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: WQ9P
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

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 **01/05/2017** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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)

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

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

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):

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 01/05/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 01/24/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_X_ 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
Posted 01/27/2017 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **12/21/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245446
January 24, 2017

Ms. Lindsay Sand, Administrator
Assumption Home
715 North First Street
Cold Spring, MN 56320

Dear Ms. Sand:

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 December 14, 2016 the above facility is certified for or recommended 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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Electronically delivered
January 24, 2017

Ms. Lindsay Sand, Administrator
Assumption Home
715 North First Street
Cold Spring, MN 56320

RE: Project Number S5446027

Dear Ms. Sand:

On December 5, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 3, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 5, 2017, 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 November 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 14, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 3, 2016, effective December 14, 2016 and therefore remedies outlined in our letter to you dated December 5, 2016, 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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
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Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245446		1/5/2017

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	Correction Completed 12/14/2016	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 12/13/2016	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 12/13/2016
ID Prefix F0334 Reg. # 483.25(n) LSC	Correction Completed 12/13/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 12/13/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 01/24/2017	SIGNATURE OF SURVEYOR 10562	DATE 01/05/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/3/2016	☐ 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

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Facility ID: 00624

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

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(L3) **ASSUMPTION HOME**
(L4) **715 NORTH FIRST STREET**
(L5) **COLD 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 **11/03/2016** (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)

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A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
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___ 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):

17. SURVEYOR SIGNATURE Date :
Sarah Kacena, HFE NE II 12/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 12/21/2016 (L20)

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

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_____ 2. Facility is not Eligible
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3. Both of the Above :

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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
Posted 12/21/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 5, 2016

Ms. Lindsay Sand, Administrator
Assumption Home
715 North First Street
Cold Spring, MN 56320

RE: Project Number S5446027

Dear Ms. Sand:

On November 3, 2016, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the 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>Electronic Plan of Correction</u> - **when a plan of correction will be due and the information to be contained in that document;**

Remedies - 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;

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

Informal Dispute Resolution - 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
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
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 December 13, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 13, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 February 3, 2017 (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 May 3, 2017 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 electronic 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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	11/03/2016

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 On October 31st, 2016 to November 3, 2016, surveyors from the Minnesota Department of Health (MDH) conducted a certification survey. Assumption Home was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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.	F 225		12/13/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 12/14/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	**11/03/2016**

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 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 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 interview and document review, the facility failed to immediately report to the State agency allegations of misappropriation of property for 2 of 5 residents (R14, R26) reviewed for abuse prohibition, whose incidents of missing money were not timely reported to the State agency. Finding include: R14's quarterly Minimum Data Set (MDS) dated 10/12/16, indicated moderately impaired	F 225	It is the policy of Assumption Home to immediately report to the State agency allegations of misappropriation of property. Administrator will oversee the in-servicing of all staff of the need to immediately report allegations of abuse/neglect/financial exploitation, including misappropriation of property. Administrator will audit incident reports	

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 ______	11/03/2016

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 2
cognition.

An Incident/Investigative Report regarding R14's missing money, with a print date 7/8/16, was reviewed. The Incident details indicated, "It is questionable $60 to $80 missing from resident's wallet. [Family member] FM-A states she noted it missing on 7/4/16. Questionable if resident had money taken from her room or if resident misplaced it herself. [FM-A] reports the incident occurred on 7/4/16." The incident details did not identify a time the incident occurred, only that it occurred on 7/4/16. The report indicated the initial incident was submitted to the State agency on 7/5/16, (the day after the incident occurred), and the final investigative report was submitted on 7/8/16.

During interview on 11/3/16, at 2:42 p.m. the director of nursing (DON) said she remembered (R14's) money, and said it was reported missing on 7/4/16. When reviewing the facility incident log, the DON said the administrator was notified of the incident via email on 7/4/16. The DON said the incident was reported to the state, and acknowledged it was reported on 7/5/16, the following day. The DON stated she would need to review notes and check with the social worker as she thought the facility was in compliance, but was not sure why the incident was reported late. The DON said missing money was a form of abuse, and needed to be treated like any other form of abuse, and be reported timely.

R26's MDS dated 10/4/16, indicated moderately impaired cognition.

An Incident/Investigative report for R26's print date of 8/18/16, indicated he had missing money.

F 225

and VA filings weekly x2 months and monthly thereafter for x1 year. Audit results and the data collected will be presented to the Quality Assurance Committee quarterly by the administrator or designee. This committee will review and make any necessary recommendations.

Facility will be in compliance by December 28, 2016.

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F 225	Continued From page 3 The report indicated R26 returned from an outing with family on 8/17/16, at 6 p.m. and reported to facility staff $100 was missing from R26's wallet. On 8/17/16, the facility called FM-B who stated she was not concerned about the missing money as R26 insisted on paying for meals when out with family. Further, FM-B stated she would talk with other family members to determine if R26 in fact had the money. On 8/18/16, FM-B verified R26 did have $100 in his wallet. The report indicated the incident was submitted to state agency on 8/18/16, one day after the incident occurred, and the Final Investigative Report was submitted on 8/23/16. During interview 11/13/16, at 2:42 p.m. the DON stated R26 reported the missing money to staff, including the administrator, on 8/17/16. The DON said the incident was reported to the state on 8/18/16, the following day. The DON stated she was not sure why this incident was reported late. The DON also said missing money was considered "abuse" and should be reported to the state agency in a timely manner. A facility policy, Abuse Prohibition Plan, revised 7/2012, indicated a mandated reporter who has reason to believe a vulnerable adult ...has been abused shall "immediately report the incident." The policy further indicated the Minnesota Department Health was to be notified, and also the report of abuse, "must be made immediately upon initial knowledge that the incident occurred." The policy identified financial or exploitation as abuse.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		12/13/16

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F 226	Continued From page 4 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 interview and document review, the facility failed to implement their policy Abuse Prohibition related to the immediate reporting to the State agency allegations of misappropriation of property for 2 of 5 residents (R14 and R26) reviewed for abuse prohibition. Finding include: The facility's Abuse Prohibition Plan, revised 7/2015, was reviewed. The policy identified that abuse included financial abuse or exploitation. The policy indicated, "A mandated reporter who has reason to believe that a vulnerable adult is being or has been abused...shall immediately report the incident internally..." Further, the policy further indicated incidents of abuse must be immediately to the Minnesota Department of Health (State Agency). R14's quarterly Minimum Data Set (MDS) dated 10/12/16, indicated moderately impaired cognition. An incident/investigative report regarding R14's missing money, with a print date 7/8/16, was reviewed. The Incident details indicated, "It is questionable $60 to $80 missing from resident's wallet. [Family member FM]-A states she noted it missing on 7/4/16. Questionable if resident had	F 226	It is the policy of Assumption Home to implement written policies and procedures that prohibit the mistreatment, neglect and abuse of residents and the misappropriation of property and ensure compliance with reporting in accordance with these policies. The Administrator and LSW will update facility policies and incident reports to ensure clarity of reporting expectations. Administrator will oversee the in-servicing of all staff to educate on these policies and of the need to immediately report allegations of abuse/neglect/financial exploitation, including misappropriation of property. Administrator will audit incident reports and VA filings weekly x2 months and monthly thereafter for x1 year. Audit results and the data collected will be presented to the Quality Assurance Committee quarterly by the Administrator or designee. This committee will review and make any necessary recommendations. Facility will be in compliance by December 28, 2016.	

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F 226	Continued From page 5	F 226		

money taken from her room or if resident misplaced it herself. FM-A reports the incident occurred on 7/4/16." The incident details did not identify a time the incident occurred, only that it occurred on 7/4/16. The report indicated the initial incident was submitted to the State agency on 7/5/16, (the day after the incident occurred), and the final investigative report was submitted on 7/8/16.

During interview on 11/3/16, at 2:42 p.m. the director of nursing (DON) said she remembered [R14's] money, and said it was reported missing on 7/4/16. The DON said the incident was reported to the state, and acknowledged it was reported on 7/5/16, the following day. When reviewing the facility incident log, the DON said the administrator was notified of the incident via email on 7/4/16. The DON stated she would need to review notes and check with the social worker as she thought the facility was in compliance, but was not sure why the incident was reported late. The DON said missing money was a form of abuse, and needed to be treated like any other form of abuse, and be reported timely as identified in the facility policy.

R26's MDS dated 10/4/16, indicated he had moderately impaired cognition.

An Incident/Investigative report for R26's with a print date of 8/18/16, indicated R26 returned from an outing with family on 8/17/16, at 6 p.m. and reported to facility staff $100 was missing from R26's wallet. On 8/17/16, facility called Family member (FM)-B who stated she was not

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F 226	Continued From page 6 concerned about the missing money as R26 insisted on paying for meals when out with family. Further, FM-B stated she would talk with other family members to determine if R26 in fact had the money. On 8/18/16, FM-B verified R26 did have $100 in his wallet. The report indicated the incident was submitted to State agency on 8/18/16, the day after the incident occurred, and the final investigative report was submitted on 8/23/16. During interview with the DON on 11/3/16, at 2:42 p.m. stated R26 reported the missing money to staff, including the administrator, on 8/17/16. The DON said the incident was reported to the State on 8/18/16 (the following day). Further, the DON stated she was not sure why this incident was reported late and the missing money was considered "abuse" and should be reported to the State agency in a timely manner, as identified by the policy. A facility policy, Abuse Prohibition Plan, revised 7/2012, indicated a mandated reporter who has reason to believe a vulnerable adult ...has been abused shall "immediately report the incident." The policy further indicated the Minnesota Department Health was to be notified, and also the report of abuse, "must be made immediately upon initial knowledge that the incident occurred." The policy identified financial or exploitation as abuse.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241		12/13/16

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F 241	Continued From page 7 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a dignified routine was consistently provided for 3 of 4 residents (R5, R44 and R38) who were dependent upon staff to complete activities of daily living. Findings include: R5's quarterly Minimum Data Set (MDS) dated 10/6/16, identified R5 had significant impaired cognition, and was totally dependent on staff for nearly all activities of daily living (ADLs). During observation on 11/2/16, at 7:04 a.m. R5 was dressed for the day, wearing glasses, and seated in her wheel chair, and was in her usual place around the table in the Northwoods dining room. R5's eyes were closed and her head tipped to the left as she dozed in her wheel chair, awaiting the breakfast meal. To the left and upwards from where R5 sat, there was a large-screen TV, which was turned off. Other than staff walking past the dining area, the dining room was quiet. R44's quarterly MDS dated 10/7/16, indicated R44 had significant impaired cognition and was totally dependent on staff for all ADLs. During observation on 11/2/16 at 7:04 a.m., R44 was also seated in her wheel chair, facing the TV in the Northwoods dining area. A large blanket covered her legs and lower body as R44 slept,	F 241	It is the policy of Assumption Home that all Residents who are totally dependent on staff for activities of daily living will have a dignified routine. Clinical Coordinators will review the care plans of all residents who are totally dependent on staff for activities of daily living, including R5, R44, and R38, to ensure that Residents are engaged in mentally stimulating activities based on their assessed interests and revise them as needed. The Administrator will oversee the in-servicing of all staff on Resident Rights, including the right for all residents to be treated with respect and dignity. Audits will be conducted weekly x3 months by members of the interdisciplinary team under oversight of the Director of Resident Services and reported to the Quality Assurance Committee to ensure compliance with dignified routine of residents. Ongoing need for auditing will be determined by the committee. Facility will be in compliance by December 28, 2016.	

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F 241	Continued From page 8	F 241		

with her head tilted to the left.

R5 and R44 were the only two residents seated in the dining room with their eyes closed until 7:21 a.m., when other residents started to enter and were seated in the Northwoods dining room. Staff intermittently walked by the dining room on their way to other resident rooms, occasionally glancing at R5 and R44, but otherwise provided no engagement with the residents. The TV remained off, and R5 and R44 continued to sleep while other resident were brought into the Northwoods dining room.

R5 and R44 remained in their wheel chairs, sleeping and otherwise unengaged, in the Northwoods dining area from 7:04 a.m. until 8:33 a.m. (a total of 88 minutes) when nursing assistant (NA)-B asked R44 to wake up for breakfast. NA-B also rubbed R5's hand, woke her up, solicited her meal and beverage requests, and assisted R5 and R44 with washing their hands. R5 and R44 received their meals at 8:39 a.m., and subsequently NA-A and NA-B assisted them to eat their breakfast.

During interview on 11/2/16, at 8:58 a.m. NA-A stated both R5 and R44 were up, dressed and seated at the dining room tables before 7:00 a.m. NA-A stated both R5 and R44 needed "full assistance" from staff to meet their needs, and usually were the first residents assisted in the morning. NA-A stated both residents were usually ready to get going in the morning and staff did not purposefully "wake" them. When asked how long R5 and R44 typically sat in the dining room before the meal, NA-A said she knew they waited "a while" before breakfast.

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F 241	Continued From page 9 During interview on 11/2/16, at 9:07 a.m. NA-B stated R5 and R44 were the first residents assisted after morning report because they required the assistance of two facility staff. Further, NA-B stated after R5 and R44 ADL's were completed, the NAs would help other residents, who required only a one person assist. During interview on 11/2/16, at 2:15 p.m. licensed practical nurse (LPN)-A acknowledged the NAs usually got R5 and R44 up first in the morning, because they required "two assist" from facility staff and "It was one of those things." LPN-A stated R44 could be in her room alone, but R5 could not. LPN-A stated it was her expectation if residents were unoccupied alone in the dining room they would have some type of mental stimulation such as the television or radio. During interview on 11/3/16, at 8:51 a.m. NA-C stated her morning routine was to check which residents were awake and would proceed to assist those residents first. NA-C stated there were 3 residents who needed assist of 2, and R5 and R44 were normally the first residents assisted in the morning. Further, NA-C also stated neither R5 nor R44 could be left alone in the rooms by themselves. During interview on 11/3/16, at 11:53 a.m. registered nurse (RN)-A stated she had witnessed residents "just sitting there" waiting in the dining area. Further, RN-A stated the facility had been working hard to involve residents in mentally stimulating activity such as 1:1 visits, music or television. RN-A stated leaving residents unattended in common areas without mental stimulation was a dignity issue and "they could do this better."	F 241		

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R38's quarterly MDS dated 08/31/16, identified R38 had severe cognitive impairment and required extensive assistance with ADL's.

During observation of the evening meal service on 11/01/16, at 6:20 p.m. facility staff placed R38 in the hallway in her wheelchair after the evening meal. During continuous observation from 6:20 p.m. until 7:39 p.m. (for one hour and nineteen minutes) R38 continued to sit in the hallway following the evening meal service. R38 was positioned in her wheelchair without television within line of version and no structured activities were observed or offered by facility staff during this time. R38 had a flat facial expression and stared ahead into the hallway.

During interview on 10/3/16, at 8:59 a.m. Family Member (F)-C stated it was "unacceptable" to leave R38 unattended in the hallway for long periods of time without any mental stimulation. Further, F-C stated she felt it would make R38 "feel bad" as R38 enjoyed mental stimulation such as television and did not prefer to be left alone.

During interview on 10/3/16, at 9:51 a.m. the administrator stated it was important for cognitively impaired residents to have mental stimulation throughout the day. Further, the administrator stated leaving residents unattended for long periods of time in facility common areas "was a concern" and staff may need further education about promoting structured activities for cognitively impaired residents.

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F 241	Continued From page 11 During interview on 1/3/16, at 10:02 a.m. the director of nursing (DON) stated it was her expectation cognitively impaired residents were involved in some type of meaningful activity throughout the day. Further, DON stated facility management was aware of cognitively impaired residents being left alone unattended in the common living areas for extended periods of time and were working with facility staff on improving this issue. Review of a facility policy titled, Quality of Life/Dignity Policy, dated 05/2012, indicated, "Each resident shall be cared for in a manner that promotes and enhances quality of life, respect and individuality."	F 241		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334		12/13/16

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(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal

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F 334	Continued From page 13 immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a policy related to pneumococcal conjugate vaccine (PCV13) for 4 of 5 residents (R7, R22, R33, R109) whose vaccination histories were reviewed. Findings include: The Centers for Disease Control and Prevention (CDC) identified; "Adults 65 years age or older who have not previously received PCV13 and who have previously received one or more doses of pneumococcal polysaccharide vaccine 23 (PPSV23) should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose." R7's Clinical Immunization Report dated 11/3/16, indicated the 86 year old had received the PPSV23 vaccine on 9/26/15, but was never offered the PCV13 according to the CDC guidelines. R22's Clinical Immunizations Report dated 11/2/16, indicated the 88 year old had received the PPSV23 vaccine on 8/27/08, but was never offered the PCV13 according to the CDC guidelines. R33's Clinical Immunizations Report dated	F 334	It is the policy of Assumption Home to offer/ administer pneumococcal vaccinations, according to the MDH and CDC recommended interval for vaccines, unless contraindicated, already immunized, or declined by the resident or responsible party. To assure compliance, the following plan has been put into place: Measures put into place to ensure deficient practice does not recur: Up admission to the facility, the admission's nurse will review past medical records and complete health history. If the resident is determined eligible per CDC guidelines and provided pneumococcal algorithm, the resident will be offered the appropriate pneumococcal vaccination and physician order will be obtained. PCV13 is offered to all new admissions to ensure compliance with the following recommended CDC guidelines: "Adults 65 years age or older who have not previously received PCV13 and who have previously received one or more does of pneumococcal polysaccharide vaccine 23 (PPSV23) should receive a dose of	

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11/3/16, indicated the 90 year old had received the PPSV23 vaccine on 7/20/16, but was never offered the PCV13 according to the CDC guidelines

R109's Clinical Immunizations Report dated 11/3/16, indicated the 74 year old had received the PPSV23 vaccine on 10/29/15, but was never offered the PCV13 according to the CDC guidelines

During interview on 11/02/16, at 12:32 p.m. the director of nursing (DON) stated the facility had not been offering PCV13 vaccinations and were in the process of developing and implementing a policy for pneumococcal vaccinations according to CDC guidelines.

Review of facility policy titled, Vaccinations-Pneumococcal /Resident, dated 11/16, indicated, "Residents will be offered pneumococcal vaccinations and administered according to the MDH and CDC recommended interval for the vaccines, unless contraindicated, already immunized,or resident declines the vaccine." Further, the policy stated registered nurses would review physician orders for indication of the vaccination upon admission for the Pneumococcal Vaccine Polyvalent vaccination.

F 334

PCV13. The dose of PCV13 should be given at least one year after receipt of the most recent PPSV23 dose". An algorithm was provided to the admission's nurse on December 14, 2016 for reference.

To ensure compliance with CDC recommendations, all current residents who have not received PCV13 will be offered the vaccination. A letter was drafted on December 13, 2016 stating that Assumption Home now offers the PCV13 vaccination to all residents whom are eligible to receive the vaccination. The letter, VIS and acknowledgement of vaccine information/ consent or decline form will be mailed to residents or responsible parties on December 19th, 2016. PCV13 will be administered following consent, review of immunization history and physician order is obtained.

Consents and declines will both be documented in Point Click Care under the immunization tab. The Vaccinations-Pneumococcal /Resident policy was updated in December 2016.
Effective implementation of actions will be monitored by:
The MDS RN is responsible to review current resident's records to determine who has not received PCV13 from an outside provider. The RN admission's nurse is responsible to ensure that all newly admitted residents are offered PCV13 if determined eligible.

To ensure that the problem does not recur, the MDS RN will audit immunization

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 ______	11/03/2016

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 334	Continued From page 15	F 334	documentation on a monthly basis and report to the DON. The data collected will be reported to the Quality Assurance Committee on a quarterly basis. Those responsible to maintain compliance: The DON, Infection Control Preventionist and RN Team are responsible for maintaining compliance. Education for the staffing coordinator will be completion for this by 12/16/2016. Implementation will take place on 12/19/2016.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		12/13/16

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 ______	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 16 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an infection control program to include the trending and analysis of collected infection data, and identify ill employee's eligibility to return to work to reduce the risk of transmission to other residents in the facility. This had the potential to affect all 71 residents whom resided in the facility. Findings include: The Facility Infection Control tracking record dated 07/2016, identified the following symptoms: 2 with edema and redness/warm legs, 2 residents with increased urgency, 1 with foul smelling stool, 1 wheezing with cough/confusion. The report identified the resident, room number, date of symptom onset, symptoms, diagnostics	F 441	It is the policy of Assumption Home to provide a safe and sanitary environment for the residents through use of best evidence-based infection prevention and control practices. To assure compliance, the following plan has been put into place: Measures put into place to ensure deficient practice does not recur: The infection control preventionist will document in the "Monthly Infection Control Log", the specific infection and organism when cultures are completed following notification from the laboratory phone call. The nursing staff is responsible to notify the infection control preventionist the	

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	245446	A. BUILDING ______ B. WING ______	11/03/2016

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F 441	Continued From page 17 completed, antibiotic ordered, community or agency acquired, risk factors and the resolved date. The record did not identify the specific infection nor was an organism identified when cultures were completed. The report also did not identify if there was any association of infection related to resident room location. The Facility Infection Control tracking record dated 08/2016, identified the following symptoms: 2 with edema and redness/warm legs, 6 with increased urgency, 1 with foul smelling stool, 1 wheezing with cough and 1 with low grade temp. The report identified the resident, room number, date of symptom onset, symptoms, diagnostics completed, antibiotic ordered, community or agency acquired, risk factors and the resolved date. The record did not identify the specific infection nor was the organism identified. The report also did not identify if there was any association of infection related to resident room location. Facility Infection Control tracking record dated 09/2016, identified the following symptoms: 1 with discharge from their eyes, 1 with increased urination, 1 with poor air exchange,1 admitted with pneumonia, 1 with crackles in their lungs, and 1 admitted with fungal infection. The report identified the resident, room number, date of symptom onset, symptoms, diagnostics completed, antibiotic ordered, community or agency acquired, risk factors and resolved date, The record did not identify the specific infection nor did it identify the organisms involved. In addition the report lacked a summary of the analysis.	F 441	same day they are notified of the specific infection/ organism. A floor map of the facility will be used when documenting the infection/ organism, to identify if there are any trends related to resident room location. The “Monthly Infection Control Log” form was updated on December 13, 2016. The form now reflects the following: resident name, room number, infection type, site, date of onset, date culture taken, organism(s), antibiotic resistance, type/ start date of antibiotic, infection classification, date resolved and if the resident was isolated. On a monthly basis, the infection control preventionist will complete an Infection Summary to determine type of infection, location, total number of infections, infection rate per resident days, and look at trending of previous months. Trending of infections will be graphed monthly. Documentation will be kept in the “Resident Infection Control Tracking and Trending” binder. Effective implementation of actions will be monitored by: The DON is responsible to review documentation completed on the “Monthly Infection Control Log” to ensure the specific infection and organism are documented, along with resident name, room number, infection type, site, date of onset, date culture taken, organism(s), antibiotic resistance, type/ start date of antibiotic, infection classification, date resolved and if the resident was isolated on a monthly basis to ensure solutions	

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	245446	A. BUILDING ______ B. WING ______	11/03/2016

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 441	Continued From page 18 Facility Infection Control tracking record dated 10/2016, identified the following symptoms: 1 with blood in their urine, 1 esophageal fungal infection, 2 with back pain, 1 with bladder spasms, 1 with foul urine, 1 with red eyes and discharge. The report identified the resident, room number, date of symptoms onset, symptoms, diagnostics completed, antibiotic ordered, community or agency acquired, risk factors and resolved date. The record did not identify the specific infection nor was the organism identified. During interview on 11/02/16, at 12:32 p.m. the director of nursing (DON) stated she and registered nurse (RN)-C were responsible for monitoring the infection control program. DON stated RN-C was "very new" with the infection control program. Further, DON stated, "We don't summarize because we do so much talking one on one." The DON stated the infection control program did not identify the microorganism and relied on day to day stand up communication at report with staff . DON stated , each registered nurse care coordinator (RNCC) was responsible for reporting any new infection and the team discussed the residents who had infections and were on antibiotics. A facility policy titled, Infection Control Program dated 10/15, indicated, "It is the policy of Assumption Community to provide a safe and sanitary environment for residents, clients, and staff through the use of best evidence based infection prevention and control practices." Further, under Administrative guidelines the second bullet indicated, "tracking is completed and kept up to date on a monthly basis and kept in a tracking book that states resident information, date of onset, symptoms, type of	F 441	implemented are sustained. The DON is responsible to review documentation completed on the Infection Summary and graph trending kept I the “Resident Infection Control Tracking and Trending” binder on a monthly basis to ensure solutions implemented are sustained. Infections will be reviewed with DON and/or ADON monthly, at the quarterly QA meetings and as needed with the nursing team. Staffing Coordinator, charge nurse and/ or HIS department will document all staff illness upon call in, on the “Employee Absentee” report sheet on a daily basis. All forms will be kept in the “Employee Infection Control Tracking and Trending Documentation” binder. The Staffing Coordinator, charge nurse or HIS department will document the reason for absence and follow the return to work policy to reduce the risk of transmission of illness to residents at Assumption Home. The location where the staff member worked in the last 72 hours will be identified for tracking purposes and to prevent the spread of disease. The Staffing Coordinator will notify the infection control preventionist if there is three or more staff illnesses of similar background reported in a similar timeframe. The Staffing Coordinator and or designated staff member, will	

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	245446	A. BUILDING ______ B. WING ______	11/03/2016

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

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F 441	Continued From page 19 infection, how acquired, risk factors and date infection resolved." EMPLOYEE ILLNESS Review of the facility staff call in report for August 2016, identified there were 8 staff sick calls for vomiting/diarrhea/fever. Call in report for September 2016 identified there were 5 staff sick calls for vomiting/diarrhea/ fever. Staff call in report for October 2016 identified there were 11 staff sick calls for vomiting/diarrhea /fever. The report did not identify if any follow up was completed with ill staff on their eligibility to return to work to ensure they were free of infections, to decrease the risk of any cross contamination with facility residents. During interview on 11/02/16, at 12:40 pm regarding any follow up on staff illness, the DON stated,"I can't say we have any thing for tracking and trending in regards to employee illness. " DON further stated she gets the facility staff call in logs monthly and human resources only reviews these for attendance. Review of the facility policy titled, Staffing 1, dated 9/1/15, indicated, " Employee return to work following illness, employee who has/had vomiting diarrhea must stay off work for at least 48 hours following ending of symptoms. Employee who has had sore throat with fever cough must stay off work for at least 24 hours."	F 441	communicate with the ill employee to notify them when they may return to work and document direction given, per policy. The infection control nurse will complete the “Employee Infection Surveillance” form and is responsible to complete the tracking and trending of documented staff illness monthly. The infection control policy and tracking infections policies have been updated to reflect changes made. Effective implementation of actions will be monitored by: To ensure that the problem does not recur, the form for calling in has been updated to reflect guidelines on when the employee may return to work, which was lacking from the previous form. The infection control nurse is responsible to audit “Employee Absentee” documentation weekly, complete the “Employee Infection Surveillance” form and is responsible to complete the tracking and trending of documented staff illness monthly. To ensure the process implemented is working, the DON will audit “Employee Infection Control Tracking and Trending Documentation” binder and review quarterly at the quality assurance meeting. Those responsible to maintain compliance: The DON, Infection Control Preventionist and RN Team are responsible for maintaining compliance.	

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 ______	11/03/2016

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

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F 441	Continued From page 20	F 441	Education for the staffing coordinator will be completion for this by 12/16/2016. Implementation will take place on 12/19/2016.	

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

F5446025

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 ____	11/02/2016

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, on November 02, 2016. 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 2012 Edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 Existing Health Care. 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. In 2009 a 2 story addition with full basement was added to the northwest side of the facility and was determined to be of typed II (111) construction. In 2010 a 1 story with no basement addition was added to the south side of the facility and was determined to be a type II (111) construction. The facility is protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces	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 ______	**11/02/2016**

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 open to the corridors that are centrally monitored. There is smoke detection in the resident sleeping rooms that is supervised by the nurse call system. The facility is licensed for 82 beds and 76 were occupied at the time of inspection. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245446	A. BUILDING: ______ B. WING ______	11/3/2016

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245446	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 11/3/2016
NAME OF PROVIDER OR SUPPLIER **ASSUMPTION HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **715 NORTH FIRST STREET COLD SPRING, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 1

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide the required Notice of Medicare Beneficiaries rights to appeal and expedited appeal upon termination of Medicare benefits in a timely manner for 2 of 5 residents (R18, R114) in the sample reviewed for liability and beneficiary rights.

Findings include:

R18's undated Face Sheet indicated R18 was admitted to facility on 9/23/16, and discharged on 10/14/16. Review of Notice of Medicare Non Coverage CMS (Centers for Medicare and Medicaid Services) Notice of Medicare Beneficiaries-10123 indicated R18 utilized medicare benefits with services which ended on 10/13/16. R18 was provided with Notice of Medicare Beneficiaries Non-Coverage notice one day prior to the end of services on 10/12/16. R18 was not provided the required 48 hour notice of termination of medicare services.

R114's undated Face Sheet identified R114 was admitted to the facility on 8/22/16, and discharged on 9/23/16. Review of Notice of Medicare Non coverage CMS of Medicare Beneficiaries-10123 indicated R114 utilized Medicare benefits with services which ended on 9/22/16. R114 was provided with Notice of Medicare Beneficiaries Non-Coverage on 9/20/16, one day prior to the end of his services on 9/21/16. R114 was not provided the required 48 hour notice of termination of medicare services.

During interview on 11/3/216, at 9:50 a.m. registered nurse (RN)-B stated R18's skilled nursing services ended on 10/13/16, and R18 received Notice of Medicare Non-Coverage on 10/12/16. RN-B stated Medicare denials needed to be provided two days before the proposed end of services. RN-B stated R18 should have received the notice on 10/11/16.
Further, RN-B stated R114's skilled nursing services ended on 9/22/16, and R114 received Notice of Medicare Non-Coverage on 9/21/16. RN-B stated R114 should have received the notice on 9/20/16. RN-B stated she does not attend the discharge planning meetings and the Notice of Medicare Beneficiaries rights to appeal forms is not handed out at the meeting and probably should be.

A policy for liability notices was requested, but not provided.

Electronically submitted
December 5, 2016

Ms. Lindsay Sand, Administrator
Assumption Home
715 North First Street
Cold Spring, MN 56320

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5446027

Dear Ms. Sand:

The above facility was surveyed on October 31, 2016 through November 3, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

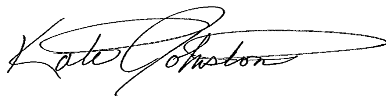
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

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

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

Please feel free to call me with any questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure(s)

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00624	A. BUILDING: ______ B. WING ______	11/03/2016

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) COMPLETE DATE
2 000	Initial Comments	2 000		

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

NH LICENSING CORRECTION ORDER

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

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

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

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

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Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On October 31st- through November 3rd 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued.
Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

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

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF

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2 000	Continued From page 2 MINNESOTA STATE STATUTES/RULES. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program, 3333 West Division St, Suite 212, St. Cloud, MN 56301.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of	21390		

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current standards of practice in infection control.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to develop an infection control program to include the trending and analysis of collected infection data, and identify ill staff eligibility to return to work to reduce the risk of transmission to other residents in the facility. This had the potential to affect all 71 residents whom resided in the facility.

Findings include:

The Facility Infection Control tracking record dated 07/2016, identified the following symptoms: 2 with edema and redness/warm legs, 2 residents with increased urgency, 1 with foul smelling stool, 1 wheezing with cough/confusion. The report identified the resident, room number, date of symptom onset, symptoms, diagnostics completed, antibiotic ordered, community or agency acquired, risk factors and the resolved date. The record did not identify the specific infection nor was an organism identified when cultures were completed. The report also did not identify if there was any association of infection related to resident room location.

The Facility Infection Control tracking record dated 08/2016, identified the following symptoms: 2 with edema and redness/warm legs, 6 with increased urgency, 1 with foul smelling stool, 1 wheezing with cough and 1 with low grade temp. The report identified the resident, room number, date of symptom onset, symptoms, diagnostics completed, antibiotic ordered, community or agency acquired, risk factors and the resolved

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date. The record did not identify the specific infection nor was the organism identified. The report also did not identify if there was any association of infection related to resident room location.

Facility Infection Control tracking record dated 09/2016, identified the following symptoms: 1 with discharge from their eyes, 1 with increased urination, 1 with poor air exchange,1 admitted with pneumonia, 1 with crackles in their lungs, and 1 admitted with fungal infection. The report identified the resident, room number, date of symptom onset, symptoms, diagnostics completed, antibiotic ordered, community or agency acquired, risk factors and resolved date, The record did not identify the specific infection nor did it identify the organisms involved. In addition the report lacked a summary of the analysis.

Facility Infection Control tracking record dated 10/2016, identified the following symptoms: 1 with blood in their urine, 1 esophageal fungal infection, 2 with back pain, 1 with bladder spasms, 1 with foul urine, 1 with red eyes and discharge. The report identified the resident, room number, date of symptoms onset, symptoms, diagnostics completed, antibiotic ordered, community or agency acquired, risk factors and resolved date. The record did not identify the specific infection nor was the organism identified.

During interview on 11/02/16, at 12:32 p.m. the director of nursing (DON) stated she and registered nurse (RN)-C were responsible for monitoring the infection control program. DON stated RN-C was "very new" with the infection control program. Further, DON stated, "We don't

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summarize because we do so much talking one on one." The DON stated the infection control program did not identify the microorganism and relied on day to day stand up communication at report with staff . DON stated , each registered nurse care coordinator (RNCC) was responsible for reporting any new infection and the team discussed the residents who had infections and were on antibiotics.

A facility policy titled, Infection Control Program dated 10/15, indicated, "It is the policy of Assumption Community to provide a safe and sanitary environment for residents, clients, and staff through the use of best evidence based infection prevention and control practices." Further, under Administrative guidelines the second bullet indicated, "tracking is completed and kept up to date on a monthly basis and kept in a tracking book that states resident information, date of onset, symptoms, type of infection, how acquired, risk factors and date infection resolved."

Review of the facility staff call in report for August 2016, identified there were 8 staff sick calls for vomiting/diarrhea/fever. Call in report for September 2016 identified there were 5 staff sick calls for vomiting/diarrhea/ fever. Staff call in report for October 2016 identified there were 11 staff sick calls for vomiting/diarrhea /fever. The report did not identify if any follow up was completed with ill staff on their eligibility to return to work to ensure they were free of infections, to decrease the risk of any cross contamination with facility residents.

During interview on 11/02/16, at 12:40 pm regarding any follow up on staff illness, the DON

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stated,"I can't say we have any thing for tracking and trending in regards to employee illness. " DON further stated she gets the facility staff call in logs monthly and human resources only reviews these for attendance.

Review of the facility policy titled, Staffing 1, dated 9/1/15, indicated, " Employee return to work following illness, employee who has/had vomiting diarrhea must stay off work for at least 48 hours following ending of symptoms. Employee who has had sore throat with fever cough must stay off work for at least 24 hours."

SUGGESTED METHOD OF CORRECTION: The director of nursing and/or their designee should review and implement the facility's policy and procedures for monitoring, tracking, trending and analyzing infections treated within the facility.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights	21800		

Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a

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person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to provide the required Notice of Medicare Beneficiaries rights to appeal and expedited appeal upon termination of Medicare benefits in a timely manner for 2 of 5 residents (R18, R114) in the sample reviewed for liability and beneficiary rights.

Findings include:

R18's undated Face Sheet indicated R18 was admitted to facility on 9/23/16, and discharged on 10/14/16. Review of Notice of Medicare Non Coverage CMS (Centers for Medicare and Medicaid Services) Notice of Medicare Beneficiaries-10123 indicated R18 utilized

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medicare benefits with services which ended on 10/13/16. R18 was provided with Notice of Medicare Beneficiaries Non-Coverage notice one day prior to the end of services on 10/12/16. R18 was not provided the required 48 hour notice of termination of medicare services.

R114's undated Face Sheet identified R114 was admitted to the facility on 8/22/16, and discharged on 9/23/16. Review of Notice of Medicare Non coverage CMS of Medicare Beneficiaries-10123 indicated R114 utilized Medicare benefits with services which ended on 9/22/16. R114 was provided with Notice of Medicare Beneficiaries Non-Coverage on 9/20/16, one day prior to the end of his services on 9/21/16. R114 was not provided the required 48 hour notice of termination of medicare services.

During interview on 11/3/216, at 9:50 a.m. registered nurse (RN)-B stated R18's skilled nursing services ended on 10/13/16, and R18 received Notice of Medicare Non-Coverage on 10/12/16. RN-B stated Medicare denials needed to be provided two days before the proposed end of services. RN-B stated R18 should have received the notice on 10/11/16.
Further, RN-B stated R114's skilled nursing services ended on 9/22/16, and R114 received Notice of Medicare Non-Coverage on 9/21/16. RN-B stated R114 should have received the notice on 9/20/16. RN-B stated she does not attend the discharge planning meetings and the Notice of Medicare Beneficiaries rights to appeal forms is not handed out at the meeting and probably should be.

A policy for liability notices was requested, but not provided.

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SUGGESTED METHOD OF CORRECTION:
The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate liability notices to provide residents at the end of Medicare services, and to ensure resident rights are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures and develop a monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) Days

21805 MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights — 21805

Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure a dignified routine was consistently provided for 3 of 4 residents (R5, R44 and R38) who were dependent upon staff to complete activities of daily living.

Findings include:

R5's quarterly Minimum Data Set (MDS) dated 10/6/16, identified R5 had significant impaired cognition, and was totally dependent on staff for

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nearly all activities of daily living (ADLs).

During observation on 11/2/16, at 7:04 a.m. R5 was dressed for the day, wearing glasses, and seated in her wheel chair, and was in her usual place around the table in the Northwoods dining room. R5's eyes were closed and her head tipped to the left as she dozed in her wheel chair, awaiting the breakfast meal. To the left and upwards from where R5 sat, there was a large-screen TV, which was turned off. Other than staff walking past the dining area, the dining room was quiet.

R44's quarterly MDS dated 10/7/16, indicated R44 had significant impaired cognition and was totally dependent on staff for all ADLs.

During observation on 11/2/16 at 7:04 a.m., R44 was also seated in her wheel chair, facing the TV in the Northwoods dining area. A large blanket covered her legs and lower body as R44 slept, with her head tilted to the left.

R5 and R44 were the only two residents seated in the dining room with their eyes closed until 7:21 a.m., when other residents started to enter and were seated in the Northwoods dining room. Staff intermittently walked by the dining room on their way to other resident rooms, occasionally glancing at R5 and R44, but otherwise provided no engagement with the residents. The TV remained off, and R5 and R44 continued to sleep while other resident were brought into the Northwoods dining room.

R5 and R44 remained in their wheel chairs, sleeping and otherwise unengaged, in the Northwoods dining area from 7:04 a.m. until 8:33 a.m. (a total of 88 minutes) when nursing

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assistant (NA)-B asked R44 to wake up for breakfast. NA-B also rubbed R5's hand, woke her up, solicited her meal and beverage requests, and assisted R5 and R44 with washing their hands. R5 and R44 received their meals at 8:39 a.m., and subsequently NA-A and NA-B assisted them to eat their breakfast.

During interview on 11/2/16, at 8:58 a.m. NA-A stated both R5 and R44 were up, dressed and seated at the dining room tables before 7:00 a.m. NA-A stated both R5 and R44 needed "full assistance" from staff to meet their needs, and usually were the first residents assisted in the morning. NA-A stated both residents were usually ready to get going in the morning and staff did not purposefully "wake" them. When asked how long R5 and R44 typically sat in the dining room before the meal, NA-A said she knew they waited "a while" before breakfast.

During interview on 11/2/16, at 9:07 a.m. NA-B stated R5 and R44 were the first residents assisted after morning report because they required the assistance of two facility staff. Further, NA-B stated after R5 and R44 ADL's were completed, the NAs would help other residents, who required only a one person assist.

During interview on 11/2/16, at 2:15 p.m. licensed practical nurse (LPN)-A acknowledged the NAs usually got R5 and R44 up first in the morning, because they required "two assist" from facility staff and "It was one of those things." LPN-A stated R44 could be in her room alone, but R5 could not. LPN-A stated it was her expectation if residents were unoccupied alone in the dining room they would have some type of mental stimulation such as the television or radio.

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During interview on 11/3/16, at 8:51 a.m. NA-C stated her morning routine was to check which residents were awake and would proceed to assist those residents first. NA-C stated there were 3 residents who needed assist of 2, and R5 and R44 were normally the first residents assisted in the morning. Further, NA-C also stated neither R5 nor R44 could be left alone in the rooms by themselves.

During interview on 11/3/16, at 11:53 a.m. registered nurse (RN)-A stated she had witnessed residents "just sitting there" waiting in the dining area. Further, RN-A stated the facility had been working hard to involve residents in mentally stimulating activity such as 1:1 visits, music or television. RN-A stated leaving residents unattended in common areas without mental stimulation was a dignity issue and "they could do this better."

SUGGESTED METHOD OF CORRECTION:
The director of nursing or social services could in-service all staff on the need to treat all residents with respect and dignity. The Quality Assessment and Assurance committee could develop a system to audit employees for dignified care and services toward residents in the facility.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults	21990		

Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device

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for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to immediately report to the State agency allegations of misappropriation of property for 2 of 5 residents (R14, R26) reviewed for abuse prohibition, whose incidents of missing money were not timely reported to the State agency.

Finding include:

R14's quarterly Minimum Data Set (MDS) dated 10/12/16, indicated moderately impaired cognition.

An Incident/Investigative Report regarding R14's missing money, with a print date 7/8/16, was reviewed. The Incident details indicated, "It is questionable $60 to $80 missing from resident's wallet. [Family member] FM-A states she noted it missing on 7/4/16. Questionable if resident had money taken from her room or if resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00624	A. BUILDING: ______ B. WING ______	11/03/2016

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) COMPLETE DATE
21990	Continued From page 14	21990		

misplaced it herself. [FM-A] reports the incident occurred on 7/4/16." The incident details did not identify a time the incident occurred, only that it occurred on 7/4/16. The report indicated the initial incident was submitted to the State agency on 7/5/16, (the day after the incident occurred), and the final investigative report was submitted on 7/8/16.

During interview on 11/3/16, at 2:42 p.m. the director of nursing (DON) said she remembered (R14's) money, and said it was reported missing on 7/4/16. When reviewing the facility incident log, the DON said the administrator was notified of the incident via email on 7/4/16. The DON said the incident was reported to the state, and acknowledged it was reported on 7/5/16, the following day. The DON stated she would need to review notes and check with the social worker as she thought the facility was in compliance, but was not sure why the incident was reported late. The DON said missing money was a form of abuse, and needed to be treated like any other form of abuse, and be reported timely.

R26's MDS dated 10/4/16, indicated moderately impaired cognition.

An Incident/Investigative report for R26's print date of 8/18/16, indicated he had missing money. The report indicated R26 returned from an outing with family on 8/17/16, at 6 p.m. and reported to facility staff $100 was missing from R26's wallet. On 8/17/16, the facility called FM-B who stated she was not concerned about the missing money as R26 insisted on paying for meals when out with family. Further, FM-B stated she would talk with other family members to determine if R26 in fact had the money. On 8/18/16, FM-B verified R26 did have $100 in his wallet. The report

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	00624	A. BUILDING: ______ B. WING ______	11/03/2016

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21990	Continued From page 15	21990		

indicated the incident was submitted to state agency on 8/18/16, one day after the incident occurred, and the Final Investigative Report was submitted on 8/23/16.

During interview 11/13/16, at 2:42 p.m. the DON stated R26 reported the missing money to staff, including the administrator, on 8/17/16. The DON said the incident was reported to the state on 8/18/16, the following day. The DON stated she was not sure why this incident was reported late. The DON also said missing money was considered "abuse" and should be reported to the state agency in a timely manner.

A facility policy, Abuse Prohibition Plan, revised 7/2012, indicated a mandated reporter who has reason to believe a vulnerable adult ...has been abused shall "immediately report the incident." The policy further indicated the Minnesota Department Health was to be notified, and also the report of abuse, "must be made immediately upon initial knowledge that the incident occurred." The policy identified financial or exploitation as abuse.

SUGGESTED METHOD OF CORRECTION:
The administrator could in-service all staff on the need to immediately reporting suspected abuse/neglect/financial exploitation to the designated state agency/common entry point. The director of nurses' could monitor incident reports for implementation of this requirement.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.