DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KXDP
Facility ID: 00624

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245446**
2. STATE VENDOR OR MEDICAID NO. (L2) **751743200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ASSUMPTION HOME**
(L4) **715 NORTH FIRST STREET**
(L5) **COLD SPRING, MN** (L6) **56320**

4. TYPE OF ACTION: 7 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/18/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **82** (L18)

13. Total Certified Beds **82** (L17)

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	82			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 03/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/10/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

Page 2
Provider Number: 24-5446
Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective March 10, 2014, the facility is certified for 82 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245446

March 26, 2014

Ms. Jannette Luthens, Administrator
Assumption Home
715 North First Street
Cold Spring, MN 56320

Dear Ms. Luthens:

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 March 10, 2014, the above facility is certified for:

82 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 82 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

March 26, 2014

Ms. Jannette Luthens, Administrator
Assumption Home
715 North First Street
Cold Spring, Minnesota 56320

RE: Project Number S5446024

Dear Ms. Luthens:

On February 11, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 29, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 18, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 29, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of . Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 29, 2014, effective March 10, 2014 and therefore remedies outlined in our letter to you dated February 11, 2014, will not be imposed.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245446	A. Building B. Wing	3/18/2014

Name of Facility	Street Address, City, State, Zip Code
ASSUMPTION HOME	715 NORTH FIRST STREET COLD SPRING, MN 56320

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**03/10/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**03/10/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	**03/10/2014**
ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	**03/10/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**03/10/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**03/10/2014**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By BF/KJ	Date: 3/26/2014	Signature of Surveyor: 10652	Date: 3/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/29/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KXDP
Facility ID: 00624

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245446**

2. STATE VENDOR OR MEDICAID NO. (L2) **751743200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ASSUMPTION HOME**
(L4) **715 NORTH FIRST STREET COLD**
(L5) **SPRING, MN** (L6) **56320**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **01/29/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **82** (L18)

13. Total Certified Beds **82** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	82			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Michelle Thompson, HFE NE II 03/07/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/03/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

Page 2
Provider Number: 24-5446
Item 16 Continuation for CMS-1539

At the time of the standard survey completed January 29, 2014, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8446

February 11, 2014

Ms. Jannette Luthens, Administrator
Assumption Home
715 North First Street
Cold Spring, Minnesota 56320

RE: Project Number S5446024

Dear Ms. Luthens:

On January 29, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320) 223-7338
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 10, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by April 29, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 29, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0541

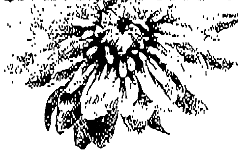
Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

ASSUMPTION
GREAT LIVING FOR GRAND PEOPLE



March 5, 2014

Minnesota Department of Health

3333 West Division

St. Cloud, MN 56301-4557

We would like to make the following corrections to our Plan of Correction from our 1/29/2014 survey as follows:

F 225 Attachment A

Section B-a, change 3/31/14 date to 3/10/14

Section B-b, remains ongoing

Section c-d, remains ongoing

F226 Attachment B

F-b, Change 3//31/14 to 3/10/14

Section G-b, remains ongoing

F 242

Page 12 -3, please add the completion date of 3/10/14

Page 13, please add completion date of 2/10/14

3/7/14
[handwritten initials]

WWW.ASSUMPTIONHOME.ORG

ASSUMPTION HOME
715 FIRST STREET NORTH
COLD SPRING, MINNESOTA 56320
320.685.3693

ASSUMPTION COURT
615 FIRST STREET NORTH
COLD SPRING, MINNESOTA 56320
320.685.4110

JOHN PAUL APARTMENTS
200 EIGHTH AVENUE NORTH
COLD SPRING, MINNESOTA 56320
320.685.4429

F 247

page 19-b, Please add a completion date of 3/10/14

F282

Page 20, 2-a,, Change to completion date to 3/10/14

Change 3-a 4/18/14 date to 3/10/14.

Page 22, #4 Please add completion date of 3/10/14

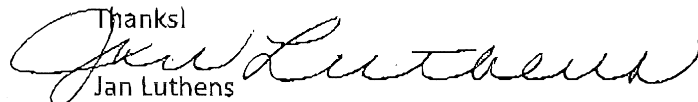
F323

Page 24, 3a, Change 4/18/14 date to 3/10/14

Page 25, #5 Please add completion date of 3/10/14.

If you have any questions, please feel free to contact me at 348-2320.

Thanks!



Jan Luthens

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED FEB 24 2014 MN Dept of Health St.Cloud

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	3/7/14 See addendum BA	3-10-14 BA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: adm — (X6) DATE: 1.24.14 — 2/24/2014

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure alleged violations involving neglect and/or injuries of unknown origin were thoroughly investigated, or reported to the administrator and state agency immediately for 3 of 6 resident (R62, R16, and R54) incidences reviewed. Findings include: R62 had fallen twice when staff were not following the care plan, this neglect of health care was not reported to the administrator or SA immediately. R62's quarterly Minimum Data Set (MDS) dated 1/10/14, identified the resident had severe cognitive impairment and required extensive two person assistance with all activities of daily living (ADL's).	F 225	See Attachment A.	

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

ATTACHMENT A

F225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

a. How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
    a. R62, R16, R54 will have daily observation and monitoring of health status and care provided including but not limited to care plan compliance, skin integrity monitoring, and emotional status for 10 days to determine if any indications or signs of mistreatment, neglect, or abuse are present and require further investigation and/or reporting. Completion date: 3/7/2014
b. How facility will identify other residents having the potential to be affected by the same deficient practice.
    a. All residents of Assumption Home are vulnerable adults and will have observation and monitoring of health status and care provided including but not limited to care plan compliance, skin integrity monitoring, and emotional status through completion of a care plan compliance audit and skin exam by a licensed nurse to determine if any indications or signs of mistreatment, neglect, or abuse are present and require further investigation and/or reporting. Completion date: 3/31/2014
c. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
    a. Assumption Homes risk management module for review of incidents including falls, will be restructured to include the interdisciplinary team investigation and evaluation of, if the incident involved mistreatment, neglect, abuse, and injuries of unknown origin. Completion date: 3/7/2014
    b. All incidents including but not limited to falls reported in Assumption Homes' risk management module will be reviewed by the interdisciplinary team to assure thorough investigation, implementation of interventions to resolve potential resolvable risk factors, and assure reporting of incident as indicated was completed. Completion date: ongoing
    c. Assumption Homes' skin integrity progress note template will be restructured to assure thorough investigation of noted skin alterations, implementation of interventions to resolve potential resolvable risk factors,and guidance/documentation for reporting. Completion date: 3/7/2014
    d. All skin integrity progress notes revealing skin alterations will be reviewed by the interdisciplinary team to assure thorough investigation of noted skin alterations, implementation of interventions to resolve potential resolvable risk factors, reporting as indicated was completed. Completion date: ongoing
d. How facility plans to monitor its performance to make sure that solutions are sustained.
    a. Director of clinical operations will audit 10% of incidents including but not limited to falls reported in Assumption Homes' risk management module to assure thorough investigation, implementation of interventions to resolve potential resolvable risk factors, and assure reporting of incident as indicated was completed.
    a. Director of clinical operations will audit 10% of skin integrity progress notes revealing skin alterations to assure thorough investigation of noted skin alterations, implementation of interventions to resolve potential resolvable risk factors, reporting as indicated was completed.
    b. Interdisciplinary team will complete care plan compliance audits on 10% of residents to monitor for any indications or signs of mistreatment, neglect, or abuse.
    c. QA committee to review and make recommendations regarding audit results.

RECEIVED

FEB 24 2014

MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 neglect of health care to the administrator or state agency. RN-B stated the facility did their own investigation and determined the "intent" of the staff was not neglectful, nor did she feel the staff involved were, "suspicious," so she did not feel these staff needed to be, "under investigation." R16 had bruising to bilateral arms and hands, the facility failed to investigate the cause of the bruising, and failed to report the bruising to the administrator or state agency (SA) immediately. R16's quarterly MDS dated 12/16/13, included Alzheimer's disease with severe cognitive impairment and dependency on staff for activities of daily living (ADL's). R16's care plan dated 12/19/13, identified R16 as a vulnerable adult and included, "Any situation identified as abuse or potential abuse will be reported to Stearns County common entry point per facility protocol." R16's progress notes dated 1/9/14, included, "5 cm [centimeter] X [by] 2.5 cm purple bruise in color on left arm, 1.25 cm X 1 cm purple bruise on left hand, 3.0 cm X 1.25 cm purple bruise on right hand and a 1.75 cm X 1 cm purple bruise on right arm. Bruising is non-suspicious in nature as resident is on ASA [aspirin] therapy and self propels in her w/c [wheel chair] in the hallway." When interviewed on 1/29/14, at 1:07 p.m., the director of nursing (DON) stated an investigation into R16's bruising had not been initiated as R16, "self propels, and when she gets too close to an object she bumps her hands and arms on it." R16 was on aspirin therapy, had fragile skin, therefore	F 225		

RECEIVED

FEB 24 2014

MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 had not investigated further, and had not reported this to the administrator or the state agency (SA). The DON had not interviewed staff or residents to determine if R16 had been seen self propelling her chair, or if any other incidences happened to cause the bruising on R16's arms. R54 was noted to have a bruises on her left hand and right wrist which were not thoroughly investigated nor immediately reported to the administrator and state agency. R54's quarterly MDS dated 10/28/13, included Alzheimer's disease with severe cognitive impairment and dependency upon staff for ADL's. R54's care plan dated 10/23/13, included she required total assistance of two staff members and a mechanical lift for transfers. The care plan also identified R54 as a vulnerable adult and directed, "Any situation identified as abuse or potential abuse will be reported to Stearns County common entry point per facility protocol." R54's progress notes dated 1/21/14, included a 1.3 by 1.5 cm bruise to left hand and a 0.7 cm by. 7 cm, and 1.5 cm by 2 cm to right wrist. "Areas do not appear to cause resident discomfort...resident is fully dependent with a sling lift for transfers and mobility." When interviewed on 1/29/14, at 1:07 p.m. the DON stated she had not investigated the bruising on R54's hand and wrists because, "We determined that the bruises were attributed to transfers in the medilift." The DON had not observed R54 being transferred with the use of a mechanical lift to identify how bruising could	F 225		

RECEIVED
FEB 24 2014
MN Dept of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 5 occur during a transfer, nor did she interview staff to determine what happened. The bruising had not been reported to the administrator or state agency. A facility policy entitled Abuse Prohibition Plan Internal Investigation, dated July 2012, included Included the facility would investigate all reported abuse matters, and unexplained resident outcomes.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure alleged violations involving neglect and/or injuries of unknown origin were thoroughly investigated, or reported to the administrator and state agency immediately per the facility policy for 3 of 6 resident (R62, R16, and R54) incidences reviewed. Findings include: A facility policy entitled Abuse Prohibition Plan Identification, dated 7/2012, included, "All Assumption employees are responsible to watch for possible signs of abuse or neglect ...injuries of	F 226		3/10/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 6 unknown source -...the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location. The facility policy and administrative guidelines intitled Abuse Prohibition Plan Reporting and Response dated 9/2012, identified, "A Concern and Suggestion Form is completed by the charge nurse when a staff member has reason to believe that vulnerable adult has sustained emotional abuse, financial abuse or exploitation, neglect ...incidents must be reported immediately to the Administrator ...must also be immediately reported to the Minnesota Department of Health ....an Incident Report Form is completed by the charge nurse when an injury of unknown source is noted ...incidents must be reported immediately to the Administrator ...must also be immediately reported to the Minnesota Department of Health ..." R62 had fallen twice when staff were not following the care plan, this neglect of health care was not reported to the administrator or SA as directly by the facility policy. R62's quarterly Minimum Data Set (MDS) dated 1/10/14, identified the resident had severe cognitive impairment and required extensive two person assistance with all activities of daily living (ADL's). R62's care plan dated 1/13/14, identified the resident was at risk for falls and instructed staff to ensure pressure alarm was on at all times and to	F 226	See attachment B	3/10/14

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

ATTACHMENT B

RECEIVED

FEB 2 4 2014

MN Dept of Health
St.Cloud

F 226 DEVELOPMENT/IMPLEMENT ABUSE/NEGLECT

e. How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
    a. R62, R16, R54 will have daily observation and monitoring of health status and care provided including but not limited to care plan compliance, skin integrity monitoring, and emotional status for 10 days to determine if any indications or signs of mistreatment, neglect, or abuse are present and require further investigation and/or reporting. Completion date: 3/7/2014
f. How facility will identify other residents having the potential to be affected by the same deficient practice.
    b. All residents of Assumption Home are vulnerable adults and will have observation and monitoring of health status and care provided including but not limited to care plan compliance, skin integrity monitoring, and emotional status through completion of a care plan compliance audit and skin exam by a licensed nurse to determine if any indications or signs of mistreatment, neglect, or abuse are present and require further investigation and/or reporting. Completion date: 3/31/2014
g. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
    a. Assumption Homes risk management module for review of incidents including falls, will be restructured to include the interdisciplinary team investigation and evaluation of, if the incident involved mistreatment, neglect, abuse, and injuries of unknown origin. Completion date: 3/7/2014
    b. All incidents including but not limited to falls reported in Assumption Homes' risk management module will be reviewed by the interdisciplinary team to assure thorough investigation, implementation of interventions to resolve potential resolvable risk factors, and assure reporting of incident as indicated was completed. Completion date: ongoing
    c. Assumption Homes' skin integrity progress note template will be restructured to assure thorough investigation of noted skin alterations, implementation of interventions to resolve potential resolvable risk factors, and guidance/documentation for reporting. Completion date: 3/7/2014
    d. All skin integrity progress notes revealing skin alterations will be reviewed by the interdisciplinary team to assure thorough investigation of noted skin alterations, implementation of interventions to resolve potential resolvable risk factors, reporting as indicated was completed. Completion date: ongoing
h. How facility plans to monitor its performance to make sure that solutions are sustained.
    a. Director of clinical operations will audit 10% of incidents including but not limited to falls reported in Assumption Homes' risk management module to assure thorough investigation, implementation of interventions to resolve potential resolvable risk factors, and assure reporting of incident as indicated was completed.
    b. Director of clinical operations will audit 10% of skin integrity progress notes revealing skin alterations to assure thorough investigation of noted skin alterations, implementation of interventions to resolve potential resolvable risk factors and reporting as indicated was completed.
    c. Interdisciplinary team will complete care plan compliance audits on 10% of residents to monitor for any indications or signs of mistreatment, neglect, or abuse.
    d. QA committee to review and make recommendations regarding audit results.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 7 ensure it was functioning with all transfers. R62's progress notes dated 7/17/14, indicated the resident had a fall on 7/15/13, at 5:00 p.m. The summary of the fall indicated, "Resident was assisted into bed at 4:15 p.m. (without pressure alarm that is care planned while in bed)...determined fall was a result of not having a pressure alarm under resident along with self transferring... education completed with staff regarding pressure alarm and care plan compliance." R62's Progress note dated 11/4/13, indicated resident had a fall on 11/2/13, at 2:15 p.m. The summary of the fall included, "Resident was found walking to bathroom in room, however, resident is care planned to have staff ambulate with her. Resident was not wearing proper footwear, nor was her alarm connected or sounding....Fall was a result of resident self transferring, not wearing proper footwear, and alarm not being used properly... reminder to staff the importance of following care plan to prevent falls. Staff follow up will also be completed for staff member last with resident..." During interview on 1/29/14, at 1:55 p.m. registered nurse (RN)-B stated R62 was to have pressure alarm on at all times. RN-B verified the care plan was not being followed during the falls on 7/15/13 and 11/2/13. RN-B stated she re-educated the staff regarding the importance of following the plan of care, but did not report the neglect of health care to the administrator or state agency. RN-B stated the facility did their own	F 226		

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 8 investigation and determined the "intent" of the staff was not neglectful, nor did she feel the staff involved were, "suspicious," so she did not feel these staff needed to be, "under investigation." RN-B verified the facility policy required neglect of health care to be reported, however, the facility did not view this as neglect, but more of a oversight. R16 was noted to have bruises on both hands and arms which were not thoroughly investigated nor immediately reported to the administrator and state agency as directed by the facility policy. R16's quarterly MDS dated 12/16/13, included Alzheimer's disease with severe cognitive impairment, and dependency on staff for ADL's. R16's care plan dated 12/19/13, identified R16 as a vulnerable adult and included, "Any situation identified as abuse or potential abuse will be reported to Stearns County common entry point per facility protocol." R16's progress notes dated 1/9/14, included, "5 cm [centimeter] X [by] 2.5 cm purple bruise in color on left arm, 1.25 cm X 1 cm purple bruise on left hand, 3.0 cm X 1.25 cm purple bruise on right hand and a 1.75 cm X 1 cm purple bruise on right arm. Bruising is non-suspicious in nature as resident is on ASA [aspirin] therapy and self propels in her w/c [wheel chair] in the hallway."	F 226		

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ____ B. WING ____	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 9 When interviewed on 1/29/14, at 1:07 p.m., the director of nursing (DON) stated an investigation into R16's bruising had not been initiated as R16, "self propels, and when she gets too close to an object she bumps her hands and arms on it." R16 was on aspirin therapy, had fragile skin, therefore had not investigated further, nor had she reported this to the administrator or the state agency (SA). The DON had not interviewed staff or residents to determine if R16 had been seen self propelling her chair, or if any other incidences happened to cause the bruising on R16's arms. R54 was noted to have a bruises on her left hand and right wrist which were not thoroughly investigated nor immediately reported to the administrator and state agency per the facility policy. R54's quarterly MDS dated 10/28/13, included Alzheimer's disease with severe cognitive impairment and dependency upon staff for ADL's. R54's care plan dated 10/23/13, included she required total assistance of two staff members and a mechanical lift for transfers. The care plan also identified R54 as a vulnerable adult and directed, "Any situation identified as abuse or potential abuse will be reported to Stearns County common entry point per facility protocol." R54's progress notes dated 1/21/14, included a 1.3 by 1.5 cm bruise to left hand and a 0.7 cm by. 7 cm, and 1.5 cm by 2 cm to right wrist. "Areas do not appear to cause resident discomfort.	F 226		

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ____ B. WING ____	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 10 Bruising is not suspicious in nature and resident is fully dependent with a sling lift for transfers and mobility." When interviewed on 1/29/14, at 1:07 p.m. the DON stated she had not investigated the bruising on R54's hand and wrists because, "We determined that the bruises were attributed to transfers in the medilift." The DON had not observed R54 being transferred in a mechanical to identify how the bruising could occur during a transfer, nor did she interview staff to determine what happened. The bruising had not been reported to the administrator or state agency.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were offered alternative food choices, for 2 of 2 residents (R96 and R93) that had prescribed modified diets in the facility. Findings include:	F 242	Meal choices will be offered to residents at Assumption Campus. Even for residents on mechanically altered diets. a. On admit the admission coordinator will assess if resident is a candidate for "Choice Menu" and alert the CDM order along with desire for choice menu or first choice. b. During admission process the CDM will visit with resident and/or family, re: food history and obtain food likes and dislikes. CDM	3-10-14 / AA

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ____ B. WING ____	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 11 R96's significant change Minimum Data Set (MDS) dated 11/25/13, indicated she was cognitively intact and received a mechanically altered diet. R93's quarterly MDS dated 10/30/13, indicated moderate cognitive impairment and received a mechanically altered diet. During observation of meal service in the Cobblestone dining room on 1/27/14, at 12:25 p.m. the menu choices for the meal included: fish nuggets, mixed vegetables, and potatoes as the main meal; with alternative choices as: chicken rice soup, deli sandwiches, chili and cornbread. Staff were observed to go to each resident and offer them these choices. However, staff did not stop and offer these choices to R96 at one table, and R93 at another table, who both recieved a pureed diet. When interviewed on 1/27/14, at 12:30 p.m. Cook-A stated they only puree the main meal, it would be too costly to puree all the alternatives, therefore residents on pureed diets are not offered the alternative menu choices. When interviewed on 1/27/14, at 5:15 p.m. R96 stated she does not always like the taste of the food, "I have been told the alternative is not available to me, because only the main meal is pureed." R96 stated she has asked in the past, as other residents get more options, but since she must have her food pureed, she was told she	F 242	food likes and dislikes. CDM will also assess at that time if resident is a candidate for the choice menu and the CDM will set up. c. With changes in food texture the CDM will set up the choice menu option as needed for those residents who are capable when receives diet order and changes are made on the diet card. d. Auditing: The choice menu will be audited weekly x1 month and then monthly x6 months. e. QA committee will review and make recommendations regarding audit.	

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 12 couldn't have any of the other options. During observation of the evening meal in the Cobblestone dining room on 1/27/14, at 6:05 p.m., staff again were observed offering each resident the main menu or alternative meal choices. R96 and R93 again were the only residents not offered these choices. The menu consisted of pulled pork sandwiches, cream of potato soup, and coleslaw. Alternatives were chili and corn bread, garden vegetable soup, and deli sandwiches. At 6:20 p.m. R96 and R93 were provided with pureed pork sandwiches and cream of potato soup, which was on the main menu. Neither was given the coleslaw or an alternative vegetable. When interviewed on 1/27/14, at 6:22 p.m. Cook-B stated the main menu is the only option available to residents on pureed diets. The coleslaw had not been pureed for R96 and R93 because they had run out, and did not have enough to puree. Cook-B stated she would normally offer tomato juice to these residents in place of the coleslaw as it is difficult to puree, but had not done so. When interviewed on 1/28/14, at 8:51 a.m. R93 stated he doesn't always like the food that is served, he is not offered any other items because he is on a pureed diet. He stated other residents get a choice of what to eat, but he does not. During observation of the noon meal in the	F 242	• Are all modified diets given opportunity for choice menu? • Observe at breakfast meal the interaction with the residents on modified diets and process for obtaining choices. • Ask all residents on modified diets who are choice menu if they are happy with the process.	

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 13 Cobblestone dining room on 1/28/14, at 12:32 p.m. nursing assistant (NA)-B, was observed to offer each resident the main menu or the alternative choices menu. NA-B asked all residents except for R96 and R93. When interviewed at 12:40 p.m. NA-B stated she does not offer the menu choices to R96 and R93 because they are on pureed diets and the alternatives are never pureed. When interviewed on 1/28/14, at 12:45 p.m. NA-C stated residents who require a pureed diet can only have the main menu, these are the only items that come pureed. When interviewed on 1/28/14, at 12:55 p.m. NA-D stated residents on pureed diets do not get the same options as residents on a regular consistency diet, the other items do not come pureed. When interviewed again on 1/29/14, at 1:00 p.m. R96 stated lunch was, "Ok," but does not like the food very much. R96 stated it makes her feel bad when all her table mates are being offered food choices, and she is skipped, "I feel like I am wearing a sign because my food has to be pureed." When interviewed on 1/29/14, at 11:15 a.m. the director of dietary (DD), stated R96 and R93 do not like the texture of the food, R96 has been evaluated by speech therapy because she does not like the texture, but needs to remain on pureed foods for safety. Both R96 and R93 loved	F 242		

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 14 the food served before they required pureed diets. DD stated R96 and R93 should be given the same options as the other residents for meal choices and she would arrange a way to ensure these choices were provided to them. Staff would need to check with them with adequate time for dietary staff to puree the requested items. Coleslaw is difficult to puree to proper consistency, therefore an alternative vegetable should have been offered to R96 and R93 on 1/27/14. When interviewed on 1/29/14, at 11:40 a.m. the consultant registered dietician (RD) stated the cook used to bring menus for the week around to each resident on Mondays to ask them what they wanted to eat at each meal for the week. This was changed a few months ago, and staff now ask residents just prior to each meal. This made it difficult to offer choices to residents on modified diets, as there would no longer be enough time to puree special requests. The RD stated they certainly could ask these residents with enough advanced notice to puree the items and would do so. A facility policy entitled Altered Textured Foods, dated 9/3/13, included, "Altered texture diets will receive foods that are first choice on menu." The policy indicated coleslaw should not be pureed.	F 242		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed.	F 247		3/10/14

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were given advanced notice when they had a room change or room mate change, for 3 of 10 residents (R105, R50, and R32) interviewed who experienced these changes. Findings include: R105 was not given advanced notice of a room change. R105's quarterly Minimum Data Set (MDS) dated 12/30/13, indicated he was cognitively intact. When interviewed on 1/28/14, at 9:20 a.m. R105 stated he had been moved to a different room about a month ago. He was in his room and staff came in, told him he was moving, and started moving his belongings which made him upset. R105 stated he wished he would have at least had a couple hours notice. R105's progress notes dated 11/19/13, included, "Spoke with with [family member] and resident regarding shared male room is open and ready for resident to move. Resident was in agreeance [sic] wit [sic] this, as well as [family member]." When interviewed on 1/29/14, at 12:30 p.m. social worker (SW)-A provided a Private Pay Room Agreement Semi-Private Room Not	F 247		3/10/14/[illegible]

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ____ B. WING ____	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 16 Available form. The form included, "I understand and agree to move to a semi-private room as soon as one becomes available." The form was signed by R105's representative on 6/23/13, over six months ago. SW-A stated normally a seven day notice is given prior to a room change, however, since R105 had been informed he would be moved as soon as a semi-private room was available upon admission, the seven days had not been required. However, staff should have given his as much notice as possible and not just at the immediate time of the physical move to a new room. R50 was not given advanced notice of a room change. R50's annual MDS dated 11/11/13, indicated mild cognitive impairment. When interviewed on 1/27/14, at 2:30 p.m. R50 stated she use to be in a private room, about six months ago, but had to move due to money concerns. She was aware she was going to move at some point, but did not know what day or week this would occur. R50 stated one day staff came in and just started moving her belongings, "That was when I knew I was moving." R50 stated she wish she had at least been given a few hours or days notice, as a move from a private to semi-private room was uncomfortable for her. In addition, she would have liked to have had a chance to review her belongings before the move to feel she was participating in this change which was difficult for her. R50's progress notes dated 10/18/13, included,	F 247	1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. Licensed social worker will review with R105, R50, and R32 their current room status to determine if any concerns are present and review with interdisciplinary team if concerns are noted. Completion date: 3/7/2014 2. How facility will identify other residents having the potential to be affected by the same deficient practice. a. Effective 1/29/2014 other residents identified as having the potential to be affected by the same deficient practice such as any changing room location or having a change in roommate. Effective 1/29/2014, all residents who were having a change in their room location or having a	

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ____ B. WING ____	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 17 "Spoke with [family member] regarding room preference. Resident can no longer financially afford private room. Shared room has come available, [family member] is happy to have resident move to this room..." There was no evidence R50 had been notified prior to the move, only the family was notifed despite R50 having only mild cognative impairment. When interviewed on 1/29/14, at 12:30 p.m. SW-A stated R50 should have received a seven day notice prior to the move, or signed a waiver for the seven day notice prior to moving her. SW-A was unable to find any documentation R50 had been given this notice, or waived her rights to the seven day notice. R32 was not given advanced notice when a new room mate moved in. R32's quarterly MDS dated 1/2/14, included moderate cognitive impairment. When interviewed on 1/27/14, at 4:00 p.m. R32 stated about six months ago, her room mate had moved in. No one had told her she was getting a new room mate, "She just showed up." This was distressing to R32 because she would have liked to prepare mentally for the arrival of a room mate. R32's room mate's (R57) medical record indicated R57 had been admitted to R32's room on 7/30/13. When interviewed on 1/29/14, at 12:30 p.m.	F 247	change in roommate were continued to be given advance notice of this. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. a. Assumption Homes' Room Changes/Transfers policy, new roommate notification, notice of room change/transfer were reviewed and updated by the interdisciplinary team on 1/29/2014 and implemented within Assumption's admission/returning resident process. 4. How facility plans to monitor its performance to make sure that solutions are sustained. a. Licensed social worker will audit 10% of residents who complete a room change/transfer or receive a new roommate to assure resident received advance notice of change.	

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

PRINTED: 02/10/2014
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ____ B. WING ____	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 247	Continued From page 18 SW-A stated she was unable to find any documentation in R32's medical record indicated R32 had been given any advanced notice of a new room mate moving in. Staff would ordinarily let a resident know as soon as possible of a new room mate coming, this would always be prior to that residents arrival at the facility. A facility policy entitled Room (Changes) Transfers, dated 6/2011, included, under number 3. "Follow proper notification periods and policies as stated in the Bill of Rights." Number 5. "Obtains approval by having residents (or when unable family member) sign Room Transfer/Discharge Form." Number 6. Notifies persons involved of room change plan giving resident(s) name(s), room numbers, date and time of move."	F 247	b. Audit results will be presented to QA committee for review and recommendations.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow care planned interventions related to falls for 1 of 4 residents (R38) reviewed for falls. Findings include:	F 282	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. Staff were educated on R38's fall prevention care plan and continue to be educated on this. R38 will have care plan implementation audits completed for 10 days at varying times during the day to assure residents fall prevention care plan is being followed. Completion date: 3/7/2014	3/10/14/[illegible]

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ____ B. WING ____	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 19 R38's quarterly Minimum Data Set (MDS) dated 10/29/13, included dementia with severe cognitive impairment, a hip fracture, and required extensive assistance with most activities of daily living (ADL's). R38's Falls Care Area Assessment (CAA) dated 8/2/13, included difficulty maintaining sitting balance as well as balance problems during transitions. R38's care plan dated 1/27/14, included risk for falling and injury due to a history of falls. Staff were instructed to use a wheelchair with anti-tip bars (bars that go on the back of the wheel chair, and tipped down to prevent a wheelchair from flipping back) and dicem (a non-skid surface) to recliner seat to prevent sliding. During observation on 1/27/14, at 5:30 p.m. R38 was sitting in her wheelchair with the anti-tip bars in the up position in her room. The position of the anti-tip bars would not have prevented the chair from falling backwards. During observation on 1/28/14, at 12:19 p.m. R38's recliner had a dicem placed on the recliner seat and a cushion on top of the dicem. A second dicem was located on the seat of her walker, not on the recliner cushion. During observation on 1/28/14, at 12:30 p.m., R38 was observed in the dining room in her wheelchair with the anti-tip bars placed in the up position, not down in the appropriate position.	F 282	2. How facility will identify other residents having the potential to be affected by the same deficient practice. a. All residents with care planned interventions related to falls will have their care plan reviewed with staff and will have the implementation of their care plan audited to assure their care plan is being followed. Completion date: 3/31/2014. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. a. Assumption Home policies regarding the review and implementation of resident care plans will be reviewed, updated, and staff education regarding policies completed. Completion date: 4/18/2014 b. Audit results will be presented to QA committee for review and recommendations.	

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 20	F 282		

R38's progress notes dated 1/24/14, included, "Resident was found with her recliner tipped forward with the feet to the chair outward and resident was sitting on the foot of the recliner, back resting up against it, with her feet on the floor." A new fall prevention intervention was to place dicem in recliner to prevent sliding.

During interview on 1/28/14, at 1:13 p.m. certified occupational therapist (COTA)-A stated R38's anti-tip bars should be placed in the down position to prevent her wheelchair from falling backwards. The COTA-A also stated to prevent R38 from sliding out of her recliner the dicem should be on top of the cushion in her recliner, and not under the cushion, unless she has skin breakdown.

During interview on 1/28/14, at 1:50 p.m. nursing assistant (NA)-D stated she was not aware R38 should have dicem on her recliner cushion to prevent her from sliding out.

During interview on 1/28/14, at 2:00 p.m., Registered Nurse (RN)-C stated R38 had slid out of her recliner chair, so she had placed dicem under the cushion of her recliner, and on top of the cushion, to prevent her from sliding out again. RN-C further stated R38 has anti-tip bars on her wheelchair for fall prevention. The surveyor informed her the anti-tip bars were in the up position and needed to be down.

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 21 During observation on 1/29/14, at 8:04 a.m. R38 was sitting in the library in her wheelchair with the anti-tip bars in the up position. The surveyor once again informed RN-C of findings. During interview 1/29/14, at 12:10 p.m. RN-C stated she was not aware that the anti-tip bars need to be in the down position to prevent falls and stated the therapy staff had educated her and the bars are now in the proper down pointing position, and the dicem is on top of R38's recliner cushion now.	F 282	4. How facility plans to monitor its performance to make sure that solutions are sustained. a. Interdisciplinary team will complete care plan compliance audits on 10% of residents to assure residents care is being provided in accordance with their written plan of care.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 4 residents (R40, R74, and R67) with swallowing, choking, and/or chewing problems, were properly positioned in their wheelchairs during meal times to prevent potential choking or swallowing hazards when eating. Findings include:	F 323	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. R40, R74, and R67 were evaluated by speech therapy on 1/29/2014 to determine appropriate positioning at meal times. Resident's care plans were updated with speech therapy recommendations and staff trained on the recommendations. The staff training on these recommendations has continued to be an ongoing process. Completion date: 3/7/2014	3/10/14/[illegible]

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22 R40 had diagnoses including dysphagia (difficulty swallowing) related to a stroke which was identified on a physician note dated 12/18/13. R40's quarterly Minimum Data Set (MDS) dated 11/13/13, identified the resident had severe cognitive impairment and was totally dependent on staff for all activities of daily living (ADL's) including eating. During observation on 1/27/14, at 12:45 p.m. R40 was sitting in the dining room in a pink colored geri chair leaned back at about 45 degrees. Nursing assistant (NA)-E was feeding R40 pureed food and thickened liquids. R40 was assisted with the entire meal reclined back in the wheelchair. On 1/27/14, at 6:45 p.m. and again on 1/28/14, at 8:35 a.m., R40 was sitting in the dining room in the pink colored geri chair, leaning back approximately 45 degrees being fed her pureed food and thickened liquids by NA-F. At no time was R40 observed chocking or coughing during meal time. R40's Dysphagia Discharge Summary from the speech therapist dated 10/28/13, included, "Patient referred for swallow evaluation due to staff noticing coughing with intake... Safest/ optimal posture is upright in wheelchair." R40's care plan dated 1/24/14, indicated the resident had pureed texture/ nectar thick liquid, required one assist with meals, and, "set up with	F 323		

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ____ B. WING ____	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 23 meals." The care plan did not identify any specific instructions regarding safe positioning during meal time. R74 Diagnostic Report identified the resident had a diagnosis of Alzheimer's disease. The annual MDS dated 11/22/13, identified the resident had severe cognitive impairment and was totally dependent on staff for all ADL's, including eating. During observation on 1/27/14, at 12:45 p.m. R74 was sitting in the dining room in a pink colored geri chair leaned back at about 45 degrees. NA-E was feeding R74 pureed food and thickened liquids. R74 was assisted the entire meal reclined back in the wheelchair. On 1/27/14 at 6:45 p.m. and again on 1/28/14 at 8:35 a.m., R74 was sitting in the dining room in the pink colored geri chair, leaning back about 45 degrees being fed her pureed food and thickened liquids by NA-F. At no time was R74 observed chocking or coughing during meal time. A facility Progress Note dated 1/1/14, indicated, "After dinner today resident appeared as if she needed to throw up...Resident was sat up by two staff members and resident was able to expel sputum... Writer checked to make sure resident had been given proper liquids per diet, and yes resident had been given nectar thick liquids..." R74's care plan dated 11/26/13, indicated the	F 323	2. How facility will identify other residents having the potential to be affected by the same deficient practice. a. On 1/29/2014 all residents in non-standard wheelchairs that can alter an appropriate position during meal times were evaluated by speech therapy to determine appropriate positioning at meal times. Residents care plans were updated with speech therapy recommendations and staff were trained on the recommendations. The staff training on these recommendations has continued to be an ongoing process. Completion date: 3/7/2014 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. a. Assumption Home, in consultation with speech therapist, will develop a policy on safe feeding techniques and educate staff on safe feeding techniques. Completion date: 4/18/2014	

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 resident had upper and lower dentures, however, the resident did not wear them. The care plan did not identify any specific instructions regarding proper positioning of the wheelchair during meal time. R67 speech therapy swallowing evaluation dated 8/13/12 included diagnoses including dysphagia (difficulty swallowing). The quarterly MDS dated 11/14/13, identified the resident had severe cognitive impairment and required supervision with eating. During observation on 1/27/14, at 12:45 p.m. R67 was sitting in the dining room in a pink colored geri chair leaned back at about 45 degrees. A family member (FM)-A was feeding R67 mechanical soft food and thickened liquids. R67 was assisted with the entire meal reclined back in the wheelchair. On 1/27/14, at 6:45 p.m. and again on 1/28/14, at 8:35 a.m., R67 was sitting in the dining room in the pink colored geri chair, leaning back about 45 degrees being fed her mechanical soft food and thickened liquids by an (unknown) NA. At no time was R67 observed choking or coughing during meal time. R67's Dysphagia Discharge Summary from speech therapy dated 3/29/13 indicated, "Safest/ optimal posture" during mealtime was "up in wheelchair."	F 323	4. How facility plans to monitor its performance to make sure that solutions are sustained. a. Interdisciplinary team will audit 10% of meal times to assure safe feeding techniques are occurring (including proper positioning of wheelchairs during meal time) and are in accordance with individualized resident care plans if specific instructions regarding position of wheelchair during mealtime. 5. Audit results to QA committee for review and recommendations.	

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25 R67's care plan dated 11/21/13, instructed staff to follow speech therapist recommendations; mechanical soft, nectar thick liquids; and the resident required one assist with eating 100% of the time. The care plan did not identify any specific instructions regarding proper positioning of the wheelchair during meal time. During interview on 1/28/14, at 12:05 p.m. NA-A stated R40, R74, and R67 had no current choking or swallowing problems she was aware of. NA-A stated all three residents were leaned back in their wheelchairs while eating and she did not think any of the wheelchairs were able to be sat in an upright. During interview on 1/28/14, at 1:25 p.m. speech therapist (ST)-A stated she was familiar with all three of the residents leaning back while eating, R40, R74, and R67. ST-A verified the residents should all be sitting upright, as close to 90 degrees as possible, while being fed to prevent aspiration or choking on food or liquids. ST-A was unsure if the wheelchairs could be sat in an upright position for eating, however, she stated the facility needed to assure the residents were being fed safely. During interview on 1/28/14, at 2:05 p.m. director of nursing (DON) stated she was aware R40, R74, and R67 all leaned back (sometimes more then 45 degrees) in their reclining wheelchair while being fed. DON stated unless staff bring a concern of the resident choking or aspirating	F 323		

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	01/29/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 26 during meal time, the residents can remain reclined for their comfort. DON was not aware if the wheelchairs were able to be locked in an upright position during meal times. During interview on 1/29/14, at 8:35 a.m. registered nurse (RN)-A verified R40, R74, and R67 were all leaning back at least 45 degrees while being assisted with meals. RN-A was not aware if the residents wheelchairs locked in the upright position, and was not aware if there were any recommendations regarding how the residents should be positioned during meal time to ensure safe feeding. During another interview on 1/29/14, at 12:50 p.m. RN-A stated the speech therapist had come to the facility the morning of 1/29/14, to evaluate safe seating during meal time for R40, R74, and R67. The speech therapist determined all three residents should be positioned in their wheelchairs so they are sitting upright, not leaning back, during mealtime. RN-A also stated it was determined all of the wheelchairs locked in the sitting position. The facility was asked to provide a policy on safe feeding techniques but was not provided.	F 323		

RECEIVED
FEB 24 2014
MN Dept of Health
St.Cloud

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5446022

Printed: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**01/29/2014**

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 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Assumption Home was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This facility was surveyed as two separate buildings. Assumption Home is a 1-story building with a partial basement. The building was constructed at 3 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 of Type II (000). In 1996 a kitchen addition was added to the north east end of the 1963 building and was determined to be of Type II (000) construction. The 1963 building is separated, by a 2-hour fire barrier, from an attached apartment building to the north and the 1963 building is separated by a 2-hour fire barrier from an attached connecting link to an apartment building to the east. The building is protected by a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification in	K 000		

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

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**01/29/2014**

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	Continued From page 1 accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Automatic fire detection is installed in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 82 beds and had a census of 78 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FS46022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING **02 - 2009 ADDITION** B. WING ______	**01/29/2014**

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 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Assumption Home was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 482.41(b), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Assumption Home added two new additions to the facility. The 2009 a 2 story addition with full basement was added to the northwest side of the facility and was determined to be of type II(111) construction. The 2010 a 1 story addition with no basement was added to the south side of the facility facility and was determined to be of type II(111) construction. The building is protected by a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Automatic fire detection is installed in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 82 beds and had a census of 78 at the time of the survey.	K 000		

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

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING **02 - 2009 ADDITION** B. WING ______	**01/29/2014**

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	Continued From page 1 The requirement at 42 CFR, Subpart 482.41(b) is MET.	K 000		