CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: WQ9P

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PAR	Г I - ТО ВЕ СОМ	PLETED BY T	HE STATI	E SURVEY	AGENCY	F	acility ID: 00624
MEDICARE/MEDICAID PROVI (L1) 245446 2.STATE VENDOR OR MEDICAID (L2) 751743200		3. NAME AND ADI (L3) ASSUMPTIO (L4) 715 NORTH (L5) COLD SPRI	ON HOME FIRST STREET	ΤΥ	I)	L ₆₎ 56320	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE O (L9)	F OWNERSHIP	7. PROVIDER/SUF	PPLIER CATEGORY	09 ESRD	<u>02</u> 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other
8. ACCREDITATION STATUS: 0 Unaccredited 1 T	01/05/2017 (L34) (L10) JC ther	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	E	FISCAL YEAR ENDING 12/31	DATE: (L35)
11. LTC PERIOD OF CERTIFICATE From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	82 (L18) 82 (L17)	B. Not in Com	nce With quirements		2. 5 3. 2 4. 5	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code A*	Following Requirements: 6. Scope of Servi 7. Medical Direc 8. Patient Room S 9. Beds/Room (L12)	ices Limit tor
18 SNF 18/19 8 (L37) (L3	2	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICABLE	SHOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE S	SURVEY AGENCY API	PROVAL	Date:
Brenda Fischer	, Unit Supervis	or	01/05/2017	(L19)	Kate J	JohnsTon, Pr	ogram Specialis	o1/24/2017 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE O	R SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIE _X	to Participate		IPLIANCE WITH C	IVIL			al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEME	NT	26. TERMII	NATION ACTION:	(1	L30)
OF PARTICIPATION 03/01/1987	BEGINNING	DATE	ENDING DATE	3	VOLUNTAR 01-Merger, C		05-Fail to Mo	eet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L2*)	(L41) 27. ALTERNATIV A. Suspension B. Rescind Su	of Admissions:	(L25)		03-Risk of Inv	voluntary Termination son for Withdrawal	OTHER	eet Agreement Status Change
			(L45)					
28. TERMINATION DATE:	29	9. INTERMEDIARY/C	ARRIER NO.		30. REMARI	KS		
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	(L32)	2. DETERMINATION (12/21/2016	OF APPROVAL DAT	(L33)		d 01/27/2017 Co.	VAI	



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.

Assumption Home January 24, 2017 Page 2

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

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.

Assumption Home January 24, 2017 Page 2

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

			POST	-CERT	IFIC	OITA	N REVIS	IT RE	EPORT	ı		
IDENTIFIC	R / SUPPLIER / CL CATION NUMBER	IA /	MULTIPLE CONS A. Building	STRUCTION								F REVISIT
245446		Y1	B. Wing							Y2	1/5/201	7 _{Y3}
	FACILITY						STREET ADDR			CODE		
ASSUMF	PTION HOME						715 NORTH FI					
							COLD SPRING	i, MN 563	20			
program, corrected provision	ort is completed b to show those ded and the date such number and the ey report form).	eficiencie ch correc	es previously repo etive action was a	orted on the accomplished	CMS-29	567, Stater deficiency	ment of Deficier should be fully	ncies and identifie	I Plan of Cored using either	rection, that have er the regulation o	been or LSC	
ITE	M		DATE	ITEM			DAT	E .	ITEM			DATE
Y4			Y5	Y4			Υ	7 5	Y4			Y5
ID Prefix	F0225		Correction	ID Prefix	F0226		Corre	ection	ID Prefix	F0241		Correction
Reg.#	483.13(c)(1)(ii)-(iii - (4)), (c)(2)	Completed	Reg. #	483.13	(c)	Comp	oleted	Reg. #	483.15(a)		Completed
LSC			12/14/2016	LSC			12/13/	/2016	LSC			12/13/2016
ID Prefix	F0334		Correction	ID Prefix	F0441		Corre	ection	ID Prefix			Correction
Reg.#	483.25(n)		Completed	Reg. #	483.65		Comp	oleted	Reg. #			Completed
LSC			12/13/2016	LSC			12/13/	/2016	LSC			
ID Prefix			Correction	ID Prefix			Corre	ection	ID Prefix			Correction
Reg. #			Completed	Reg. #			Comp	oleted	Reg. #			Completed
LSC			_	LSC					LSC			-
ID Prefix			Correction	ID Prefix			Corre	ection	ID Prefix			Correction
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Reg.#			Completed	Reg. #			Comp	oleted	Reg. #			Completed
LSC			_	LSC					LSC			
REVIEWE	D BY	REVIEW	/ED BY	DATE		SIGNATUI	RE OF SURVEYO	DR .	'		DATE	

Form CMS - 2567B (09/92) EF (11/06)

FOLLOWUP TO SURVEY COMPLETED ON

(INITIALS)

(INITIALS)

REVIEWED BY

BF/KJ

01/24/2017

DATE

STATE AGENCY

REVIEWED BY

CMS RO

11/3/2016

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

TITLE

10562

DATE

01/05/2017

YES NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: WQ9P

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I - TO BE COMPLETED BY THE					STATE SURVEY AGENCY Facility ID: 00624			
1. MEDICARE/MEDICAID PROVIDER N (L1) 245446 2.STATE VENDOR OR MEDICAID NO. (L2) 751743200	0.	3. NAME AND ADD (L3) ASSUMPTIO (L4) 715 NORTH (L5) COLD SPRII	ON HOME FIRST STREET	ГҮ	(L6) 56320		1. Initia 3. Term 5. Valid	ination ation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUR	PPLIER CATEGOR' 05 HHA	Y 09 ESRD	02 13 PTIP	(L7) 22 CLIA	7. On-Si 8. Full S	Survey After Compl	9. Other aint
6. DATE OF SURVEY 11/03/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIC	CE		EAR ENDING DA	TE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	82 (L18) 82 (L17)	X B. Not in Com	nce With quirements		2. 3. 4.	pproved Waivers Of Technical Personnel 24 Hour RN 7-Day RN (Rural SI Life Safety Code B*		uirements: Scope of Services Medical Director Patient Room Size Beds/Room	Limit
14. LTC CERTIFIED BED BREAKDOWN					15. FACILI	TY MEETS			
18 SNF 18/19 SNF 82	19 SNF	ICF	IID		1861 (e) (1	1) or 1861 (j) (1):		(L15)	
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL	.ATION DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE S	SURVEY AGENCY	APPROVAL		Date:
Sarah Kacena	a, HFE NE I	<u>I</u>	12/16/2016	(L19)					- 12/21/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE O	OR SINGLE ST	ATE AGENCY	7	
DETERMINATION OF ELIGIBILITY			IPLIANCE WITH C HTS ACT:	IVIL	21.	Statement of Fin Ownership/Cont Both of the Abov	rol Interest Disclosu		513)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEME	ENT	26. TERMI	INATION ACTION:	:	(L30)
OF PARTICIPATION 03/01/1987	BEGINNING	DATE	ENDING DATE	Е	VOLUNTAR 01-Merger, C	Closure	00	INVOLUNTAR 05-Fail to Meet	
(L24)	(L41)		(L25)			action W/ Reimburse		06-Fail to Meet	Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE A. Suspension		(I.44)			avoluntary Termination	on	OTHER 07-Provider Star 00-Active	tus Change
(L27)	B. Rescind Sus	pension Date:	(L44) (L45)					oo richive	
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMAR	iks			
		03001							
	(L28)	03001		(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	ГЕ	Posted	12/21/2016 Co.			
	(L32)			(L33)	DETERM	IINATION APPI	ROVAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

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

Assumption Home December 5, 2016 Page 5

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

Assumption Home December 5, 2016 Page 6

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

PRINTED: 12/16/2016 FORM APPROVED OMB NO. 0938-0391

	AND BLAN OF CORRECTION TO THE TOTAL TIME IN THE TOTAL TOTAL THE TOTAL TO		` '	TIPLE CONSTE	(X3) DATE SURVEY COMPLETED		
		245446	B. WING			11/	03/2016
	PROVIDER OR SUPPLIER			715 NORTH	DRESS, CITY, STATE, ZIP CODE H FIRST STREET PRING, MN 56320	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION SHOULD DSS-REFERENCED TO THE APPROPIDER OF T) BE	(X5) COMPLETION DATE
F 000	surveyors from the Health (MDH) cond Assumption Home	2016 to November 3, 2016, Minnesota Department of ucted a certification survey, was found to not be in e regulations at 42 CFR Part	F 0	00			
SS=D	483, subpart B, req Facilities. The facility's plan or as your allegation or Department's accept enrolled in ePOC, yat the bottom of the form. Your electron be used as verificated. Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. 483.13(c)(1)(ii)-(iii), INVESTIGATE/REFALLEGATIONS/INDECTIONS/INDECTIONS/INDECTIONS of the facility must not been found guilty of mistreating resident had a finding enterer registry concerning of residents or misate and report any known court of law against indicate unfitness for other facility staff to or licensing authority.	f correction (POC) will serve of compliance upon the otance. Because you are rour signature is not required of first page of the CMS-2567 nic submission of the POC will cion of compliance. acceptable electronic POC, andur facility may be conducted to notial compliance with the en attained in accordance with the en attained in accordance with abusing, neglecting, or test by a court of law; or have end into the State nurse aide abuse, neglect, mistreatment appropriation of their property; whedge it has of actions by a can employee, which would or service as a nurse aide or the State nurse aide registry	F 2	25	TITLE		12/13/16 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

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.

Facility ID: 00624

	N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245446	B. WING _		11/03/2016
	PROVIDER OR SUPPLIER PTION HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 715 NORTH FIRST STREET COLD SPRING, MN 56320	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 225	involving mistreatm including injuries of misappropriation of immediately to the to other officials in through established State survey and of the facility must have a violations are thorous prevent further pote investigation is in put to the administrator representative and with State law (includent, and if the	asure that all alleged violations sent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law diprocedures (including to the ertification agency). In the evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 22	25	
	by: Based on interview facility failed to immagency allegations for 2 of 5 residents abuse prohibition, woney were not timagency. Finding include: R14's quarterly Min	NT is not met as evidenced y and document review, the nediately report to the State of misappropriation of property (R14, R26) reviewed for whose incidents of missing nely reported to the State		It is the policy of Assumption Homediately report to the State and allegations of misappropriation of property. Administrator will oversee the inord all staff of the need to immediate report allegations of abuse/neglect/financial exploitation including misappropriation of pro-	gency f servicing ately on, perty.

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED		
		245446	B. WING		11/0	03/2016
	PROVIDER OR SUPPLIER	,	7	STREET ADDRESS, CITY, STATE, ZIP CODE 715 NORTH FIRST STREET COLD SPRING, MN 56320		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	cognition. An Incident/Investigmissing money, wit reviewed. The Inciduestionable \$60 to wallet. [Family memissing on 7/4/16. money taken from misplaced it hersel occurred on 7/4/16 identify a time the ioccurred on 7/4/16 initial incident was on 7/5/16, (the day and the final invest on 7/8/16. During interview on director of nursing (R14's) money, and on 7/4/16. When relog, the DON said tof the incident was reacknowledged it wfollowing day. The to review notes and as she thought the was not sure why the The DON said missabuse, and needed form of abuse, and R26's MDS dated timpaired cognition. An Incident/Investigmissions.	gative Report regarding R14's th a print date 7/8/16, was dent details indicated, "It is \$80 missing from resident's mber] FM-A states she noted it Questionable if resident had her room or if resident had her room or if resident f. [FM-A] reports the incident ." The incident details did not necident occurred, only that it . The report indicated the submitted to the State agency after the incident occurred), igative report was submitted a said it was reported missing eviewing the facility incident the administrator was notified email on 7/4/16. The DON said ported to the state, and ras reported on 7/5/16, the DON stated she would need a check with the social worker facility was in compliance, but the incident was reported late. Sing money was a form of it to be treated like any other be reported timely.	F 225	and VA filings weekly x2 month monthly thereafter for x1 year. results and the data collected was presented to the Quality Assura Committee quarterly by the adror designee. This committee wand make any necessary recommendations. Facility will be in compliance by 28, 2016.	Audit vill be ance ninistrator ill review	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245446	B. WING		11/	03/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 715 NORTH FIRST STREET COLD SPRING, MN 56320			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE	
F 225	with family on 8/17/facility staff \$100 w On 8/17/16, the face she was not concert as R26 insisted on with family. Further with other family me fact had the money R26 did have \$100 indicated the incide agency on 8/18/16, occurred, and the Faubmitted on 8/23/15 During interview 11 stated R26 reported including the admin said the incident was 8/18/16, the following was not sure why the DON also said considered "abuse" state agency in a time. A facility policy, Abu 7/2012, indicated a reason to believe a abused shall "immed The policy further in Department Health the report of abuse upon initial knowled. The policy identified	d R26 returned from an outing 16, at 6 p.m. and reported to vas missing from R26's wallet. illity called FM-B who stated rned about the missing money paying for meals when out r, FM-B stated she would talk embers to determine if R26 in . On 8/18/16, FM-B verified in his wallet. The report nt was submitted to state one day after the incident final Investigative Report was 16. 1/13/16, at 2:42 p.m. the DON d the missing money to staff, instrator, on 8/17/16. The DON as reported to the state on ng day. The DON stated she his incident was reported late. missing money was and should be reported to the	F 2	25			
F 226 SS=D	abuse. 483.13(c) DEVELO ABUSE/NEGLECT		F 2	226		12/13/16	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245446	B. WING		11/03	3/2016
	PROVIDER OR SUPPLIER PTION HOME		7	TREET ADDRESS, CITY, STATE, ZIP CODE 15 NORTH FIRST STREET COLD SPRING, MN 56320		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	The facility must de policies and proced mistreatment, negle and misappropriation	evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.	F 226			
	by: Based on interview facility failed to imp Prohibition related the State agency al	NT is not met as evidenced and document review, the lement their policy Abuse to the immediate reporting to legations of misappropriation 5 residents (R14 and R26) prohibition.		It is the policy of Assumption Home implement written policies and proof that prohibit the mistreatment, negleabuse of residents and the misappropriation of property and er compliance with reporting in accord with these policies.	and procedures ent, neglect and ty and ensure	
	7/2015, was review abuse included fina The policy indicated has reason to belie being or has been a report the incident if further indicated incimmediately to the	Prohibition Plan, revised red. The policy identified that ancial abuse or exploitation. It is mandated reporter who we that a vulnerable adult is abusedshall immediately internally" Further, the policy cidents of abuse must be Minnesota Department of		The Administrator and LSW will upon facility policies and incident reports ensure clarity of reporting expectati Administrator will oversee the in-se of all staff to educate on these policiand of the need to immediately repallegations of abuse/neglect/financi exploitation, including misappropria property.	to ons. rvicing sies ort al tion of	
	10/12/16, indicated cognition. An incident/investig missing money, wit reviewed. The Inci questionable \$60 to wallet. [Family mer	imum Data Set (MDS) dated moderately impaired gative report regarding R14's h a print date 7/8/16, was dent details indicated, "It is \$80 missing from resident's mber FM]-A states she noted it Questionable if resident had		Administrator will audit incident repand VA filings weekly x2 months an monthly thereafter for x1 year. Audit results and the data collected will be presented to the Quality Assurance Committee quarterly by the Administor designee. This committee will reand make any necessary recommendations. Facility will be in compliance by Dec 28, 2016.	d lit e strator view	

AND DUAN OF CORRECTION INTERIOR NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245446	B. WING		11/	/03/2016
	PROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 715 NORTH FIRST STREET COLD SPRING, MN 56320	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	misplaced it hersel occurred on 7/4/16 identify a time the i occurred on 7/4/16 initial incident was on 7/5/16, (the day and the final invest on 7/8/16. During interview or director of nursing [R14's] money, and on 7/4/16. The DOI reported to the stat reported on 7/5/16, reviewing the facilit the administrator we mail on 7/4/16. The need to review not worker as she thou compliance, but was a form of abus like any other form	her room or if resident f. FM-A reports the incident ." The incident details did not ncident occurred, only that it . The report indicated the submitted to the State agency after the incident occurred), igative report was submitted 11/3/16, at 2:42 p.m. the (DON) said she remembered d said it was reported missing N said the incident was the following day. When ty incident log, the DON said has notified of the incident via he DON stated she would hes and check with the social hight the facility was in has not sure why the incident he DON said missing money he, and needed to be treated of abuse, and be reported in the facility policy.	F 226			
	An Incident/Investig print date of 8/18/1 from an outing with and reported to fact from R26's wallet.	10/4/16, indicated he had ed cognition. gative report for R26's with a 6, indicated R26 returned a family on 8/17/16, at 6 p.m. illity staff \$100 was missing On 8/17/16, facility called M)-B who stated she was not				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED	
		245446	B. WING _		11/	03/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 715 NORTH FIRST STREET COLD SPRING, MN 56320	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 226	insisted on paying f Further, FM-B state family members to the money. On 8/18 have \$100 in his wa incident was submi 8/18/16, the day aft the final investigativ 8/23/16. During interview wit p.m. stated R26 rep staff, including the a DON said the incide on 8/18/16 (the follo stated she was not reported late and the considered "abuse" State agency in a ti the policy. A facility policy, Abu 7/2012, indicated a reason to believe a abused shall "imme The policy further in Department Health the report of abuse upon initial knowled The policy identified abuse. 483.15(a) DIGNITY	ge 6 e missing money as R26 or meals when out with family. ed she would talk with other determine if R26 in fact had 8/16, FM-B verified R26 did allet. The report indicated the tted to State agency on er the incident occurred, and er report was submitted on the DON on 11/3/16, at 2:42 ported the missing money to administrator, on 8/17/16. The ent was reported to the State owing day). Further, the DON sure why this incident was be missing money was and should be reported to the mely manner, as identified by use Prohibition Plan, revised mandated reporter who has vulnerable adulthas been ediately report the incident." indicated the Minnesota was to be notified, and also gen must be made immediately lige that the incident occurred." If financial or exploitation as	F 22			12/13/16
SS=D	manner and in an e	omote care for residents in a environment that maintains or ident's dignity and respect in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245446	B. WING		11/03	/2016
	PROVIDER OR SUPPLIER PTION HOME		7	TREET ADDRESS, CITY, STATE, ZIP CODE 15 NORTH FIRST STREET COLD SPRING, MN 56320		.= 0.10
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE C	(X5) COMPLETION DATE
F 241	This REQUIREMENT by: Based on observatoreview, the facility for routine was consistoresidents (R5, R44 dependent upon standard living). Findings include: R5's quarterly Minimal 10/6/16, identified For cognition, and was nearly all activities of During observation was dressed for the seated in her whee place around the taroom. R5's eyes we tipped to the left as awaiting the breakfupwards from wher large-screen TV, which is the seated in the left as awaiting the preakfupwards from wher large-screen TV, which is the seated in the left as awaiting the preakfupwards from wher large-screen TV, which is the seated in the left as awaiting the preakfupwards from wher large-screen TV, which is the seated in the left as awaiting the preakfupwards from wher large-screen TV, which is the seated on the left as a waiting the preakfupwards from where large-screen TV, which is the seated on the left as a waiting the preakfupwards from where large-screen TV, which is the seated on the left as a waiting the preakfupwards from where large-screen TV, which is the seated on the left as a waiting the preakfupwards from where large-screen TV, which is the seated on the left as a waiting the preakfupwards from where large-screen TV, which is the seated on the left as a waiting the preakfupwards from where large-screen TV, which is the seated on the left as a waiting	ge 7 is or her individuality. NT is not met as evidenced tion, interview, and document ailed to ensure a dignified ently provided for 3 of 4 and R38) who were aff to complete activities of totally dependent on staff for of daily living (ADLs). on 11/2/16, at 7:04 a.m. R5 e day, wearing glasses, and I chair, and was in her usual ble in the Northwoods dining ere closed and her head she dozed in her wheel chair, ast meal. To the left and e R5 sat, there was a hich was turned off. Other than he dining area, the dining room	F 241	It is the policy of Assumption Home all Residents who are totally depen staff for activities of daily living will dignified routine. Clinical Coordinators will review the plans of all residents who are totally dependent on staff for activities of cliving, including R5, R44, and R38, ensure that Residents are engaged mentally stimulating activities base their assessed interests and revise as needed. The Administrator will oversee the in-servicing of all staff on Resident including the right for all residents to treated with respect and dignity. Audits will be conducted weekly x3 months by members of the interdisciplinary team under oversign the Director of Resident Services a reported to the Quality Assurance Committee to ensure compliance weekly and the plant of the plant	dent on have a e care y daily to d on them Rights, o be	
	R44's quarterly MD R44 had significant totally dependent of During observation was also seated in	on 11/2/16 at 7:04 a.m., R44 her wheel chair, facing the TV		dignified routine of residents. Ongoineed for auditing will be determined committee. Facility will be in compliance by De 28, 2016.	oing d by the	
		dining area. A large blanket and lower body as R44 slept.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245446	B. WING _		11.	/03/2016	
	PROVIDER OR SUPPLIER PTION HOME			STREET ADDRESS, CITY, STATE, ZIP CO 715 NORTH FIRST STREET COLD SPRING, MN 56320			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 241	the dining room with a.m., when other rewere seated in the intermittently walke way to other resident glancing at R5 and no engagement with remained off, and F while other resident Northwoods dining R5 and R44 remains sleeping and other Northwoods dining a.m. (a total of 88 nassistant (NA)-B as breakfast. NA-B alsher up, solicited her and assisted R5 and hands. R5 and R4a.m., and subsequenthem to eat their brown to eat their brown stated both R5 and seated at the dining NA-A stated both R assistance" from st usually were the firs morning. NA-A stated usually ready to get did not purposefully how long R5 and R	to the left. The only two residents seated in their eyes closed until 7:21 sidents started to enter and Northwoods dining room. Staff d by the dining room on their nooms, occasionally R44, but otherwise provided the residents. The TV R5 and R44 continued to sleep to were brought into the room. The din their wheel chairs, wise unengaged, in the area from 7:04 a.m. until 8:33 minutes) when nursing liked R44 to wake up for so rubbed R5's hand, woke remeal and beverage requests, d R44 with washing their 4 received their meals at 8:39 ently NA-A and NA-B assisted eakfast. The distribution of the residents assisted in the ted both residents were agoing in the morning and staff reveals when they washed the wake they are them. When asked 44 typically sat in the dining eal, NA-A said she knew they	F 24				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED	
		245446	B. WING			11/	03/2016	
	PROVIDER OR SUPPLIER PTION HOME			71	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH FIRST STREET OLD SPRING, MN 56320			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 241	stated R5 and R44 assisted after morn required the assista Further, NA-B state were completed, the residents, who required During interview on practical nurse (LPI usually got R5 and because they require staff and "It was on stated R44 could be could not. LPN-A st residents were unouroom they would has stimulation such as During interview on stated her morning residents were awa assist those residents were 3 residents whand R44 were norm assisted in the morn stated neither R5 nethe rooms by thems During interview on registered nurse (R witnessed residents the dining area. Fur had been working h mentally stimulating music or television. residents unattende	11/2/16, at 9:07 a.m. NA-B were the first residents ing report because they ance of two facility staff. d after R5 and R44 ADL's e NAs would help other sired only a one person assist. 11/2/16, at 2:15 p.m. licensed N)-A acknowledged the NAs R44 up first in the morning, red "two assist" from facility e of those things." LPN-A e in her room alone, but R5 ated it was her expectation if ccupied alone in the dining are some type of mental the television or radio. 11/3/16, at 8:51 a.m. NA-C routine was to check which ke and would proceed to the first. NA-C stated there no needed assist of 2, and R5 hally the first residents ning. Further, NA-C also or R44 could be left alone in selves. 11/3/16, at 11:53 a.m. N)-A stated she had s "just sitting there" waiting in ther, RN-A stated the facility hard to involve residents in g activity such as 1:1 visits, RN-A stated leaving ed in common areas without was a dignity issue and "they was a dignity issue and "they	F2	241				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245446	B. WING _	····	11	/03/2016		
	PROVIDER OR SUPPLIER PTION HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 715 NORTH FIRST STREET COLD SPRING, MN 56320		, • • • • • • • • • • • • • • • • • • •		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH ACTION SHOUTH ACTION SHOUTH APPOSES OF THE APPOSES OF T	OULD BE	(X5) COMPLETION DATE		
F 241	Continued From pa	nge 10	F 24	.1				
	R38 had severe co required extensive During observation on 11/01/16, at 6:20 in the hallway in he meal. During conti p.m. until 7:39 p.m. minutes) R38 cont following the evenir positioned in her wi within line of versio were observed or of this time. R38 had stared ahead into the distance of the control	S dated 08/31/16, identified gnitive impairment and assistance with ADL's. of the evening meal service p.m. facility staff placed R38 respectively wheelchair after the evening nuous observation from 6:20 (for one hour and nineteen inued to sit in the hallwaying meal service. R38 was heelchair without television in and no structured activities offered by facility staff during a flat facial expression and he hallway. 10/3/16, at 8:59 a.m. Family ed it was "unacceptable" to ded in the hallway for long nout any mental stimulation. she felt it would make R38 enjoyed mental stimulation and did not prefer to be left						
	administrator stated cognitively impaired stimulation through administrator stated for long periods of "was a concern" and	1 10/3/16, at 9:51 a.m. the dit was important for diresidents to have mental out the day. Further, the dileaving residents unattended time in facility common areas and staff may need further comoting structured activities uired residents.						

			E SURVEY PLETED			
		245446	B. WING		11/	03/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 715 NORTH FIRST STREET COLD SPRING, MN 56320		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	director of nursing (expectation cognitivinvolved in some type throughout the day management was a residents being left common living area and were working withis issue. Review of a facility Life/Dignity Policy, or "Each resident shall promotes and enhall and individuality." 483.25(n) INFLUEN IMMUNIZATIONS The facility must dethat ensure that (i) Before offering the each resident, or the representative receivenefits and potent immunization; (ii) Each resident is immunization October annually, unless the contraindicated or to the representative has immunization; and	1/3/16, at 10:02 a.m. the DON) stated it was her rely impaired residents were pe of meaningful activity. Further, DON stated facility aware of cognitively impaired alone unattended in the as for extended periods of time with facility staff on improving. policy titled, Quality of dated 05/2012, indicated, I be cared for in a manner that naces quality of life, respect. IZA AND PNEUMOCOCAL velop policies and procedures are influenza immunization, e resident's legal ives education regarding the ital side effects of the offered an influenza per 1 through March 31 immunization is medically the resident has already been this time period; the resident's legal the opportunity to refuse	F 24			12/13/16
	` '	nedical record includes indicates, at a minimum, the				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		TE SURVEY MPLETED
		245446	B. WING _		11	/03/2016
	PROVIDER OR SUPPLIER PTION HOME			STREET ADDRESS, CITY, STATE, ZIP CO 715 NORTH FIRST STREET COLD SPRING, MN 56320		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 334	representative was the benefits and po immunization; and (B) That the reside influenza immunization influenza immunization contraindications of the facility must dethat ensure that (i) Before offering the immunization, each legal representative the benefits and po immunization; (ii) Each resident is immunization, unless medically contraind already been immunization; (iii) The resident or representative has immunization; and (iv) The resident or documentation that following: (A) That the reside representative was the benefits and popneumococcal immunication or (V) As an alternative and practitioner records.	ent or resident's legal provided education regarding tential side effects of influenza ent either received the tion or did not receive the tion due to medical refusal. Evelop policies and procedures the pneumococcal resident, or the resident's exceives education regarding tential side effects of the ential record includes indicated, at a minimum, the ent or resident's legal provided education regarding tential side effects of ential side effe	F 33	4		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG		E SURVEY PLETED
		245446	B. WING _		11/0	03/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 715 NORTH FIRST STREET COLD SPRING, MN 56320		
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F 334	the resident or the refuses the second This REQUIREMENT by:	ess medically contraindicated or resident's legal representative	F 33	It is the policy of Assumption Ho	me to	
	facility failed to imp pneumococcal con of 5 residents (R7, vaccination historie Findings include: The Centers for Dis (CDC) identified; "A who have not previously of pneumococcal p	lement a policy related to jugate vaccine (PCV13) for 4 R22, R33, R109) whose		offer/ administer pneumococcal vaccinations, according to the ME CDC recommended interval for vunless contraindicated, already immunized, or declined by the resresponsible party. To assure compliance, the following has been put into place: Measures put into place to ensure deficient practice does not recur: Up admission to the facility, the	DH and accines, sident or	
	dose of PCV13 shot after receipt of the after receipt of the R7's Clinical Immurindicated the 86 yet PPSV23 vaccine or offered the PCV13 guidelines. R22's Clinical Immuring 11/2/16, indicated the PPSV23 vaccine offered the PCV13 guidelines.	puld be given at least 1 year most recent PPSV23 dose." nization Report dated 11/3/16, ar old had received the n 9/26/15, but was never according to the CDC unizations Report dated he 88 year old had received e on 8/27/08, but was never according to the CDC unizations Report dated he Second had received e on 8/27/08, but was never according to the CDC		admission's nurse will review pas records and complete health historesident is determined eligible peguidelines and provided pneumor algorithm, the resident will be offer appropriate pneumococcal vaccinand physician order will be obtain PCV13 is offered to all new admisensure compliance with the follow recommended CDC guidelines: "years age or older who have not previously received PCV13 and we previously received one or more of pneumococcal polysaccharide variable."	ory. If the r CDC coccal cred the nation ed. ssions to ving Adults 65 who have does of ccine 23	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
		245446	B. WING			11/0	03/2016
	PROVIDER OR SUPPLIER PTION HOME			71	REET ADDRESS, CITY, STATE, ZIP CODE 15 NORTH FIRST STREET OLD SPRING, MN 56320		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	11/3/16, indicated the PPSV23 vaccin offered the PCV13 guidelines R109's Clinical Imm 11/3/16, indicated the PPSV23 vaccin offered the PCV13 guidelines During interview on director of nursing (not been offering Printhe process of depolicy for pneumocato CDC guidelines. Review of facility povaccinations-Pneumocacal vaccinations-Pneumocacal vaccinations to the Minterval for the vaccine already immunized vaccine." Further, the nurses would review	ne 90 year old had received e on 7/20/16, but was never according to the CDC nunizations Report dated ne 74 year old had received e on 10/29/15, but was never according to the CDC 11/02/16, at 12:32 p.m. the DON) stated the facility had CV13 vaccinations and were eveloping and implementing a poccal vaccinations according olicy titled, mococcal /Resident, dated esidents will be offered cinations and administered DH and CDC recommended of the stated registered with physician orders for ecination upon admission for contact of the contact of th	F3	334	PCV13. The dose of PCV13 should given at least one year after receipt most recent PPSV23 dose". An alg was provided to the admission's nu December 14, 2016 for reference. To ensure compliance with CDC recommendations, all current resid who have not received PCV13 will offered the vaccination. A letter was drafted on December 13, 2016 stat Assumption Home now offers the F vaccination to all residents whom a eligible to receive the vaccination. letter, VIS and acknowledgement of vaccine information/ consent or deform will be mailed to residents or responsible parties on December 1 2016. PCV13 will be administered following consent, review of immunistory and physician order is obtain. Consents and declines will both be documented in Point Click Care un immunization tab. The Vaccinations Pneumococcal /Resident policy was updated in December 2016. Effective implementation of actions monitored by: The MDS RN is responsible to revicurrent resident's records to determ who has not received PCV13 from outside provider. The RN admission nurse is responsible to ensure that newly admitted residents are offered PCV13 if determined eligible. To ensure that the problem does not recur, the MDS RN will audit immunication, the MDS RN will audit immunication immunication that the problem does not recur, the MDS RN will audit immunication.	ents oe sing that PCV13 re The fcline 9th, ization ned. der the s- s will be ew nine an n's all od	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY PLETED
		245446	B. WING			11/0	03/2016
	PROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH FIRST STREET COLD SPRING, MN 56320		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441 SS=F	SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and o to help prevent the of disease and infection (a) Infection Control The facility must es Program under whic (1) Investigates, con in the facility; (2) Decides what pr should be applied to (3) Maintains a recol actions related to in (b) Preventing Spre	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, or an individual resident; and ord of incidents and corrective ifections.	F 3	141	documentation on a monthly basis report to the DON. The data collected will be reported Quality Assurance Committee on a quarterly basis. Those responsible to maintain compliance: The DON, Infection Control Prever and RN Team are responsible for maintaining compliance. Education for the staffing coordinat be completion for this by 12/16/201 Implementation will take place on 12/19/2016.	to the	12/13/16
		•					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION		SURVEY PLETED
		245446	B. WING		····	11/0	3/2016
	PROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH FIRST STREET COLD SPRING, MN 56320		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each dhand washing is incorprofessional practic (c) Linens Personnel must ha	esident needs isolation to of infection, the facility must	F4	141			
	by: Based on interview facility failed to dev program to include collected infection eligibility to return to transmission to oth had the potential to resided in the facility. The Facility Infection dated 07/2016, ide 2 with edema and with increased urged 1 wheezing with colidentified the resided.	NT is not met as evidenced and document review, the elop an infection control the trending and analysis of data, and identify ill employee's o work to reduce the risk of er residents in the facility. This affect all 71 residents whom ty. On Control tracking record ntified the following symptoms: redness/warm legs, 2 residents ency, 1 with foul smelling stool, ugh/confusion. The report ent, room number, date of mptoms, diagnostics			It is the policy of Assumption Home provide a safe and sanitary environ for the residents through use of best evidence-based infection prevention control practices. To assure compliance, the following has been put into place: Measures put into place to ensure deficient practice does not recur: The infection control preventionist we document in the "Monthly Infection Log", the specific infection and organ when cultures are completed follow notification from the laboratory phore. The nursing staff is responsible to the infection control preventionist the	ment it n and yill Control inism ing ne call. notify	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		SURVEY PLETED
		245446	B. WING		11/0	3/2016
	PROVIDER OR SUPPLIER PTION HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 715 NORTH FIRST STREET COLD SPRING, MN 56320		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	completed, antibiot agency acquired, ri date. The record di infection nor was a cultures were compidentify if there was related to resident in the Facility Infection dated 08/2016, idea with edema and rincreased urgency, wheezing with coug The report identified date of symptom or completed, antibiot agency acquired, ri date. The record di infection nor was the report also did not in association of infection. Facility Infection Cougl/2016, identified discharge from the urination, 1 with powith pneumonia, 1 and 1 admitted with identified the reside symptom onset, sycompleted, antibiot agency acquired, ri The record did not nor did it identify the	ic ordered, community or sk factors and the resolved d not identify the specific n organism identified when bleted. The report also did not any association of infection	F 441	same day they are notified of the infection/ organism. A floor map of facility will be used when docume infection/ organism, to identify if the any trends related to resident room location. The "Monthly Infection of Log" form was updated on Decem 2016. The form now reflects the foresident name, room number, infective, site, date of onset, date cultivate, organism(s), antibiotic resistype/ start date of antibiotic, infections resident was isolated. On a monthly basis, the infection preventionist will complete an Infection preventionist will complete an Infection rate per resident days, a at trending of previous months. To infections will be graphed mont Documentation will be kept in the "Resident Infection Control Trackit Trending" binder. Effective implementation of action monitored by: The DON is responsible to review documentation completed on the Infection Control Log" to ensure the specific infection and organism and documented, along with resident room number, infection type, site, onset, date culture taken, organis antibiotic resistance, type/ start date antibiotic, infection classification, resolved and if the resident was is on a monthly basis to ensure solution a monthly basis to ensure solutions.	of the nting the nere are montrol ober 13, collowing: ection certion ection, ection ection, ection ection, et and look rending hly. "Monthly ne ename, date of m(s), ate of date colated	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	TIPLE CONSTRUCTION		E SURVEY PLETED
		245446	B. WING		11/(03/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (715 NORTH FIRST STREET COLD SPRING, MN 56320	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 441	10/2016, identified blood in their urine, 2 with back pain, 1 foul urine, 1 with re report identified the of symptoms onset completed, antibiot agency acquired, ri The record did not nor was the organis. During interview on director of nursing registered nurse (R monitoring the infectated RN-C was "v control program. Fusummarize becaus on one." The DON program did not iderelied on day to day report with staff. Donurse care coordinated for reporting any nediscussed the resid were on antibiotics. A facility policy titled dated 10/15, indicated	control tracking record dated the following symptoms: 1 with 1 esophageal fungal infection, with bladder spasms, 1 with deepes and discharge. The resident, room number, date, symptoms, diagnostics or ordered, community or sk factors and resolved date. Identify the specific infection sm identified. 11/02/16, at 12:32 p.m. the DON) stated she and N)-C were responsible for ction control program. DON very new" with the infection arther, DON stated, "We don't e we do so much talking one stated the infection control entify the microorganism and vistand up communication at ON stated, each registered ator (RNCC) was responsible to infection and the team ents who had infections and the team ents who had infections and in for residents, clients, and e of best evidence based and control practices." inistrative guidelines the ated, "tracking is completed on a monthly basis and kept	F 4	implemented are sustained. The DON is responsible to documentation completed of Summary and graph trendi. "Resident Infection Control Trending" binder on a montensure solutions implement sustained. Infections will be reviewed and/or ADON monthly, at the meetings and as needed witeam. Staffing Coordinator, charge HIS department will docum illness upon call in, on the Absentee" report sheet on All forms will be kept in the Infection Control Tracking a Documentation" binder. The Coordinator, charge nurse department will document to absence and follow the return policy to reduce the risk of illness to residents at Assure The location where the staff worked in the last 72 hours identified for tracking purpore prevent the spread of disease Staffing Coordinator will no infection control prevention three or more staff illnesses background reported in a stimeframe. The Staffing Coordinator and designated staff member, we staff in the staff member, we staff member, we staff in the staff member in the staff member in the staff member.	review on the Infection ng kept I the Tracking and thly basis to ted are with DON ne quarterly QA with the nursing or ent all staff 'Employee a daily basis. "Employee and Trending ne Staffing or HIS the reason for urn to work transmission of mption Home. If member will be oses and to ase. The tify the ist if there is so of similar imilar	

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 call in September 2016 identified there were 5 staff call in have been updated to reflect changes		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
ASSUMPTION HOME STREET ADDRESS, CITY, STATE, ZIP CODE			245446	B. WING		11/0	03/2016
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 Vomiting/diarrhea/fever. Call in report for September 2016 identified there were 5 staff sick calls for vomiting/diarrhea/fever. Staff call in F 441 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 441 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 441 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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			,		715 NORTH FIRST STREET		
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 call in September 2016 identified there were 5 staff call in have been updated to reflect changes	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
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 24 hours." 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 hasentee" documentation weekly, complete the "Employee Infection Surveillance" form and is responsible to complete the tracking and trending of documented staff illness monthly. 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 and return to work and it is responsible to audit "Employee of the	F 441	infection, how acquinfection resolved." EMPLOYEE ILLNE Review of the facili 2016, identified the vomiting/diarrhea/fs September 2016 is calls for vomiting/diarrhea/fs September 2016 is calls for vomiting/diarrhea/fs sick calls for view report did not ident completed with ill sto work to ensure the decrease the risk of facility residents. During interview or regarding any follow stated,"I can't say wand trending in regulated, and trending in regulated in logs monthly and reviews these for a Review of the facili 9/1/15, indicated, following illness, er diarrhea must stay following ending of has had sore throat	ty staff call in report for August ere were 8 staff sick calls for ever. Call in report for dentified there were 5 staff sick diarrhea/ fever. Staff call in 2016 identified there were 11 romiting/diarrhea /fever. The ify if any follow up was taff on their eligibility to return hey were free of infections, to of any cross contamination with an 11/02/16, at 12:40 pm w up on staff illness, the DON we have any thing for tracking ards to employee illness. "It is she gets the facility staff call in human resources only attendance. Ity policy titled, Staffing 1, dated Employee return to work imployee who has/had vomiting off work for at least 48 hours symptoms. Employee who t with fever cough must stay	F 441	communicate with the ill employed notify them when they may return and document direction given, The infection control nurse will the "Employee Infection Surve form and is responsible to complete tracking and trending of document illness monthly. The infection of policy and tracking infections phave been updated to reflect commade. Effective implementation of act monitored by: To ensure that the problem document to recur, the form for calling in has updated to reflect guidelines of employee may return to work, lacking from the previous form. The infection control nurse is reported to audit "Employee Absentee" documentation weekly, complete tracking and trending of document illness monthly. To ensure the process implem working, the DON will audit "Enforcementation" binder and requarterly at the quality assurant meeting. Those responsible to maintain compliance: The DON, Infection Control Process in the poon.	urn to work per policy. complete illance" aplete the nented staff control colicies hanges tions will be seen on when the which was been and the ce" form the nented staff ented is apployee Trending view acce.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	C	X3) DATE COMP	B) DATE SURVEY COMPLETED	
		245446	B. WING			11/0	3/2016	
	PROVIDER OR SUPPLIER PTION HOME			STREET ADDRESS, CITY, STATE, ZIP C 715 NORTH FIRST STREET COLD SPRING, MN 56320				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B		(X5) COMPLETION DATE	
F 441	Continued From pa	ge 20	F 4	Education for the staffing cobe completion for this by 12 Implementation will take plate 12/19/2016.	2/16/2016			

F5446025

Printed: 12/05/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A, BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245446

B, WING _____

11/02/2016

NAME OF PROVIDER OR SUPPLIER

ASSUMPTION HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

715 NORTH FIRST STREET COLD SPRING, MN 56320

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	K 000		
	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			
ABORATO	DRY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	SNATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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.

Printed: 12/05/2016 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED A. BUILDING 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245446 B. WING 11/02/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 715 NORTH FIRST STREET **ASSUMPTION HOME** COLD SPRING, MN 56320 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 000 Continued From page 1 K 000 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.

	FOR MEDICARE & MEDICAID SERVICES			"A" FORM				
STATEMENT (OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY				
	TH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:				
FOR SNFs ANI) NFs	245446	B. WING	11/3/2016				
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDRESS, (CITY, STATE, ZIP CODE	·				
ASSUMPTI	ION HOME		715 NORTH FIRST STREET COLD SPRING, MN					
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC	CIES						
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES							
F 156	The facility must inform the resident both his or her rights and all rules and regulation the facility. The facility must also provunder §1919(e)(6) of the Act. Such notification resident's stay. Receipt of such information admission to the nursing facility or, when services that are included in nursing facilities be charged; those other items and services and the amount of charges for those services and services specified in paragraphs (5)(i). The facility must inform each resident be resident's stay, of services available in the services not covered under Medicare or both the facility must furnish a written descript A description of the manner of protecting. A description of the requirements and proto request an assessment under section 19 resources at the time of institutionalization resources which cannot be considered avained and activities of the services and telephore. A posting of names, addresses, and telephore the State survey and certification agency,	n orally and in writing ons governing resident wide the resident with to action must be made placed in the resident becomes it in the resident become and inform each resident in the facility of the resident in the	in a language that the resident understands conduct and responsibilities during the statche notice (if any) of the State developed prior to or upon admission and during the note to it, must be acknowledged in writing. And benefits, in writing, at the time of eligible for Medicaid of the items and State plan and for which the resident may note and for which the resident may be charged esident when changes are made to the item cotion. Admission, and periodically during the set for those services, including any charges in rate. And includes: An appropriate paragraph (c) of this section; And eligibility for Medicaid, including the right est the extent of a couple's non-exempt community spouse an equitable share of ward the cost of the institutionalized spoused deligibility levels. An article, the State ombudsman program, the ol unit; and a statement that the resident may oncerning resident abuse, neglect, and	not dd, ss for ght				
	The facility must inform each resident of for his or her care.	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.						
	applicants for admission oral and written	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

Event ID: WQ9P11 If continuation sheet 1 of 2

	FOR MEDICARE & MEDICAID SERVICES OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER //	MILITINE CONSTRUCTION	"A" FOI					
		PROVIDER#	MULTIPLE CONSTRUCTION A. BUILDING:	DATE SURVEY COMPLETE:					
O HARM WI OR SNFs ANI	TH ONLY A POTENTIAL FOR MINIMAL HARM D NFs			COMPLETE:					
		245446	B. WING	11/3/2016					
AME OF PRO	OVIDER OR SUPPLIER		ITY, STATE, ZIP CODE						
SSUMPTI	ION HOME	715 NORTH FIRS COLD SPRING, I							
O REFIX		Norma							
AG	SUMMARY STATEMENT OF DEFICIENCIES								
F 156	Continued From Page 1	Continued From Page 1							
	This REQUIREMENT is not met as ev	videnced by:							
	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.								
	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. Eighther, RN P, stated R114/s skilled pursing services anded an 0/22/16, and R114 received Nation of								
		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		eeting and probably shou	ld be.						
	A policy for liability notices was reques	sted, but not provided.							
	1								



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

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 <u>only a suggestion</u> 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

Assumption Home December 5, 2016 Page 2

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	auliding: (X3) DATE SURVEY COMPLETED	
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	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correcting pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of where corrected requires corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessments.	ther a violation has been mpliance with all			
	that may result from norders provided that a	earing on any assessments con-compliance with these written request is made to 15 days of receipt of a for non-compliance.			
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic ure orders consistent with ment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inf icensing orders are			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	CONSTRUCTION	(X3) DATE S	
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040.45	CLIMMA DV CT		·	PROVIDER'S PLAN OF CORRECTION	iNI	0/5
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	Department of Health you electronically. Al is necessary for State enter the word "correctext. You must then in State licensure proce completion date, the corrected prior to elect Minnesota Department on October 31st- throsurveyors of this Depabove provider and the orders are issued. Minnesota Department the State Licensing C federal software. Tag	orders being submitted to though no plan of correction e Statutes/Rules, please cted" in the box available for idicate in the electronic ss, under the heading date your orders will be ctronically submitting to the int of Health. Sough November 3rd 2016 artment's staff, visited the ine following correction int of Health is documenting orrection Orders using				
	column entitled "ID F statute/rule out of con "Summary Statement and replaces the "To correction order. This findings which are in after the statement, "evidence by." Following are the Suggested Mc Time period for Corre PLEASE DISREGAR FOURTH COLUMN WITH PROVIDER'S PLAN APPLIES TO FEDER THIS WILL APPEAR	Inpliance is listed in the of Deficiencies" column Comply" portion of the column also includes the violation of the state statute This Rule is not met as ng the surveyors findings ethod of Correction and ction. Deficiency of the the the provided in the provided in the				

Minnesota Department of Health

STATE FORM 6899 WQ9P11 If continuation sheet 2 of 16

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	. •				
	MINNESOTA STATE	STATUTES/RULES.			
	date, make a copy of original to the Minnes Division of Compliance	completed, please sign and these orders and return the ota Department of Health, se Monitoring, Licensing and 3333 West Division St, MN 56301.			
21390	MN Rule 4658.0800 S	Subp. 4 A-I Infection Control	21390		
	control program must procedures which pro A. surveillance be collection to identify n residents; B. a system for decontrol of outbreaks of C. isolation and preduce risk of transming D. in-service edule prevention and control E. a resident heat immunization program defined in part 4658.0 procedures of resident the prevention and treating procedures of resident the prevention and treating procedures of resident the prevention and treating procedures, including a defined in part 4658.0 G. a system for resproducts which affect	vide for the following: ased on systematic data osocomial infections in etection, investigation, and if infectious diseases; orecautions systems to assion of infectious agents; cation in infection ol; Ith program including an in, a tuberculosis program as 0810, and policies and it care practices to assist in extment of infections; ent and implementation of cies and infection control tuberculosis program as 1815; eviewing antibiotic use; eview and evaluation of infection control, such as			
	disinfectants, antisept incontinence products I. methods for ma	_			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
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21390	Continued From page	: 3	21390			
	current standards of p	practice in infection control.				
	by: Based on interview ar facility failed to developrogram to include the collected infection date eligibility to return to volume transmission to other had the potential to a resided in the facility. Findings include: The Facility Infection dated 07/2016, identified with edema and red with increased urgency 1 wheezing with coug identified the resident symptom onset, symptom onset, symptom pleted, antibiotic agency acquired, risk date. The record did resident increased did resident.	e trending and analysis of a, and identify ill staff work to reduce the risk of residents in the facility. This fect all 71 residents whom Control tracking record fied the following symptoms: ness/warm legs, 2 residents by, 1 with foul smelling stool, h/confusion. The report, room number, date of				
		ted. The report also did not ny association of infection m location.				
	dated 08/2016, identification of the completed and the complete of the complet	Control tracking record fied the following symptoms: ness/warm legs, 6 with with foul smelling stool, 1 and 1 with low grade temp. he resident, room number, et, symptoms, diagnostics ordered, community or factors and the resolved				

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Minnesota Department of Health

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2,000	date. The record did r infection nor was the report also did not ide	not identify the specific organism identified. The	21000			
	09/2016, identified the discharge from their eurination, 1 with poor with pneumonia, 1 with and 1 admitted with fuidentified the resident symptom onset, symptom onset, symptom pleted, antibiotic agency acquired, risk The record did not iden nor did it identify the or	erol tracking record dated e following symptoms: 1 with eyes, 1 with increased air exchange,1 admitted th crackles in their lungs, ungal infection. The report r, room number, date of otoms, diagnostics ordered, community or factors and resolved date, entify the specific infection organisms involved. In exced a summary of the				
	10/2016, identified the blood in their urine, 1 2 with back pain, 1 with red or report identified the re of symptoms onset, s completed, antibiotic agency acquired, risk The record did not idenor was the organism During interview on 1 director of nursing (Diregistered nurse (RN) monitoring the infection of the properties of the prope	1/02/16, at 12:32 p.m. the ON) stated she and o-C were responsible for control program. DON				
	stated RN-C was "ver	on control program. DON y new" with the infection her, DON stated, "We don't				

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STATE FORM 6899 WQ9P11 If continuation sheet 5 of 16

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NAME OF PROVIDER OR SUPPLIER ASSUMPTION HOME T15 NORTH FIRST STREET COLD SPRING, MN 56320 [X4) ID SUMMARY STATEMENT OF DEFICIENCIES THE RECULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CONTINUED FINE SPRING, MN 56320 21390 Continued From page 5 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 antibiotes. 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 11 **THEORY OF THE TOTAL PROVIDED TO THE		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	CONSTRUCTION	(X3) DATE S COMPL	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE. 2IP CODE 715 NORTH FIRST STREET COLD SPRING, MN 55320 CALL D. PROVIDERS PLAN OF CORRECTION PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION PREFIX TAG PROVIDERS PLAN OF CORRECTION PREFIX TAG PROVIDERS PLAN OF CORRECTION PREFIX TAG 21390 Continued From page 5 21390 21390 21390 21390 Continued From page 5 21390 PROVIDERS PLAN OF CORRECTION PREFIX TAG PROVIDERS PLAN OF CORRECTION PROVIDER				D WING			
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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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETE
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	21390	summarize because to on one." The DON staprogram did not ident relied on day to day seport with staff. DOI nurse care coordinate for reporting any new discussed the resider were on antibiotics. A facility policy titled, dated 10/15, indicated Assumption Communication and the communication of the commu	we do so much talking one ated the infection control ify the microorganism and stand up communication at N stated, each registered or (RNCC) was responsible infection and the team of the who had infections and infection and infections and infecti	21390			

Minnesota Department of Health

STATE FORM 6899 WQ9P11 If continuation sheet 6 of 16

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21390	stated,"I can't say we and trending in regard DON further stated so in logs monthly and horeviews these for attermined the Review of the facility 9/1/15, indicated, "Enfollowing illness, empediarrhea must stay of following ending of sy has had sore throat wo off work for at least 2 SUGGESTED METH	have any thing for tracking ds to employee illness. " he gets the facility staff call uman resources only endance. policy titled, Staffing 1, dated mployee return to work loyee who has/had vomiting f work for at least 48 hours emptoms. Employee who vith fever cough must stay	21390			
	review and implemen procedures for monito analyzing infections to	t the facility's policy and bring, tracking, trending and reated within the facility. CORRECTION: Twenty-one				
21800	residents shall, at adrare legal rights for the stay at the facility or to treatment and mainted that these are describilities set for responsibilities set for are legal responsibilities.	Bill of Rights on about rights. Patients and mission, be told that there eir protection during their hroughout their course of nance in the community and bed in an accompanying he applicable rights and rth in this section. In the tted to residential programs 253C.01, the written	21800			

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Minnesota Department of Health

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	provided in section 28 shall list the names at individuals and organ advocacy and legal s residential programs. accommodations sha communication impai speak a language oth facility policies, inspel local health authoritie the written statement to patients, residents, chosen representative to the administrator o person, consistent with individuals and organized to the section of	services for patients in				
	by: Based on interview and facility failed to provide Medicare Beneficiarie expedited appeal upon benefits in a timely more (R18, R114) in the same and beneficiary rights. Findings include: R18's undated Face Sadmitted to facility on	Sheet indicated R18 was 9/23/16, and discharged on Notice of Medicare Non ters for Medicare and otice of Medicare				

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Minnesota Department of Health

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SU COMPLE	
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	10/13/16. R18 was provided the day prior to the end of was not provided the termination of medical R114's undated Face admitted to the facility on 9/23/16. Review of coverage CMS of Medicated R114 utilized services which ended provided with Notice of Non-Coverage on 9/2 and of his services on provided the required termination of medical During interview on 1's registered nurse (RN) nursing services endereceived Notice of Medicare Notice of Medicare Notice of Medicare Notice of Medicare Notice on 9/20/16. RN attend the discharge probably should be.	n services which ended on rovided with Notice of s Non-Coverage notice one f services on 10/12/16. R18 required 48 hour notice of re services. Sheet identified R114 was on 8/22/16, and discharged f Notice of Medicare Non dicare Beneficiaries-10123 d Medicare benefits with on 9/22/16. R114 was of Medicare Beneficiaries 0/16, one day prior to the 19/21/16. R114 was not 48 hour notice of re services. 1/3/216, at 9:50 a.m. B stated R18's skilled ad on 10/13/16, and R18 dicare Non-Coverage on d Medicare denials needed ys before the proposed end the R18 should have 10/11/16. R114's skilled nursing 22/16, and R114 received on-Coverage on 9/21/16. ould have received the B stated she does not olanning meetings and the eneficiaries rights to appeal	21800			

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Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	LE CONSTRUCTION (X3) DATE S COMPL		
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21800	The administrator or or review, and/or revise ensure staff are educ liability notices to provide Medicare services, and are communicated ap The administrator or of appropriate staff on the and develop a monitor ongoing compliance.	OD OF CORRECTION: designee could develop, policies and procedures to ated on the appropriate vide residents at the end of nd to ensure resident rights propriately and acted upon. designee could educate all ne policies and procedures wring systems to ensure	21800			
21805	residents have the rig courtesy and respect	Bill of Rights treatment. Patients and	21805			
	by: Based on observatior review, the facility fail routine was consister residents (R5, R44 ar dependent upon staff daily living. Findings include: R5's quarterly Minimu 10/6/16, identified R5	t is not met as evidenced n, interview, and document ed to ensure a dignified httly provided for 3 of 4 hd R38) who were to complete activities of Im Data Set (MDS) dated had significant impaired tally dependent on staff for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED			
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		00624	B. WING		11/03/2016	
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21805	Continued From page	e 10	21805			
	nearly all activities of	daily living (ADLs).				
	was dressed for the diseated in her wheel control place around the table room. R5's eyes were tipped to the left as shawaiting the breakfas upwards from where large-screen TV, which staff walking past the was quiet. R44's quarterly MDS R44 had significant in totally dependent on some During observation or was also seated in he in the Northwoods direction.	ch was turned off. Other than dining area, the dining room dated 10/7/16, indicated inpaired cognition and was staff for all ADLs. In 11/2/16 at 7:04 a.m., R44 or wheel chair, facing the TV ining area. A large blanket lower body as R44 slept,				
	the dining room with t a.m., when other resid were seated in the No intermittently walked I way to other resident glancing at R5 and R4 no engagement with t	44, but otherwise provided the residents. The TV and R44 continued to sleep vere brought into the				
	sleeping and otherwis	ea from 7:04 a.m. until 8:33				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		1				
20004		B. WING				
		00624	D. WIING		11/0	3/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		715 NORTH	I FIRST STRE	ET.		
ASSUMPT	TON HOME		ING, MN 5632			
			1140, 19114 3032			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
1710		,	17.0	DEFICIENCY)		
21805	Continued From page	e 11	21805			
	assistant (NA)-B aske	ed R44 to wake up for				
	• ,	rubbed R5's hand, woke				
		neal and beverage requests,				
		R44 with washing their				
		eceived their meals at 8:39				
	a.m., and subsequently NA-A and NA-B assisted					
	them to eat their brea	kfast.				
	Desire a fata a desse a d	4/0/40 =± 0.50 = NA A				
	During interview on 11/2/16, at 8:58 a.m. NA-A stated both R5 and R44 were up, dressed and					
	•	oom tables before 7:00 a.m.				
	NA-A stated both R5 and R44 needed "full					
		to meet their needs, and				
	•	residents assisted in the				
	morning. NA-A stated					
	usually ready to get g	oing 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" befor	e breakfast.				
	During interview on 1	1/2/16, at 9:07 a.m. NA-B				
	stated R5 and R44 we					
	assisted after morning	g report because they				l
	required the assistant					
	•	after R5 and R44 ADL's				
	were completed, the I					
	•	ed only a one person assist.				
	rosidorito, wrio require	or only a one person assist.				
	During interview on 1	1/2/16, at 2:15 p.m. licensed				l
	_	-A acknowledged the NAs				
		14 up first in the morning,				
		d "two assist" from facility				
		of those things." LPN-A				
		n her room alone, but R5				l
		ed it was her expectation if				
		upied alone in the dining				
		e some type of mental				
	stimulation such as th	e television or radio.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED			
		00624 B. WING			11/03/2016	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
ASSUMPT	TON HOME		H FIRST STRE RING, MN 5632			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	ETE
21805			21805			
21990	(21) days. MN St. Statute 626.55	57 Subd. 4 Reporting -	21990			
	immediately make an	A mandated reporter shall oral report to the common telecommunications device				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00624	B. WING		11/03/2016
NAME OF PE	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
ASSUMPT	TION HOME		'H FIRST STREI RING, MN 5632		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
21990	SUMPTION HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		21990		

Minnesota Department of Health

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			(X3) DATE SI			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		00624	B. WING		11/0	3/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
A COLIMDA	TION LIONE	715 NORT	H FIRST STRE	ET		
ASSUMP	TION HOME	COLD SP	RING, MN 5632	20		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21990	Continued From page	= 14	21990			
21990	misplaced it herself. occurred on 7/4/16." identify a time the incoccurred on 7/4/16. Tinitial incident was su on 7/5/16, (the day af and the final investiga on 7/8/16. During interview on 1 director of nursing (Dr. (R14's) money, and son 7/4/16. When revi	[FM-A] reports the incident The incident details did not ident occurred, only that it The report indicated the bmitted to the State agency for the incident occurred), ative report was submitted 1/3/16, at 2:42 p.m. the ON) said she remembered aid it was reported missing fewing the facility incident administrator was notified	21990			
	of the incident via em the incident was repo acknowledged it was following day. The Doto review notes and cas she thought the farwas not sure why the The DON said missin	ail on 7/4/16. The DON said rted to the state, and reported on 7/5/16, the ON stated she would need heck with the social worker cility was in compliance, but incident was reported late. g money was a form of be treated like any other				
	impaired cognition. An Incident/Investigat date of 8/18/16, indicated Family on 8/17/16 facility staff \$100 was On 8/17/16, the facility she was not concerns as R26 insisted on pawith family. Further, I with other family memfact had the money.	tive report for R26's print ated he had missing money. R26 returned from an outing 6, at 6 p.m. and reported to s missing from R26's wallet. By called FM-B who stated about the missing money aying for meals when out FM-B stated she would talk abors to determine if R26 in On 8/18/16, FM-B verified his wallet. The report				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 NORTH FIRST STREET COLD SPRING, MN 56320 (K4) ID PRETEX (EACH DEFICIENCY MUST BE PRECEDED BY FULL FREDULATORY OR LSC IDENTIFYING INFORMATION) PRETEX (EACH CORRECTIVE ACTION SHOULD BE ASSUMMENT AS IDENTIFYING INFORMATION) 21990 Continued From page 15 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 asid 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 adulthas 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."	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER ASSUMPTION HOME 715 NORTH FIRST STREET COLD SPRING, MN 56320 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PILL PREFIX TAG CONTINUED FROM THE PROVIDER SPLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21990 Continued From page 15 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 adulthas 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."	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED		
ASSUMPTION HOME T15 NORTH FIRST STREET COLD SPRING, MN 56320 CALL DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DATE DATE DATE DATE DATE D	00624		B. WING		11/03/2016		
ASSUMPTION HOME COLD SPRING, MN 56320	NAME OF PROVID	DER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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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.	indiage occ sub Dur stat incl saic 8/18 was The constat A fa 7/20 reas abu The upo The abu SU0 The abu des The repr	icated the incident ency on 8/18/16, or curred, and the Final omitted on 8/23/16. ring interview 11/13 ted R26 reported the luding the administed the incident was 8/16, the following sone not sure why this encount at eagency in a time acility policy, Abuse 2012, indicated a mason to believe a vulue of the incident was encounted the policy further indipartment Health was report of abuse, "ron initial knowledge policy identified finals. IGGESTED METHOM administrator couled to immediately rouse/neglect/financials in the incident of the i	was submitted to state ne day after the incident all Investigative Report was all Investigative Report of the Market on all Investigation Reported to the state on all Investigation all Investigation Reported to the early manner. The Prohibition Plan, revised and and and and all Investigation Plan, revised and and all Investigation Reporter who has all Investigation al	21990	DEFICIENCY)		

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Minnesota Department of Health STATE FORM

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