Electronically Delivered
February 24, 2022

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

RE: CCN: 245446
Cycle Start Date: January 11, 2022

Dear Administrator:

On February 15, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
January 24, 2022

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

RE: CCN: 245446
Cycle Start Date: January 11, 2022

Dear Administrator:

On January 11, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

If substantial compliance with the regulations is not verified by April 11, 2022 (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).

In addition, if substantial compliance with the regulations is not verified by July 11, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING _____ B. WING _____	C 01/11/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/11/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5446030C (MN79774), with deficiencies cited at F550 & F656 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		2/14/22

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

Electronically Signed | 01/31/2022

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity for 1 of 3 residents, (R1), reviewed for call lights. R1's call light had been canceled without finding out if the residents needs were met, causing a potential risk of the resident needing emergency care. Findings include: R1's significant change Minimum Data Set	F 550	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: Staff member was provided education on call light answering immediately after reported by surveyor. How the facility will identify other residents having the potential to be affected by the	

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F 550	Continued From page 2 (MDS), dated 1/4/22, indicated R1 required extensive assistance with activities of daily living and was totally dependent upon staff for bed and transfer mobility. R1's brief inventory of mental status (BIMS) had a score of 0 indicating severe cognitive impairment. During observation on 1/10/22, at 11:42 a.m., R1 had pressed the call light wanting to be laid down in bed, have incontinent pad changed and allow surveyor to observe perineal skin area. At 11:55 a.m. a male staff member wearing gray scrubs came into the room and canceled the call light. The staff member did not identify himself or ask the resident what was needed. During an interview on 1/10/22, at 11:44 a.m. R1 reported staff canceling the call light is not unusual. R1 could not identify who the staff member was as the interaction was so quick and words were not exchanged. R1 stated, "Think of how that makes a person feel? Do I keep turning on my light or do I sit and wait and pray someone comes back? I never know. Can't they tell me?" During interview on 1/10/22, at 12:19 p.m. registered nurse (RN)-A reported to the surveyor and R1 that it is not the expectation of the facility for staff to turn off a resident's light without asking what the need is. "Staff should let the resident know they will be back or finding the person whom the resident is requesting. I didn't know this was happening." During an interview on 1/10/22, at 1:12 p.m. nursing assistant (NA)-A reported that he did come into the room and turn off the call light. He stated he saw surveyor in the room and thought R1 had a visitor, so she didn't need assistance.	F 550	same deficient practice: All residents could potentially be affected by this deficient practice. If their call light is turned on and someone turns it off without meeting resident□s needs. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Started staff education to call light answering expectations. Reviewed and revised current call light policy to reflect updated practices and expectations. Clinical staff will review the policy and take quiz to demonstrate knowledge. How the facility plans to monitor its performance to make sure that solutions are sustained: Management or delegated staff will do call light audits weekly for one month. Results will be reported to QA for ongoing determination. This plan will be implemented and the corrective action evaluated for its effectiveness. DON/RNCC	

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F 550	Continued From page 3 He stated the protocol for answering a light. is to ask for what the person needs and assist them, not to turn off the light and not return. "I was busy and forgot to check back." Upon interview on 1/10/22, at 1:30 p.m. NA-B reported she was trained to answer the call light, and to assist the resident if able. If an NA is not able to assist leave the call light on until a nurse can assist the resident. Upon interview on 1/10/22, at 4:42 p.m. the director of nursing (DON) stated that the call lights should be answered, the staff should find out what the resident's needs, turn off the call light, so it doesn't appear that lights were going off for long periods of time. "Our staff now has walkies, so they are to use the walkie to state who the resident needs for other departments." Assumption Home Call Light Usage Policy dated 2/17/21, indicated Assumption Home strives to respond to resident call lights within 5 minutes. When answering a call light within the room, if responding staff member can fully assist, punch appropriate response button. If staff member is unable to fully meet resident needs, leave call light on and indicate your presence. If staff member needs emergent assistance, punch red emergency button.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		2/14/22

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F 656	Continued From page 4 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to have a process to ensure direct care staff were aware of and	F 656	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:	

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F 656	Continued From page 5 educated about the care plan interventions for 1 of 3 residents (R1), whose care plan indicated assessing for urinary tract infections. The intervention was not addressed on the Kardex used by the direct care staff, leaving the staff unaware to monitor for the signs and symptoms. Failure of the monitoring could have potentially led to R1's hospitalization for urosepsis (life threatening infection of the urinary tract. Findings include: R1's significant change Minimum Data Set (MDS), dated 1/4/22, indicated R1 required extensive assistance with activities of daily living and was totally dependent upon staff for bed and transfer mobility. R1's brief inventory of mental status (BIMS) had a score of 0 indicating severe cognitive impairment. R1's care plan dated 10/25/19, indicated R1 was to be monitored for signs and symptoms of urinary tract infection (UTI), concentrated urine, odorous urine, frequency, urgency, discomfort, low back pain, and change in mental status. Upon interview on 1/10/22, at 10:30 a.m. R1's Family (FA)-A stated that the facility was not assessing her urinary status along with her skin integrity. FA-A reported the night R1 became ill, the facility called the family. The nurse told the family R1's blood pressure was high, and she had a fever, but most concerning her pulse was down to 24. The family requested her to be sent to the emergency room. R1 was admitted to hospital and was found to be septic from a urinary tract infection (UTI). FA-A stated "My Mom has been through a lot, but she wanted to die. She also had kidney stone built up causing her significant	F 656	Reviewed resident care plan updated Clinical monitoring for nursing to document specific targeted symptoms for R1 How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents could potentially be affected by this deficient practice. All resident care plans will be reviewed, if specific clinical monitoring is indicated, a template will be added for nursing to document accordingly. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Care plan policy was reviewed and updated. LPN and RN's educated to process for care plan implementation/ monitoring/documentation. All clinical staff will continue to have training upon hire and annually via Healthcare academy on ADLs which includes changes in resident condition and reporting to the nurse. How the facility plans to monitor its performance to make sure that solutions are sustained: RN's will audit all care plans of current residents over the next 30 days to ensure compliance. Results will be reported to QA for ongoing determination.	

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F 656	Continued From page 6 pain." FA-A stated in follow-up with the hospital she was informed by hospital nursing that R1 was sent to the hospital with BM in her depends, rancid smelling urine and scaling of skin "probably from my mother sitting in infected urine prior to hospitalization." Upon Interview on 1/10/22, at 11:08 a.m. R1 reported that she is aware staff is to be monitoring her for UTI symptoms. "I don't recall staff asking me, I hardly ever urinate. I can't tell when I have to urinate, it just comes." R1 confirmed that staff offers her the bedpan, but she mainly has already urinated in her pad, so she has her pad changed by the nursing assistants. Upon observation on 1/10/22, at 12:25 p.m. Nursing assistant (NA)-A and (NA)-B assisted resident to lay down on the bed and changed her brief. The aides did not ask R1 any questions regarding her urination or check for any signs of symptoms of a urinary tract infection. NA-B applied barrier cream to both from and back sides of resident. Upon interview on 1/10/22, at 1:12 with nursing assistant (NA)-A denied being trained to specifically look at R1 for any urinary concerns. NA-A verified that the Kardex only states to toilet her every 2-3 hours and to either use a bed pan or change her Depends pad. He stated, "nursing must watch for the UTI stuff, of course if she mentioned anything out of the ordinary, I would report to nursing." NA-A denied awareness of Kardex's being placed in residents' closets. He reported if he needed to find out something he would have to run to the nurses' office and look for the Kardex binder.	F 656	This plan will be implemented and the corrective action evaluated for its effectiveness. DON/RNCC	

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F 656	Continued From page 7	F 656		

Upon interview on 1/10/22, at 1:30 p.m. NA-B reported being aware to monitor R1 for signs and symptoms of a urinary tract infection only because she heard the nurses talk about it. NA-B verified that monitoring for a urinary tract infection (UTI) was not on R1's Kardex. NA-B denied knowing what questions to ask for urinary tract infections and denied observing the pad before it was thrown away. NA-B described UTI signs and symptoms would be residents having to "go to the bathroom often and pain when they go." NA-B denied carrying around a copy of the Kardex, that the Kardex's are in a binder in the nurses' office and another one is hung in the residents' closets.

Upon interview on 1/10/22, at 1:39 p.m. licensed practical nurse (LPN)-A reported that both nursing assistants and nurses are responsible to monitor R1 for a UTI. LPN-A was unaware where any documentation of the UTI to be placed. "I don't really know; I think the nursing assistants would report this in daily huddle. I don't know how they would be aware to monitor if it wasn't on the resident Kardex, you have to ask the manager."

Upon interview on 1/10/22, at 2:17 p.m. registered nurse (RN-A) verified that R1's care plan dated 10/25/19, indicated to monitor R1 for signs and symptoms of a UTI, concentrated urine, odorous urine, frequency, urgency or discomfort with urination, low back pain and change in mental status. RN-A verified that monitoring for a UTI was not on the NA's Kardex. RN-A stated the UTI monitoring is not documented anywhere, "The nursing assistants would verbally report signs and symptoms to a nurse and the nurse would then assess and

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F 656	Continued From page 8 document a note if there was a concern." Upon interview on 1/10/22, at 4:42 p.m. the director of nursing (DON) stated that if the nursing assistants are to monitor a resident for any changes or symptoms then what is on the care plan needs to be on the Kardex. A policy on reporting was requested, however a policy was not received.	F 656		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 24, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: V97F11

Dear Administrator:

The above facility was surveyed on January 11, 2022 through January 11, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00624	A. BUILDING: _____ B. WING _____	C 01/11/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/11/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5446030C (MN79774) with a licensing order issued at F550 (1805) & F656 (0565) 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to have a process to ensure direct care staff were aware of and educated about the care plan interventions for 1 of 3 residents (R1), whose care plan indicated assessing for urinary tract infections. The intervention was not addressed on the Kardex used by the direct care staff, leaving the staff unaware to monitor for the signs and symptoms. Failure of the monitoring could have potentially led to R1's hospitalization for urosepsis (life threatening infection of the urinary tract. Findings include: R1's significant change Minimum Data Set (MDS), dated 1/4/22, indicated R1 required extensive assistance with activities of daily living and was totally dependent upon staff for bed and	2 565	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: Reviewed resident care plan updated Clinical monitoring for nursing to document specific targeted symptoms for R1 How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents could potentially be affected by this deficient practice. All resident care plans will be reviewed, if specific clinical monitoring is indicated, a template will be added for nursing to document accordingly.	2/14/22

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2 565	Continued From page 3 transfer mobility. R1's brief inventory of mental status (BIMS) had a score of 0 indicating severe cognitive impairment. R1's care plan dated 10/25/19, indicated R1 was to be monitored for signs and symptoms of urinary tract infection (UTI), concentrated urine, odorous urine, frequency, urgency, discomfort, low back pain, and change in mental status. Upon interview on 1/10/22, at 10:30 a.m. R1's Family (FA)-A stated that the facility was not assessing her urinary status along with her skin integrity. FA-A reported the night R1 became ill, the facility called the family. The nurse told the family R1's blood pressure was high, and she had a fever, but most concerning her pulse was down to 24. The family requested her to be sent to the emergency room. R1 was admitted to hospital and was found to be septic from a urinary tract infection (UTI). FA-A stated "My Mom has been through a lot, but she wanted to die. She also had kidney stone built up causing her significant pain." FA-A stated in follow-up with the hospital she was informed by hospital nursing that R1 was sent to the hospital with BM in her depends, rancid smelling urine and scaling of skin "probably from my mother sitting in infected urine prior to hospitalization." Upon Interview on 1/10/22, at 11:08 a.m. R1 reported that she is aware staff is to be monitoring her for UTI symptoms. "I don't recall staff asking me, I hardly ever urinate. I can't tell when I have to urinate, it just comes." R1 confirmed that staff offers her the bedpan, but she mainly has already urinated in her pad, so she has her pad changed by the nursing assistants.	2 565	What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Care plan policy was reviewed and updated. LPN and RN□s educated to process for care plan implementation/ monitoring/documentation. All clinical staff will continue to have training upon hire and annually via Healthcare academy on ADLs which includes changes in resident condition and reporting to the nurse. How the facility plans to monitor its performance to make sure that solutions are sustained: RN□s will audit all care plans of current residents over the next 30 days to ensure compliance. Results will be reported to QA for ongoing determination. This plan will be implemented and the corrective action evaluated for its effectiveness. DON/RNCC	

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2 565	Continued From page 4 Upon observation on 1/10/22, at 12:25 p.m. Nursing assistant (NA)-A and (NA)-B assisted resident to lay down on the bed and changed her brief. The aides did not ask R1 any questions regarding her urination or check for any signs of symptoms of a urinary tract infection. NA-B applied barrier cream to both from and back sides of resident. Upon interview on 1/10/22, at 1:12 with nursing assistant (NA)-A denied being trained to specifically look at R1 for any urinary concerns. NA-A verified that the Kardex only states to toilet her every 2-3 hours and to either use a bed pan or change her Depends pad. He stated, "nursing must watch for the UTI stuff, of course if she mentioned anything out of the ordinary, I would report to nursing." NA-A denied awareness of Kardex's being placed in residents' closets. He reported if he needed to find out something he would have to run to the nurses' office and look for the Kardex binder. Upon interview on 1/10/22, at 1:30 p.m. NA-B reported being aware to monitor R1 for signs and symptoms of a urinary tract infection only because she heard the nurses talk about it. NA-B verified that monitoring for a urinary tract infection (UTI) was not on R1's Kardex. NA-B denied knowing what questions to ask for urinary tract infections and denied observing the pad before it was thrown away. NA-B described UTI signs and symptoms would be residents having to "go to the bathroom often and pain when they go." NA-B denied carrying around a copy of the Kardex, that the Kardex's are in a binder in the nurses' office and another one is hung in the residents' closets. Upon interview on 1/10/22, at 1:39 p.m. licensed practical nurse (LPN)-A reported that both nursing	2 565		

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2 565	Continued From page 5	2 565		

assistants and nurses are responsible to monitor R1 for a UTI. LPN-A was unaware where any documentation of the UTI to be placed. "I don't really know; I think the nursing assistants would report this in daily huddle. I don't know how they would be aware to monitor if it wasn't on the resident Kardex, you have to ask the manager."

Upon interview on 1/10/22, at 2:17 p.m. registered nurse (RN-A) verified that R1's care plan dated 10/25/19, indicated to monitor R1 for signs and symptoms of a UTI, concentrated urine, odorous urine, frequency, urgency or discomfort with urination, low back pain and change in mental status. RN-A verified that monitoring for a UTI was not on the NA's Kardex. RN-A stated the UTI monitoring is not documented anywhere, "The nursing assistants would verbally report signs and symptoms to a nurse and the nurse would then assess and document a note if there was a concern."

Upon interview on 1/10/22, at 4:42 p.m. the director of nursing (DON) stated that if the nursing assistants are to monitor a resident for any changes or symptoms then what is on the care plan needs to be on the Kardex.

A policy on reporting was requested, however a policy was not received.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance.

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

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21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity for 1 of 3 residents, (R1), reviewed for call lights. R1's call light had been canceled without finding out if the residents needs were met, causing a potential risk of the resident needing emergency care. Findings include: R1's significant change Minimum Data Set (MDS), dated 1/4/22, indicated R1 required extensive assistance with activities of daily living and was totally dependent upon staff for bed and transfer mobility. R1's brief inventory of mental status (BIMS) had a score of 0 indicating severe cognitive impairment. During observation on 1/10/22, at 11:42 a.m., R1 had pressed the call light wanting to be laid down in bed, have incontinent pad changed and allow surveyor to observe perineal skin area. At 11:55 a.m. a male staff member wearing gray scrubs came into the room and canceled the call light. The staff member did not identify himself or ask the resident what was needed. During an interview on 1/10/22, at 11:44 a.m. R1 reported staff canceling the call light is not	21805	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: Staff member was provided education on call light answering immediately after reported by surveyor. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents could potentially be affected by this deficient practice. If their call light is turned on and someone turns it off without meeting resident□s needs. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Started staff education to call light answering expectations. Reviewed and revised current call light policy to reflect updated practices and expectations. Clinical staff will review the policy and take quiz to demonstrate knowledge.	2/14/22

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21805	Continued From page 7 unusual. R1 could not identify who the staff member was as the interaction was so quick and words were not exchanged. R1 stated, "Think of how that makes a person feel? Do I keep turning on my light or do I sit and wait and pray someone comes back? I never know. Can't they tell me?" During interview on 1/10/22, at 12:19 p.m. registered nurse (RN)-A reported to the surveyor and R1 that it is not the expectation of the facility for staff to turn off a resident's light without asking what the need is. "Staff should let the resident know they will be back or finding the person whom the resident is requesting. I didn't know this was happening." During an interview on 1/10/22, at 1:12 p.m. nursing assistant (NA)-A reported that he did come into the room and turn off the call light. He stated he saw surveyor in the room and thought R1 had a visitor, so she didn't need assistance. He stated the protocol for answering a light. is to ask for what the person needs and assist them, not to turn off the light and not return. "I was busy and forgot to check back." Upon interview on 1/10/22, at 1:30 p.m. NA-B reported she was trained to answer the call light, and to assist the resident if able. If an NA is not able to assist leave the call light on until a nurse can assist the resident. Upon interview on 1/10/22, at 4:42 p.m. the director of nursing (DON) stated that the call lights should be answered, the staff should find out what the resident's needs, turn off the call light, so it doesn't appear that lights were going off for long periods of time. "Our staff now has walkies, so they are to use the walkie to state who the resident needs for other departments."	21805	How the facility plans to monitor its performance to make sure that solutions are sustained: Management or delegated staff will do call light audits weekly for one month. Results will be reported to QA for ongoing determination. This plan will be implemented and the corrective action evaluated for its effectiveness. DON/RNCC	

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21805	Continued From page 8 Assumption Home Call Light Usage Policy dated 2/17/21, indicated Assumption Home strives to respond to resident call lights within 5 minutes. When answering a call light within the room, if responding staff member can fully assist, punch appropriate response button. If staff member is unable to fully meet resident needs, leave call light on and indicate your presence. If staff member needs emergent assistance, punch red emergency button. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21805		