top of the medication cart in the hallway on the Cobblestone unit. At 1:35 p.m. two unidentified staff and a woman and man walked by the medication cart with the unsecured insulin KwikPen. At 1:37 p.m. registered nurse (RN)-C walked by the medication cart with the unsecured insulin KwikPen. RN-C asked two unidentified staff to assist a resident and then RN-C walked by the medication cart with the unsecured insulin KwikPen to the nursing station. At 1:43 p.m. nursing assistant (NA)-B, NA-C, and NA-E walked by the medication cart with the unsecured insulin KwikPen to the nursing station. At 1:51 p.m. NA-C and NA-E walked up to the medication cart on Cobblestone and took a piece of hard candy off the top of the medication cart for a resident. At 1:51 RN-C came to the medication cart on Cobblestone and took the KwikPen off the medication cart and found the resident and gave the insulin KwikPen dose. Then RN-C documented the KwikPen was given and unlocked the medication cart and put the insulin KwikPen in and locked the medication cart. During an interview on 3/8/22, at 1:57 p.m. RN-C stated the insulin KwikPen should have been secured in the medication cart while no one was at the cart. RN-C stated she did not usually leave medications unsecured on top of the mediation cart.	F 761	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Education modules for LPNs, RNs and TMAs on medication administration including security/storage of medications. How the facility plans to monitor its performance to make sure that solutions are sustained: In addition to consulting pharmacy auditing quarterly,RN or designee will audit med passes every shift for 7 days, then weekly for the next quarter. Results to be reviewed at QA. This plan will be implemented and the corrective action evaluated for its effectiveness. DON/RNCC	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 6 During an interview on 3/822, at 2:07 p.m. RN-B stated it would not be best practice to draw up a medication and leave it sitting on top of the medication cart. RN-B stated the insulin KwikPen should not have been left on top of the medication cart unsecured. The facility policy Medication Administration dated 4/21, included, not leave medication unattended.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		4/15/22

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F 842	Continued From page 7 representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 842		

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F 842	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to maintain accurate and complete medical records for 1 of 1 residents (R14) reviewed for weight loss. Findings include: R14's annual Minimum Data Set (MDS) dated 12/22/21, identified R14 was independent with eating after meal set up by staff. R14 had diagnoses of protein-calorie malnutrition (a condition resulting from inadequate intake of calories and/or protein, or an inability to absorb and/or digest adequate calories and/or protein) and Alzheimer's dementia. R14's care plan reviewed 1/12/2022, indicated R14 was at risk for malnutrition related to Alzheimer's disease and problems with gallbladder, was only eating one quarter to three quarters of her meals. R14's care plan had a goal to maintain weight at 100 pounds plus or minus 5 pounds. Interventions included R14 liked ice cream and salty snacks, preferred to eat in room, assist with preferences, was encouraged to snack throughout the day, provided supplements and referred to dietician for evaluations and recommendations. When observed on 3/7/22, at 1:04 p.m. R14 was in dining room eating lunch and was served a turkey sandwich, bowl of wild rice soup, mixed fruit and dessert bar. Resident consumed several spoonfuls of soup and few biters of dessert bar. R14 did not consume the sandwich or mixed fruit. During interview on 3/9/22, at 8:47 a.m. nursing	F 842	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: Reviewed weight policy. All resident weights were reviewed. All residents have a current weight is in the system. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents could potentially be affected by this deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: IDT will review weights weekly and alert MD of any significant weight loss or gain. Dietician reviews all weights monthly and updates IDT with any concerns. LPNs, RNs, and TMAs educated to Weights policy. How the facility plans to monitor its performance to make sure that solutions are sustained: DON or designee will do a monthly audit that weights are being obtained and monitored for significant changes and documentation entered into system. Will review results at QA.	

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F 842	Continued From page 9 assistant (NA) -B stated residents were weighted weekly when they received their bath, the weight was written on a piece of paper which was given the trained medication assistant (TMA) or the nurse. If being weighed was refused that would be reported to the TMA or nurse. When interviewed on 3/9/22, at 10:25 a.m. NA-C stated, weights were done weekly, if refused would re-approach three times then a coworker was asked to attempt to get residents weight. Weights were given to the TMA or nurse to record. When interviews on 3/9/22, at 12:37 p.m. registered nurse (RN)-B stated weights were completed weekly and weight loss was reviewed during the morning interdisciplinary team meeting (IDT). Review of R14's medical record identified no order was entered in computer system to record weights in the medical record. R14's orders did include nutritional supplement four times daily to maintain current weight, and offer ice cream with meals and between meals daily. Review of R14's weights indicated R14's medical record failed to include weekly weights from 12/22/21 to 3/9/22. weight on 12/22/21, was 90 pounds; on 11/23/21, was 88.5 pounds; on 7/31/21 R14 weighed 96 pounds. There was no record of weights recorded between 7/31/21 and 11/23/21. There were no progress notes indicating that R14 had refused to have weight completed. Progress note dated 12/2/21, at 12:25 p.m. by registered dietitian indicated R14's current weight was 88.5 pounds, showed a decline in weight.	F 842	This plan will be implemented and the corrective action evaluated for its effectiveness. DON/RNCC	

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F 842	Continued From page 10 R14 was informed of the weight loss, snacks were kept in room and "continue to monitor intake at meals and weight for changes." A policy related to weight monitoring was requested, however none was provided.	F 842		
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: §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	F 880		4/15/22

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F 880	Continued From page 11 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 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 observation, interview, and document review, the facility failed to ensure hand hygiene was completed for 2 of 2 residents (R1 and R16)	F 880	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:	

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F 880	Continued From page 12 observed. In addition, the facility failed to ensure ongoing surveillance, investigation of infections and analysis of collected data to determine interventions to prevent the spread of infection. This had the potential to affect all 46 residents residing in the facility. Findings include: R1's admission Minimum Data Set (MDS) dated 11/16/21, indicated R1 had moderately impaired cognition. R1 was an extensive assist from staff with bed mobility, transfers, dressing, toileting, and personal hygiene. On 3/9/22, at 8:32 a.m. nursing assistant (NA)-A was observed assisting R1 to the bathroom. NA-A placed the harness behind R1's back for the mechanical standing lift secured R1 and moved the lift to the bathroom toilet. NA-A put gloves on and lowered R1's pants and brief. Then lowered R1 to the toilet. R1 used the toilet and NA-A raised him up wiped front peri area then the bottom area front to back. NA-A secured the brief and pants and took the dirty gloves off. NA-A moved R1 to the wheelchair and lowered R1 to a sitting position. NA-A unhooked the harness and moved the mechanical standing lift to the hallway. NA-A took R1 to his place the dining room. NA-A did not wash or sanitize hands. At 8:41 a.m. NA-A was observed putting gloves on then wiping the mechanical standing lift with a sani-wipe in the hall. NA-A brought the mechanical standing lift to the alcove where other lifts were. NA-A took her dirty gloves off and went to the dining room. R16's quarterly MDS, dated 12/23/21, indicated	F 880	Updated hand hygiene policy. Providing education on hand hygiene and return demonstration. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents that this staff member worked with could potentially be affected by this deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Added signage in charting rooms, break rooms and bathrooms for reminders and proper hand hygiene. Providing education and observing return demonstration of all staff. Upon new hire, annually and as needed, staff will be required to perform hand hygiene competency. How the facility plans to monitor its performance to make sure that solutions are sustained: Will do audits every shift for 7 days then weekly for the next quarter. Results to be reviewed at QA. This plan will be implemented and the corrective action evaluated for its effectiveness.	

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F 880	Continued From page 13 R16 had severe cognitive impairment. R16 was an extensive assist from staff with bed mobility, transfers, dressing, eating, toileting, and personal hygiene. At 8:43 a.m. NA-A put clean gloves on, still without washing hands, and sat down by R16 to assist her with eating breakfast. NA-A assisted to feed her eggs. At 8:47 a.m. NA-A got up took off dirty gloves, still not washing hands, and got a yogurt for R16. NA-A put on clean gloves and assisted her with eating the yogurt. At 8:52 a.m. NA-A took off the dirty gloves, talked with R16. R16 wanted a bit of toast. NA-A put on clean gloves, still without washing hands, and gave R16 toast and more yogurt. At 9:00 a.m. an unidentified resident wanted the eggs and coffee heated up. NA-A took off the dirty gloves and put on clean gloves, and still had not washed hands, and heated up the eggs and coffee. NA-A brought them to the unidentified resident. NA-A took off the dirty gloves. At 9:03 a.m. NA-A took off R16's clothing protector and assisted R16 to the hallway. At 9:05 a.m. NA-A then got orange juice for R29 put on clean gloves, and still had not washed hands, and brought the orange juice to R29. NA-A was observed not used any soap and water or an alcohol-based hand rub (ABR) after each dirty glove removal. An interview on 3/9/22, at 9:07 a.m. with NA-A	F 880	DON/RNCC	

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F 880	Continued From page 14 stated she had hand hygiene training annually. NA-A stated she should wash her hands after every interaction with residents. NA-A stated she did not notice that she did not wash her hands or hand sanitize after removing her gloves. NA-A stated she should have washed her hands or used hand sanitizer after removing her dirty gloves. An interview on 3/9/22, at 2:27 p.m. registered nurse (RN)-E stated hand hygiene could be done with ABR or soap and water after doing personal cares. RN-E stated hand hygiene should be done when gloves are taken off, when gloves are visibly soiled, after using the bathroom, before feeding residents, before you eat. RN-E stated NA-A should have ABR or washed her hands every time she took her gloves off. The facility policy Hand Hygiene dated 3/21, revealed it was mandatory that direct caregivers wear gloves when doing resident care that may involve contact with any body fluid. It was also mandatory that gloves were removed prior to moving onto a "clean" task and hands are washed as to not contaminate the clean surface/articles. It further revealed, to wash hands before eating and drinking, before and after having direct contact with a resident's intact skin, after contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings, after contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident, after glove removal, after using the rest room, when reporting to work and before going home, after sneezing, coughing, or blowing your nose, after touching hair, face, etc., after smoking, and whenever hands are obviously soiled.	F 880		

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F 880	Continued From page 15 On 3/9/22, at 1:04 p.m. surveillance records were requested, but not provided by the facility. Director of nursing (DON) and registered nurse (RN)-E confirmed the facility did not have a form to complete ongoing surveillance or investigation of resident infections. DON acknowledged they did have policies and procedures for surveillance but had not established a process to ensure surveillance was completed. DON stated it was important to investigate resident infections to look for patterns and trends to prevent possible outbreak. No tracking and trending of infections had been completed at all, the facility had no information to provide. Facility policy, Infection Prevention and Control Program, reviewed 7/2021, noted the infection control preventionist will provide continuous monitoring of the residents and staff for the acquisition or clinical manifestations of infection. The infection control preventionist, DON and/or RN teams, upon notice of an infectious problem or trend will investigate potential causes such as sanitation, infection control breaches, or improper use of precautions.	F 880		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this	F 888		4/15/22

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F 888	Continued From page 16 section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have	F 888		

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F 888	Continued From page 17 been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who	F 888		

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F 888	Continued From page 18 is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by:	F 888		

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(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 888	Continued From page 19 Based on interview and document review, the facility failed to ensure policies were in place regarding the COVID-19 vaccination mandate. In addition, the facility failed to ensure the COVID-19 testing policy for staff included language preventing staff who refused to test for COVID from working with the residents. This had the potential to affect all 46 residents residing in the facility. Findings include: On 3/8/22, at 1:31 p.m. the director of nursing (DON) confirmed there was no policy available regarding the COVID-19 vaccination mandate. DON stated she was aware the facility needed to develop these policies but had not done so due to a recent change in staff in the infection preventionist (IP) position. Procedures in place included all current staff and new hires were required to show proof of vaccination or submit a request for exemption, contracted staff provided proof of vaccination or exemption before working and unvaccinated staff were required to test for COVID twice weekly. The facility met the 100% vaccination rate requirement. On 3/9/22, at 1:04 p.m. DON stated staff who refuse to be tested for COVID were not allowed to work. Staff would not be allowed to work regardless of test results during that testing cycle. DON confirmed, facility policy regarding staff testing for COVID did not include this direction. Facility policy, COVID-19 Resident and Staff Testing, reviewed 9/2021, gave direction: If the facility participates in PPS [Point-Prevalence Survey] testing and staff refuse to participate, the facility may ask them to self-quarantine at home if	F 888	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: Revised COVID19 vaccination for staff policy to reflect the mandate and the exemption processes. Revised COVID19 staff testing policy. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents could potentially be affected by this deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Upon new hire, staff are provided education from Human Resources on the vaccine mandate and the exemption process. Staff will either have the 1st dose of a vaccine or an approved exemption prior to their 1st scheduled shift. Human Resources educated to new staff vaccine policy and process for onboarding new staff. Staff are provided education on hire regarding COVID testing and the policy. Staff that refuse testing are unable to work until able to show proof of a negative test.	

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 _____	C 03/10/2022

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F 888	Continued From page 20 there are positive results with the PPS testing of any staff or residents.	F 888	Existing staff have been sent a copy of COVID 19 testing policy. Infection Control or DON will provide 1:1 education as needed for staff if they refuse to test. How the facility plans to monitor its performance to make sure that solutions are sustained: DON and Infection Control monitor the CMS guidelines for ongoing testing and monitor testing results and frequencies of staff. This plan will be implemented and the corrective action evaluated for its effectiveness. DON/RNCC	

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 _____	**03/08/2022**

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 by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/08/2022. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 04/11/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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 basement and was determined to be built 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 built of Type II (000) construction. The 1963 building is separated, by a	K 000		

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K 000	Continued From page 2 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. In 2009 two wings were constructed to the North of the 1988 addition. The southwest wing is one-story with a basement, and the North Wing is two stories and was determined to be built 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 built of Type II (111) construction. 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 46 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K 345		4/21/22

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K 345	Continued From page 3 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/08/2022 at 9:30 AM, it was revealed by a review of available documentation the semi-annual fire alarm inspection documentation was not available at the time of the survey. An interview with the Director of Maintenance Facilities verified this deficient finding at the time of discovery.	K 345	Semi-annual inspection of initiating devices was completed on the fire alarm system on 04/21/22. Documentation sheet has been added to verify proper operation and maintain compliance. Maintenance Director will be responsible for ensuring compliance of initiating devices is completed. Responsible Person = Paul Stadtler Director of Maintenance and Facilities	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 1, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: FFOW11

Dear Administrator:

The above facility was surveyed on March 7, 2022 through March 10, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

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
	00624	A. BUILDING: _____ B. WING _____	C 03/10/2022

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ASSUMPTION HOME	715 NORTH FIRST STREET COLD SPRING, MN 56320

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On March 7th - 9th, 2022, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be not in compliance with MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 UNSUBSTANTIATED: H5446032C (MN00080958) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 555	Continued From page 2	2 555		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop the care plan to include monitoring for the use of anticoagulants, and to monitor for the potential signs and symptoms of bruising and bleeding for 1 of 1 residents (R38) who was prescribed Coumadin (and anticoagulant). Findings include: R38's Diagnosis Report (print date of 3/09/22) indicated the diagnoses of Alzheimer's disease, acute embolism and thrombosis of unspecified deep veins of right lower extremity, and tachycardia. R38's annual Minimum Data Set (MDS) dated 1/21/22, identified R38 was severely cognitively impaired and required extensive assistance with with all activities of daily living.	2 555	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: Reviewed all resident care plans/med lists, updated monitoring for nursing to document specific targeted symptoms related to anticoagulant medications. Monitoring was also added to PCC every shift (Observe for side effects of anticoagulation, if present, alert nurse for a focused assessment and to enter a progress note and update MD. Common Side effects: Black tarry stools, severe headache, stomachache, unusual or excessive bruising, nose or gum bleeding. Bleeding that is hard to control.)	4/15/22

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2 555	Continued From page 3 R38's physician orders (print date of 03/09/2022) documented the following anticoagulant orders: > Coumadin tablet (Warfarin Sodium) Give 3 milligrams (mg) by mouth in the evening every [Wednesday] for Acute Saddle Embolism. > Coumadin tablet (Warfarin Sodium) Give 4 mg by mouth in the evening every [Monday, Tuesday, Thursday, Friday, Saturday, Sunday] for Acute Saddle Embolism. R38's care plan (undated) lacked acknowledgement R38 not only was prescribed Coumadin, further lacked the reason why the medications was prescribed, and the need to observe of signs and symptoms of bruising and bleeding which could occur when Coumadin is prescribed. During interview on 03/08/22, at 1:53 p.m. registered nurse (RN)-A, after review of R38's care plan and medication administration record (MAR), verified resident's care plan did not address R38 was receiving Coumadin and both the care plan and MAR lacked documentation reminding nursing to monitor for sings and symptoms of bruising and bleeding. RN-A stated it was important for the staff to be aware of medication side effects so the physician could be updated and interventions / holding of medications could be done. A review of the facility policy, entitled: Care Plans (last revised January 10, 2022) indicated under the section of "Permanent Plan of Care" subpart b. 15 only: "Medication Administration Status" and under the section of : "[Care Plan] Implementation/Monitoring/Documentation"	2 555	How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents on anticoagulant medications could potentially be affected by this deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Nursing staff and Health Information staff being educated of the need to add monitoring for side effects related to anticoagulant medications. How the facility plans to monitor its performance to make sure that solutions are sustained: RN□s or designee will audit care plans and PCC for residents on anticoagulation therapy monthly for the next quarter. Results to be reviewed at QA. This plan will be implemented and the corrective action evaluated for its effectiveness. DON/RNCC	

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2 555	Continued From page 4 subpart 1d.: "A template will be added to [Point Click Care] under "Clinical Monitoring" indicating specific symptoms to monitor for related diagnosis or specific to that resident. This will flag for the floor [licensed practical nurse] or [registered nurse] for the unit." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to plan of care. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are comprehensively developed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was completed for 2 of 2 residents (R1 and R16) observed. In addition, the facility failed to ensure ongoing surveillance, investigation of infections and analysis of collected data to determine interventions to prevent the spread of infection. This had the potential to affect all 46 residents	21375	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: Updated hand hygiene policy. Providing education on hand hygiene and return demonstration.	4/15/22

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21375	Continued From page 5 residing in the facility. Findings include: R1's admission Minimum Data Set (MDS) dated 11/16/21, indicated R1 had moderately impaired cognition. R1 was an extensive assist from staff with bed mobility, transfers, dressing, toileting, and personal hygiene. On 3/9/22, at 8:32 a.m. nursing assistant (NA)-A was observed assisting R1 to the bathroom. NA-A placed the harness behind R1's back for the mechanical standing lift secured R1 and moved the lift to the bathroom toilet. NA-A put gloves on and lowered R1's pants and brief. Then lowered R1 to the toilet. R1 used the toilet and NA-A raised him up wiped front peri area then the bottom area front to back. NA-A secured the brief and pants and took the dirty gloves off. NA-A moved R1 to the wheelchair and lowered R1 to a sitting position. NA-A unhooked the harness and moved the mechanical standing lift to the hallway. NA-A took R1 to his place the dining room. NA-A did not wash or sanitize hands. At 8:41 a.m. NA-A was observed putting gloves on then wiping the mechanical standing lift with a sani-wipe in the hall. NA-A brought the mechanical standing lift to the alcove where other lifts were. NA-A took her dirty gloves off and went to the dining room. R16's quarterly MDS, dated 12/23/21, indicated R16 had severe cognitive impairment. R16 was an extensive assist from staff with bed mobility, transfers, dressing, eating, toileting, and personal hygiene. At 8:43 a.m. NA-A put clean gloves on, still	21375	How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents that this staff member worked with could potentially be affected by this deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Added signage in charting rooms, break rooms and bathrooms for reminders and proper hand hygiene. Providing education and observing return demonstration of all staff. Upon new hire, annually and as needed, staff will be required to perform hand hygiene competency. How the facility plans to monitor its performance to make sure that solutions are sustained: Will do audits every shift for 7 days then weekly for the next quarter. Results to be reviewed at QA. This plan will be implemented and the corrective action evaluated for its effectiveness. DON/RNCC	

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	00624	A. BUILDING: _____ B. WING _____	C 03/10/2022

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21375	Continued From page 6 without washing hands, and sat down by R16 to assist her with eating breakfast. NA-A assisted to feed her eggs. At 8:47 a.m. NA-A got up took off dirty gloves, still not washing hands, and got a yogurt for R16. NA-A put on clean gloves and assisted her with eating the yogurt. At 8:52 a.m. NA-A took off the dirty gloves, talked with R16. R16 wanted a bit of toast. NA-A put on clean gloves, still without washing hands, and gave R16 toast and more yogurt. At 9:00 a.m. an unidentified resident wanted the eggs and coffee heated up. NA-A took off the dirty gloves and put on clean gloves, and still had not washed hands, and heated up the eggs and coffee. NA-A brought them to the unidentified resident. NA-A took off the dirty gloves. At 9:03 a.m. NA-A took off R16's clothing protector and assisted R16 to the hallway. At 9:05 a.m. NA-A then got orange juice for R29 put on clean gloves, and still had not washed hands, and brought the orange juice to R29. NA-A was observed not used any soap and water or an alcohol-based hand rub (ABR) after each dirty glove removal. An interview on 3/9/22, at 9:07 a.m. with NA-A stated she had hand hygiene training annually. NA-A stated she should wash her hands after every interaction with residents. NA-A stated she did not notice that she did not wash her hands or hand sanitize after removing her gloves. NA-A stated she should have washed her hands or used hand sanitizer after removing her dirty	21375		

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21375	Continued From page 7 gloves. An interview on 3/9/22, at 2:27 p.m. registered nurse (RN)-E stated hand hygiene could be done with ABR or soap and water after doing personal cares. RN-E stated hand hygiene should be done when gloves are taken off, when gloves are visibly soiled, after using the bathroom, before feeding residents, before you eat. RN-E stated NA-A should have ABR or washed her hands every time she took her gloves off. The facility policy Hand Hygiene dated 3/21, revealed it was mandatory that direct caregivers wear gloves when doing resident care that may involve contact with any body fluid. It was also mandatory that gloves were removed prior to moving onto a "clean" task and hands are washed as to not contaminate the clean surface/articles. It further revealed, to wash hands before eating and drinking, before and after having direct contact with a resident's intact skin, after contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings, after contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident, after glove removal, after using the rest room, when reporting to work and before going home, after sneezing, coughing, or blowing your nose, after touching hair, face, etc., after smoking, and whenever hands are obviously soiled. On 3/9/22, at 1:04 p.m. surveillance records were requested, but not provided by the facility. Director of nursing (DON) and registered nurse (RN)-E confirmed the facility did not have a form to complete ongoing surveillance or investigation of resident infections. DON acknowledged they did have policies and procedures for surveillance	21375		

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21375	Continued From page 8 but had not established a process to ensure surveillance was completed. DON stated it was important to investigate resident infections to look for patterns and trends to prevent possible outbreak. No tracking and trending of infections had been completed at all, the facility had no information to provide. Facility policy, Infection Prevention and Control Program, reviewed 7/2021, noted the infection control preventionist will provide continuous monitoring of the residents and staff for the acquisition or clinical manifestations of infection. The infection control preventionist, DON and/or RN teams, upon notice of an infectious problem or trend will investigate potential causes such as sanitation, infection control breaches, or improper use of precautions. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21375		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data	21390		4/15/22

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21390	Continued From page 9 collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure policies were in place regarding the COVID-19 vaccination mandate. In addition, the facility failed to ensure the COVID-19 testing policy for staff included language preventing staff who refused to test for COVID from working with the residents. This had the potential to affect all 46 residents residing in the facility. Findings include:	21390	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: Revised COVID19 vaccination for staff policy to reflect the mandate and the exemption processes. Revised COVID19 staff testing policy. How the facility will identify other residents having the potential to be affected by the	

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21390	Continued From page 10 On 3/8/22, at 1:31 p.m. the director of nursing (DON) confirmed there was no policy available regarding the COVID-19 vaccination mandate. DON stated she was aware the facility needed to develop these policies but had not done so due to a recent change in staff in the infection preventionist (IP) position. Procedures in place included all current staff and new hires were required to show proof of vaccination or submit a request for exemption, contracted staff provided proof of vaccination or exemption before working and unvaccinated staff were required to test for COVID twice weekly. The facility met the 100% vaccination rate requirement. On 3/9/22, at 1:04 p.m. DON stated staff who refuse to be tested for COVID were not allowed to work. Staff would not be allowed to work regardless of test results during that testing cycle. DON confirmed, facility policy regarding staff testing for COVID did not include this direction. Facility policy, COVID-19 Resident and Staff Testing, reviewed 9/2021, gave direction: If the facility participates in PPS [Point-Prevalence Survey] testing and staff refuse to participate, the facility may ask them to self-quarantine at home if there are positive results with the PPS testing of any staff or residents. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures to ensure proper infection control policies included up to date COVID 19 vaccination mandates are followed per CDC and CMS guidelines. TIME PERIOD FOR CORRECTION: seven (7)	21390	same deficient practice: All residents could potentially be affected by this deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Upon new hire, staff are provided education from Human Resources on the vaccine mandate and the exemption process. Staff will either have the 1st dose of a vaccine or an approved exemption prior to their 1st scheduled shift. Human Resources educated to new staff vaccine policy and process for onboarding new staff. Staff are provided education on hire regarding COVID testing and the policy. Staff that refuse testing are unable to work until able to show proof of a negative test. Existing staff have been sent a copy of COVID 19 testing policy. Infection Control or DON will provide 1:1 education as needed for staff if they refuse to test. How the facility plans to monitor its performance to make sure that solutions are sustained: DON and Infection Control monitor the CMS guidelines for ongoing testing and monitor testing results and frequencies of staff.	

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21390	Continued From page 11 days.	21390	This plan will be implemented and the corrective action evaluated for its effectiveness. DON/RNCC	
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure an insulin KwikPen was kept locked or under direct observation of authorized staff in an area where residents and visitors could access the medication. This deficient practice had the potential to affect 16 residents who resided on the Cobblestone unit. Findings include: During a continuous observation on 3/8/22, from 1:25 p.m. to 1:51 p.m. the Cobblestone medication cart was observed. There was an insulin KwikPen (a disposable pre-filled pen containing 3 milliliter of insulin) with a needle attached to the KwikPen and dialed up for the number of units to give to a resident, sitting unsecured on top of the medication cart in the hallway on the Cobblestone unit.	21610	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: Updated medication storage policy. Providing education to all TMAs, RNs and LPNs on medication storage and administration. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents receiving medications could potentially be affected by this deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:	4/15/22

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21610	Continued From page 12 At 1:35 p.m. two unidentified staff and a woman and man walked by the medication cart with the unsecured insulin KwikPen. At 1:37 p.m. registered nurse (RN)-C walked by the medication cart with the unsecured insulin KwikPen. RN-C asked two unidentified staff to assist a resident and then RN-C walked by the medication cart with the unsecured insulin KwikPen to the nursing station. At 1:43 p.m. nursing assistant (NA)-B, NA-C, and NA-E walked by the medication cart with the unsecured insulin KwikPen to the nursing station. At 1:51 p.m. NA-C and NA-E walked up to the medication cart on Cobblestone and took a piece of hard candy off the top of the medication cart for a resident. At 1:51 RN-C came to the medication cart on Cobblestone and took the KwikPen off the medication cart and found the resident and gave the insulin KwikPen dose. Then RN-C documented the KwikPen was given and unlocked the medication cart and put the insulin KwikPen in and locked the medication cart. During an interview on 3/8/22, at 1:57 p.m. RN-C stated the insulin KwikPen should have been secured in the medication cart while no one was at the cart. RN-C stated she did not usually leave medications unsecured on top of the mediation cart. During an interview on 3/822, at 2:07 p.m. RN-B stated it would not be best practice to draw up a medication and leave it sitting on top of the medication cart. RN-B stated the insulin KwikPen should not have been left on top of the	21610	Education modules for LPNs, RNs and TMAs on medication administration including security/storage of medications. How the facility plans to monitor its performance to make sure that solutions are sustained: In addition to consulting pharmacy auditing quarterly,RN or designee will audit med passes every shift for 7 days, then weekly for the next quarter. Results to be reviewed at QA. This plan will be implemented and the corrective action evaluated for its effectiveness. DON/RNCC	

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21610	Continued From page 13 medication cart unsecured. SUGGESTED METHOD OF CORRECTION: The Administrator, director of nursing (DON), or designee, could develop, review, and/or revise policies and procedures for proper storage of medications; educate all appropriate staff on the policies and procedures; and, conduct audits on a regular basis to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		