



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 24, 2023

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

RE: CCN: 245446
Cycle Start Date: January 11, 2023

Dear Administrator:

On January 11, 2023, a survey was completed at your facility by the Minnesota Department of Health, 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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, 2023, (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, 2023, (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/ltr_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.

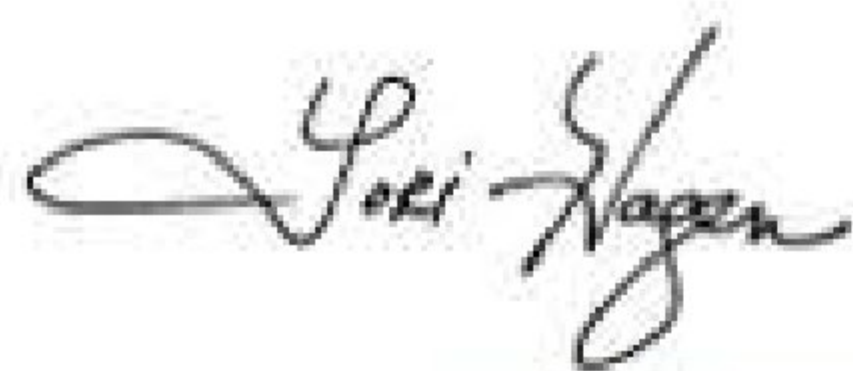
Assumption Home

January 24, 2023

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Please contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Lori Hagen". The signature is fluid and cursive, with the first name "Lori" and last name "Hagen" clearly distinguishable.

Lori Hagen, Compliance Analyst

Federal Enforcement | Licensing and Certification

Health Regulation Division

Minnesota Department of Health

Telephone: 651-201-4306

E-mail: Lori.Hagen@state.mn.us

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

PRINTED: 03/07/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/11/2023
NAME OF PROVIDER OR SUPPLIER ASSUMPTION HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 1/10/23 through 1/11/23, 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 UNSUBSTANTIATED: H54467401C (MN89340). The following complaint was found to be SUBSTANTIATED: H54467078C (MN89649), with a deficiency cited at F600. As a result of the investigation, an additional deficiency was cited at F610. 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600			3/2/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/03/2023

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

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F 600	Continued From page 1 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure each resident was free from abuse for 1 of 3 residents (R1), when R1's care plan was not followed by staff member for repositioning causing R1 to become "emotionally distraught" when pain was not relieved. Findings include: R1's face sheet printed 1/12/23, indicated R1 had diagnoses which included dementia, and chronic pain. R1's significant change Minimal Data Set (MDS) dated 10/20/22, indicated R1 had moderately impaired cognition. Further, MDS indicated R1 required extensive staff assistance for activities of daily living (ADLs) such as bed mobility, transfers, dressing and toileting. R1 did not exhibit any behaviors.			F 600	This plan of correction is the facilities credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. F600 Free from Abuse and Neglect SS=D CFR(s): 483.12(a)(1) It is the practice of Assumption Home to assure each resident is free from abuse and neglect. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED:		

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F 600	Continued From page 2 R1's care plan as of 8/18/22, indicated an alteration in cognition related to dementia and directed staff to allow resident time to communicate wants/needs; resident prefers pad type call light; verbal, speak clearly and distinctly to resident or use resident preferred communication method. Further, R1's care plan indicated R1 had potential for alteration in skin integrity related to impaired mobility and incontinence and directed staff to turn and reposition every three hours and as needed. Alteration in comfort related to generalized pain with interventions listed as offer as needed (PRN) ice/heat; positioning, rest, massage; pain medication as ordered; document effectiveness; encourage resident to verbalize discomfort. Revisions on 1/3/23, clarified alteration in communication related to aphasia and dementia diagnosis; allow extra time for conversation as resident has difficulty finding words. R1 had alteration in comfort related to generalized pain and directed staff to ensure resident was boosted up in bed to prevent discomfort if R1 expresses pain to knees. R1's Medication Administration Record (MAR) dated 1/11/23, indicated R1 could receive Voltaren Gel topically as needed for bilateral knee pain, which was given at 1:50 a.m. on 12/27/22, by LPN-A for pain rated 5/10 (use Pain Scale 1-3 mild pain, 4-6 moderate pain, 7-10 severe pain) and was effective. Review of R1's pain scale assessment revealed on 12/27/22, at 1:50 a.m. R1 rated her pain a 5 out of 10 and at 4:46 a.m. rated her pain a 1 out of 10. Review of facility's Toileting/Repo Tracker dated	F 600	All residents of Assumption Home have the potential to be affected by the deficient practice; however, no similar findings and/or negative effects have been identified by this alleged deficient practice. The facility's corrective actions outlined below include policy, procedure and systemic changes; training and education; and monitoring and audits. POLICIES/PROCEDURES/SYSTEMIC CHANGES: " A team was formed to perform root cause analysis to identify the underlying process and system issues (root causes) of the deficient practice and to develop intervention(s) or corrective action plan(s) to prevent recurrence. The team met on February 1, 2023 and the outcome of the RCA is attached. " Administrator, DON and Social Services Director have reviewed the policies and procedures for abuse prevention and abuse reporting and revised as needed. " Update Current Onboarding Program - The new employee orientation committee is meeting on February 15, 2023 to discuss the following systemic changes. The DON and the orientation committee are responsible for this action item. o Augment current Health Academy abuse prevention and reporting education to include staff led education. The DON, HR Manager and Staff Development Nurse are responsible for creating and initiating the staff led education.		

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F 600	Continued From page 3 12/27/22, indicated staff to encourage R1 to reposition every 2-3 hours and overnights per request (do not wake) which revealed R1 was sleeping on rounds at 12:00 a.m., 2:00 a.m. and 4:00 a.m.. Review of facility report number 350590 to the State Agency (SA) dated 12/27/22, indicated nursing assistant (NA)-A was assisting R1 on the morning of 12/27/22, when R1 was tearful. R1 had reported to NA-A "that girl is a monster, I don't want her in here again" referring to NA-B, who worked the overnight shift. R1 reported her call light was on to request assistance from NA-B to get boosted up in bed as her left knee was hurting due to feet being against the footboard of the bed. R1 reported NA-B answered her call light but did not meet her needs and turned off the call light, this occurred four more times. R1 reported she was hollering out in pain during this time and did not have pain relief due to R1's feet remaining to be pressed against the footboard. In addition, R1 denied any lasting pain after NA-A took over cares but was "emotionally distraught". On 1/10/23, at 3:15 p.m. NA-B indicated during interview during the night on 12/27/22, at approximately 4:00 a.m. R1 placed on her call light and NA-B was unable to understand what R1 was requesting so NA-B remained silent to let R1 express what she needed. NA-B thought R1 was requesting her feet to be wrapped, however, NA-B was not sure since R1 did not require wraps. NA-B stated she did not notify the licensed practical nurse (LPN)-A until approximately 5:00 a.m. after R1 put her call light on for the second time. NA-B indicated R1 put on her call light for the third time and when NA-B went into R1's room, R1 had directed her to leave. NA-B	F 600	- o Initiate 30-60-90 day reviews for new staff with supervisor incorporating input from peers. The information will help supervisors with identifying and addressing performance issues early on or determining within 90 days or sooner if a staff member is not a good fit. The RNCCs, DON, ADON and HR manager are responsible for the completion of this action item. - o Add Organizational chart, chain of command, and how to report concerns to your supervisor or to use Assumption Home's grievance process. The administrator and HR manager are responsible for this task. - o Post current list of Supervisors and direct reports in the break room and charting rooms so that employees know who to contact with concerns about a co-worker. The HR manager is responsible for the completion of this action item. - o Supervisors will meet with new direct reports on the first day of orientation for lunch and will check-in with the new employees after the first week training on the floor to help establish rapport with the goal of making supervisors more approachable when a staff member has a concern about another coworker that needs to be reported. We want to increase the likelihood that concerns are reported to supervisors. The HR manager, DON and RNCCs are responsible for the completion of this task. TRAINING/EDUCATION " No later than February 17, 2023, the		

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F 600	Continued From page 4 reported to LPN-A R1 did not want her in her room, and LPN-A suggested at that time R1's ankle could be hurting and directed NA-B to assist R1 to elevate them, but NA-B stated she did not return to R1's room due to respecting R1's wishes of not wanting NA-B in her room. NA-B denied asking other NAs in or around her unit to assist. Further, NA-B stated R1's call light remained on for the remainder of NA-B's shift when she left at approximately 6:30 a.m. In addition, NA-B confirmed she did not reposition R1 during the overnight because R1 was asleep. On 1/11/23, at 7:25 a.m. LPN-A indicated during interview R1 did not display any cognitive impairments but did have difficulty with communicating due to aphasia. LPN-A indicated R1 had pain in legs, however, repositioning or boosting R1 up in bed would usually alleviate R1's pain. Further, LPN-A indicated she did not recall much detail about the night of 12/27/22, when the allegation was made but did recall she was alerted by NA-B one time during her shift that R1 was reporting pain in her legs, and LPN-A had applied Voltaren gel to R1's legs at that time and checked on R1 at approximately 5:00 a.m. and R1 was comfortable with a pain rating of one. On 1/11/23, at 8:50 a.m. NA-C indicated during interview R1 required to be repositioned in bed every two to three hours or as requested, and R1's cognition did not appear impaired and R1 was able to express her needs and wants. Further, NA-C stated R1 was "tearful", which was unusual for R1, throughout the morning about the alleged incident that occurred during the night and R1 kept calling NA-B a "monster". In addition, NA-C stated she had noticed upon coming onto her shift after NA-B's over night shift residents	F 600	DON, ADON and the Administrator will hold a mandatory all-staff meeting. The agenda will include: - o Interactive Dialogue about timely reporting and definitions, examples, scenarios and discussion of neglect, verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion. - o Use of grievance forms to identify resident concerns that are not reportable. - o Investigation of reportable incidents and the importance of timely responses to requests for interviews and witness statements so that the investigations are thorough and complete within the allotted 5 days. " All nurse supervisors will be trained on how to complete performance reviews no later than February 20, 2023. This training will be added to the onboarding process for nurse supervisors. The Administrator, DON and HR manager are responsible for this action item. MONITORING/AUDITING: " An RN will conduct random audits of 2 employees knowledge pertaining to the education provided at the mandatory all-staff meeting once a week for 4 weeks and then once a month times 2 months. Audits include employees from all departments and all shifts. The Staff Development Nurse is responsible for coordinating and tracking the audits and reporting the audit data to the QAPI Committee. " For 2 months, the HR manager will		

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F 600	Continued From page 5 had not been toileted or repositioned and indicated other coworkers had noticed the same concerns which have been reported to the charge nurse. On 1/11/23, at 9:19 a.m. NA-D indicated during interview R1 had reported concerns regarding NA-B being rough with her but did not know any further details related to the allegation. Further, NA-D indicated concerns related to NA-B had been reported by NA-D and other coworkers "to management" regarding NA-B "always sitting at the nursing station, sitting on her phone" and not attending to the residents however NA-D was not able to provide any dates when incidents occurred. On 1/11/23, at 10:18 a.m. LPN-B indicated during interview R1 required assistance from staff for all ADLs and no cognitive impairments noted. LPN-B indicated at 6:45 a.m. on 12/27/22, NA-A reported R1 was "super upset" and had stated that something happened with NA-B on the overnight. LPN-B met with R1 in her room and R1 was crying, and LPN-B was attempting to calm R1 down for approximately 10 minutes. LPN-B stated R1 remained upset and crying related to the incident until after breakfast. In addition, LPN-B stated other nursing assistants had reported to her concerns regarding NA-B's work performance related to not completing rounds on overnights, "multiple" residents being wet from not checking on them and telling residents she does not have time to dress them for the day. LPN-B stated she had reported these things to the unit manager however was not able to provide any dates. On 1/11/23, at 12:41 p.m. NA-A indicated during	F 600	track completion of 30-60-90 day reviews. This data will be reported to IDT weekly and to the QAPI committee at the end of the 2 months. " For 2 months, the HR manager will conduct weekly random audits to track if supervisors are having lunch with their new direct reports and checking in with them after their first week on training on the floor. This information will be submitted to the QAPI committee. " The Director of Social Services will track all employee submitted grievances and review with the IDT team. Volume of grievances will be tracked for 2 months and submitted to the QAPI committee. The Administrator and DON are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training. The facility alleges that it will be in substantial compliance and complete all action items by March 2, 2023.		

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F 600	Continued From page 6 interview she entered R1's room on 12/27/22, at approximately 6:40 a.m. following morning report due to R1's call light being on. NA-A entered R1's room and R1 was in bed on her back and "scooted down" in her bed with enough pressure on her feet from the footboard where it would be uncomfortable, and NA-A noted R1 reported to be in pain. NA-A indicated R1 then began to cry and called NA-B a "monster". Further, NA-A indicated R1 was tearful "for a while" regarding the incident but R1 was better as the day went on, and no increased pain was noted. In addition, NA-A indicated NA-A and other coworkers had expressed concerns about NA-B related to residents being "very wet and not changed" through out the night and those were "continuous occurrences" which were reported to the licensed nurses; however NA-A was not able to give any further details related to dates or licensed nurses these concerns were reported to. On 1/11/23, at 12:53 p.m. care coordinator (CC)-A indicated during interview R1 had a "slight" decline in cognition but was able to express needs and concerns. CC-A indicated R1 had a communication deficit due to aphasia but if you gave R1 time she was able to express her needs. Further, CC-A indicated R1 required to be repositioned every 2-3 hours and whenever she requests, which included during the overnight. CC-A indicated she was not involved in the investigation of R1's allegation regarding NA-B other than the allegation was reported to the SA regarding "neglected to care for her" referring to R1. Further, CC-A indicated she was not aware of any complaints from staff regarding NA-B's work performance. On 1/11/23, at 1:40 p.m. interim director of	F 600			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page 7 nursing (DON) indicated during interview when arriving to work on 12/27/22, staff reported R1 was "distraught" and "crying". DON went to speak with R1 and R1 reported she was in pain due to her feet being against the footboard of the bed and NA-B did not assist when R1 would turn on her call light. Further, DON indicated staff were expected to follow the care plan which directed staff to reposition R1 every three hours, which would be during the night as well, as proper bed positioning helps alleviate R1's pain in her hips and legs. DON confirmed NA-B had not repositioned R1 during the night of 12/26/22-12/27/22 but was not aware until surveyor asked and stated the incident could have been avoided had R1 been repositioned as required and as care plan indicated. DON confirmed education was not provided to staff related to answering call lights prior to start of survey and an email was sent to all staff on 1/10/23, as well as no education related to following care plans and repositioning. In addition, DON indicated she has had "numerous complaints about her [NA-B's] work performance from several staff members, she was terminated for her work performance in question related to not completing cares which was a lot of he said, she said too. We were trying to look into it further." DON indicated there had been only one formal coaching completed with NA-B related to repositioning in November 2022 and was unable to provide any evidence of work performance monitoring or auditing completed for NA-B despite being aware of complaints from her co-workers. When questioned further about NA-B's work performance DON then stated the concerns were not brought to her attention about NA-B neglecting residents but more concerns about NA-B being "lazy".	F 600			

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

PRINTED: 03/07/2023
FORM APPROVED
OMB NO. 0938-0391

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F 600	Continued From page 8 On 1/11/23, at 3:20 p.m. R1 was laying in bed with the head of bed slightly elevated and feet were not observed to be touching the foot board. R1 stated during interview she recalled an incident with a night aid who was "mean" and would not help R1 be boosted up in bed. R1 could not recall how long she was laying in her bed in pain but stated it felt like a while. R1 indicated the incident made her feel "mad, in pain" and indicated she was crying. Requested policy related to Care Plans, however, facility was not able to provide prior to survey exit. Facility did develop policy titled Using Care Plan Policy which was effective as of 1/13/23.	F 600			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 610			3/2/23

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F 610	Continued From page 9 by: Based on interview and document review, the facility failed to complete a thorough investigation following a neglect allegation for 1 of 1 residents (R1) reviewed when R1 alleged neglect by a staff member. Findings include: Review of facility report number 350590 to the State Agency (SA) dated 12/27/22, indicated nursing assistant (NA)-A was assisting R1 on the morning of 12/27/22, when R1 was tearful. R1 had reported to NA-A "that girl is a monster, I don't want her in here again" referring to NA-B, who worked the overnight shift. R1 reported her call light was on to request assistance from NA-B to get boosted up in bed as her left knee was hurting due to feet being against the footboard of the bed. R1 reported NA-B answered her call light but did not meet her needs and turned off the call light, this occurred four more times. R1 reported she was hollering out in pain during this time and did not have pain relief due to R1's feet remaining to be pressed against the footboard. In addition, R1 denied any lasting pain after relief of NA-A assisting but was "emotionally distraught". NA-B was suspended pending the investigation. Review of facility's 5-day investigation to the SA dated 1/3/23, indicated NA-B (alleged perpetrator) was interviewed, R1 was interviewed, and R1's care plan was updated regarding pain and communication. In addition, report indicated no verbal education was provided to NA-B "as she is no longer employed here for different reasons". On 1/11/23, at interim director of nursing (DON) indicated she completed the facility's 5-day	F 610	This plan of correction is the facilities credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. F610 Investigate/Prevent/Correct Alleged Violation SS=D CFR(s): 483.12(c)(2)-(4) It is the practice of Assumption Home to respond to allegations of abuse, neglect, exploitation, or mistreatment by thoroughly investigating the allegations and creating documentation as evidence of that investigation. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED: All residents of Assumption Home have the potential to be affected by the deficient practice; however, no similar findings and/or negative effects have been identified by this alleged deficient practice. The facility's corrective actions outlined below include policy, procedure and systemic changes; training and education; and monitoring and audits. POLICIES/PROCEDURES/SYSTEMIC CHANGES: " The reportable abuse investigation		

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F 610	Continued From page 10 investigation following R1's allegation. DON indicated the investigation consisted of interviewing other residents on the same unit as R1 and no additional concerns were expressed at that time. DON indicated she reviewed R1's care plan and updated the care plan related to pain management and communication. DON stated she did not interview any other staff that worked with NA-B the night of the alleged incident, 12/27/22. DON indicated she attempted to contact licensed practical nurse (LPN)-B who NA-B was working with on the overnight of 12/26/22-12/27/22, however attempt was unsuccessful as the call went to voicemail and DON did not make any other attempts other than by phone call. DON confirmed interviewed LPN-B would have been an important part of the investigation. Further, DON confirmed R1's record was not reviewed and did not interview NA-B on when R1 was last repositioned. DON indicated education regarding not answering call lights and if unable to meet resident needs to notify the nurse and ask for assistance which was not addressed prior to survey entrance when an email was sent to all staff on 1/10/23. Review of facility policy titled Resident Protection Program Policy dated 5/5/17, revealed the investigation process was used to determine what happened and must begin immediately. The investigation will include who was involved, resident statements, involved staff and witness statements.			F 610	packet is being reviewed and updated by the IDT team to stream line the process and make it easier for floor staff to initiate the investigation immediately. The new packet will be in place no later than February 20, 2022. The DON and ADON are responsible for ensuring that this action item is completed. " The Administrator, DON, ADON, LSW, HR and RNCCs will huddle whenever an incident is reported to OHFC. During the huddle, the team will delegate tasks to individuals along with a completion date. Until the 5-day report is submitted, this team will meet briefly each day after stand-up or as necessary to discuss the investigation. The Administrator and DON are responsible for ensuring that the huddles take place when required. " The reportable investigation process will be added to our agency/pool orientation packet. The Staff Development nurse and HR Manager are responsible for this action item. TRAINING/EDUCATION " The DON and ADON will meet with all licensed nurses one on one to review the new incident investigation checklist and packet and to train them on how to immediately initiate an investigation of a reportable incident. This education will be added to the licensed nurse onboarding competency checklist. The DON and ADON are responsible for this action item. " During the all-staff meeting mentioned in the correction for F600, staff will be trained on the policies and procedures for		

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F 610	Continued From page 11	F 610	investigating a reportable incident and the importance of timely responses to requests for interviews and witness statements so that the investigation is thorough and complete within the allotted 5 days. MONITORING/AUDITING: " For 2 months, within 1 week of submitting a 5-day investigative report, the IDT team will audit and review the investigation documentation for completeness. The results will be reported to the QAPI committee at the end of 2 months. " Once a week for 4 weeks and then once a month for 2 months, the Staff Development nurse will conduct random audits to verify that the licensed nurses understand the training they received on the new investigation checklist and packet. The Administrator and DON are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training. The facility alleges that it will be in substantial compliance and complete all action items by March 2, 2023.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 24, 2023

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

Re: Event ID: NMDI11

Dear Administrator:

The above facility survey was completed on January 11, 2023, 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please contact me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00624	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/11/2023
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/10/23 through 1/11/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found be in compliance with the MN State Licensure.	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

02/03/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00624	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/11/2023
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2 000	Continued From page 1 The following complaint was found to be UNSUBSTANTIATED: H54467401C (MN89340). The following complaint was found to be SUBSTANTIATED: H54467078C (MN89649) with no licensing order issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 4, 2023

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

RE: CCN: 245446
Cycle Start Date: January 11, 2023

Dear Administrator:

On January 31, 2023, we notified you a remedy was imposed. On March 10, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 2, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 2, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 31, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 2, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 2, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 24, 2023

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

RE: CCN: 245446
Cycle Start Date: January 11, 2023

Dear Administrator:

On January 11, 2023, a survey was completed at your facility by the Minnesota Department of Health, 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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, 2023, (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, 2023, (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/ltr_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.

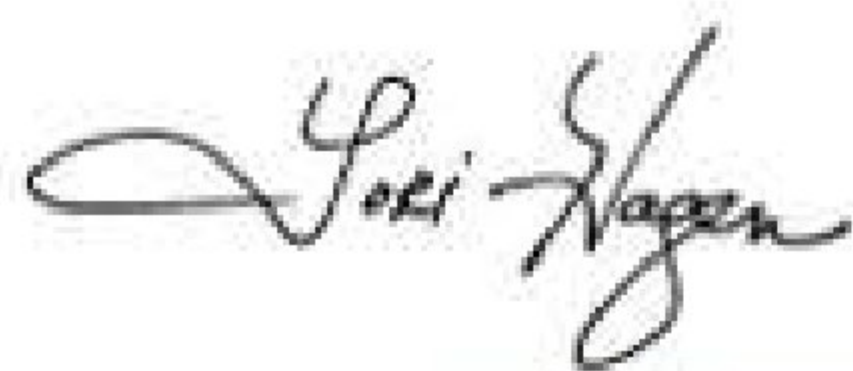
Assumption Home

January 24, 2023

Page 4

Please contact me if you have questions.

Sincerely,

A handwritten signature in dark ink, reading "Lori Hagen". The signature is fluid and cursive, with the first name "Lori" and last name "Hagen" clearly distinguishable.

Lori Hagen, Compliance Analyst

Federal Enforcement | Licensing and Certification

Health Regulation Division

Minnesota Department of Health

Telephone: 651-201-4306

E-mail: Lori.Hagen@state.mn.us

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

PRINTED: 03/07/2023
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F 000	INITIAL COMMENTS On 1/10/23 through 1/11/23, 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 UNSUBSTANTIATED: H54467401C (MN89340). The following complaint was found to be SUBSTANTIATED: H54467078C (MN89649), with a deficiency cited at F600. As a result of the investigation, an additional deficiency was cited at F610. 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600			3/2/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/03/2023

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

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

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F 600	Continued From page 1 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure each resident was free from abuse for 1 of 3 residents (R1), when R1's care plan was not followed by staff member for repositioning causing R1 to become "emotionally distraught" when pain was not relieved. Findings include: R1's face sheet printed 1/12/23, indicated R1 had diagnoses which included dementia, and chronic pain. R1's significant change Minimal Data Set (MDS) dated 10/20/22, indicated R1 had moderately impaired cognition. Further, MDS indicated R1 required extensive staff assistance for activities of daily living (ADLs) such as bed mobility, transfers, dressing and toileting. R1 did not exhibit any behaviors.			F 600	This plan of correction is the facilities credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. F600 Free from Abuse and Neglect SS=D CFR(s): 483.12(a)(1) It is the practice of Assumption Home to assure each resident is free from abuse and neglect. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED:		

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F 600	Continued From page 2 R1's care plan as of 8/18/22, indicated an alteration in cognition related to dementia and directed staff to allow resident time to communicate wants/needs; resident prefers pad type call light; verbal, speak clearly and distinctly to resident or use resident preferred communication method. Further, R1's care plan indicated R1 had potential for alteration in skin integrity related to impaired mobility and incontinence and directed staff to turn and reposition every three hours and as needed. Alteration in comfort related to generalized pain with interventions listed as offer as needed (PRN) ice/heat; positioning, rest, massage; pain medication as ordered; document effectiveness; encourage resident to verbalize discomfort. Revisions on 1/3/23, clarified alteration in communication related to aphasia and dementia diagnosis; allow extra time for conversation as resident has difficulty finding words. R1 had alteration in comfort related to generalized pain and directed staff to ensure resident was boosted up in bed to prevent discomfort if R1 expresses pain to knees. R1's Medication Administration Record (MAR) dated 1/11/23, indicated R1 could receive Voltaren Gel topically as needed for bilateral knee pain, which was given at 1:50 a.m. on 12/27/22, by LPN-A for pain rated 5/10 (use Pain Scale 1-3 mild pain, 4-6 moderate pain, 7-10 severe pain) and was effective. Review of R1's pain scale assessment revealed on 12/27/22, at 1:50 a.m. R1 rated her pain a 5 out of 10 and at 4:46 a.m. rated her pain a 1 out of 10. Review of facility's Toileting/Repo Tracker dated			F 600	All residents of Assumption Home have the potential to be affected by the deficient practice; however, no similar findings and/or negative effects have been identified by this alleged deficient practice. The facility's corrective actions outlined below include policy, procedure and systemic changes; training and education; and monitoring and audits. POLICIES/PROCEDURES/SYSTEMIC CHANGES: " A team was formed to perform root cause analysis to identify the underlying process and system issues (root causes) of the deficient practice and to develop intervention(s) or corrective action plan(s) to prevent recurrence. The team met on February 1, 2023 and the outcome of the RCA is attached. " Administrator, DON and Social Services Director have reviewed the policies and procedures for abuse prevention and abuse reporting and revised as needed. " Update Current Onboarding Program - The new employee orientation committee is meeting on February 15, 2023 to discuss the following systemic changes. The DON and the orientation committee are responsible for this action item. o Augment current Health Academy abuse prevention and reporting education to include staff led education. The DON, HR Manager and Staff Development Nurse are responsible for creating and initiating the staff led education.		

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F 600	Continued From page 3 12/27/22, indicated staff to encourage R1 to reposition every 2-3 hours and overnights per request (do not wake) which revealed R1 was sleeping on rounds at 12:00 a.m., 2:00 a.m. and 4:00 a.m.. Review of facility report number 350590 to the State Agency (SA) dated 12/27/22, indicated nursing assistant (NA)-A was assisting R1 on the morning of 12/27/22, when R1 was tearful. R1 had reported to NA-A "that girl is a monster, I don't want her in here again" referring to NA-B, who worked the overnight shift. R1 reported her call light was on to request assistance from NA-B to get boosted up in bed as her left knee was hurting due to feet being against the footboard of the bed. R1 reported NA-B answered her call light but did not meet her needs and turned off the call light, this occurred four more times. R1 reported she was hollering out in pain during this time and did not have pain relief due to R1's feet remaining to be pressed against the footboard. In addition, R1 denied any lasting pain after NA-A took over cares but was "emotionally distraught". On 1/10/23, at 3:15 p.m. NA-B indicated during interview during the night on 12/27/22, at approximately 4:00 a.m. R1 placed on her call light and NA-B was unable to understand what R1 was requesting so NA-B remained silent to let R1 express what she needed. NA-B thought R1 was requesting her feet to be wrapped, however, NA-B was not sure since R1 did not require wraps. NA-B stated she did not notify the licensed practical nurse (LPN)-A until approximately 5:00 a.m. after R1 put her call light on for the second time. NA-B indicated R1 put on her call light for the third time and when NA-B went into R1's room, R1 had directed her to leave. NA-B	F 600	- o Initiate 30-60-90 day reviews for new staff with supervisor incorporating input from peers. The information will help supervisors with identifying and addressing performance issues early on or determining within 90 days or sooner if a staff member is not a good fit. The RNCCs, DON, ADON and HR manager are responsible for the completion of this action item. - o Add Organizational chart, chain of command, and how to report concerns to your supervisor or to use Assumption Home's grievance process. The administrator and HR manager are responsible for this task. - o Post current list of Supervisors and direct reports in the break room and charting rooms so that employees know who to contact with concerns about a co-worker. The HR manager is responsible for the completion of this action item. - o Supervisors will meet with new direct reports on the first day of orientation for lunch and will check-in with the new employees after the first week training on the floor to help establish rapport with the goal of making supervisors more approachable when a staff member has a concern about another coworker that needs to be reported. We want to increase the likelihood that concerns are reported to supervisors. The HR manager, DON and RNCCs are responsible for the completion of this task. TRAINING/EDUCATION " No later than February 17, 2023, the		

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F 600	Continued From page 4 reported to LPN-A R1 did not want her in her room, and LPN-A suggested at that time R1's ankle could be hurting and directed NA-B to assist R1 to elevate them, but NA-B stated she did not return to R1's room due to respecting R1's wishes of not wanting NA-B in her room. NA-B denied asking other NAs in or around her unit to assist. Further, NA-B stated R1's call light remained on for the remainder of NA-B's shift when she left at approximately 6:30 a.m. In addition, NA-B confirmed she did not reposition R1 during the overnight because R1 was asleep. On 1/11/23, at 7:25 a.m. LPN-A indicated during interview R1 did not display any cognitive impairments but did have difficulty with communicating due to aphasia. LPN-A indicated R1 had pain in legs, however, repositioning or boosting R1 up in bed would usually alleviate R1's pain. Further, LPN-A indicated she did not recall much detail about the night of 12/27/22, when the allegation was made but did recall she was alerted by NA-B one time during her shift that R1 was reporting pain in her legs, and LPN-A had applied Voltaren gel to R1's legs at that time and checked on R1 at approximately 5:00 a.m. and R1 was comfortable with a pain rating of one. On 1/11/23, at 8:50 a.m. NA-C indicated during interview R1 required to be repositioned in bed every two to three hours or as requested, and R1's cognition did not appear impaired and R1 was able to express her needs and wants. Further, NA-C stated R1 was "tearful", which was unusual for R1, throughout the morning about the alleged incident that occurred during the night and R1 kept calling NA-B a "monster". In addition, NA-C stated she had noticed upon coming onto her shift after NA-B's over night shift residents	F 600	DON, ADON and the Administrator will hold a mandatory all-staff meeting. The agenda will include: - o Interactive Dialogue about timely reporting and definitions, examples, scenarios and discussion of neglect, verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion. - o Use of grievance forms to identify resident concerns that are not reportable. - o Investigation of reportable incidents and the importance of timely responses to requests for interviews and witness statements so that the investigations are thorough and complete within the allotted 5 days. " All nurse supervisors will be trained on how to complete performance reviews no later than February 20, 2023. This training will be added to the onboarding process for nurse supervisors. The Administrator, DON and HR manager are responsible for this action item. MONITORING/AUDITING: " An RN will conduct random audits of 2 employees knowledge pertaining to the education provided at the mandatory all-staff meeting once a week for 4 weeks and then once a month times 2 months. Audits include employees from all departments and all shifts. The Staff Development Nurse is responsible for coordinating and tracking the audits and reporting the audit data to the QAPI Committee. " For 2 months, the HR manager will		

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F 600	Continued From page 5 had not been toileted or repositioned and indicated other coworkers had noticed the same concerns which have been reported to the charge nurse. On 1/11/23, at 9:19 a.m. NA-D indicated during interview R1 had reported concerns regarding NA-B being rough with her but did not know any further details related to the allegation. Further, NA-D indicated concerns related to NA-B had been reported by NA-D and other coworkers "to management" regarding NA-B "always sitting at the nursing station, sitting on her phone" and not attending to the residents however NA-D was not able to provide any dates when incidents occurred. On 1/11/23, at 10:18 a.m. LPN-B indicated during interview R1 required assistance from staff for all ADLs and no cognitive impairments noted. LPN-B indicated at 6:45 a.m. on 12/27/22, NA-A reported R1 was "super upset" and had stated that something happened with NA-B on the overnight. LPN-B met with R1 in her room and R1 was crying, and LPN-B was attempting to calm R1 down for approximately 10 minutes. LPN-B stated R1 remained upset and crying related to the incident until after breakfast. In addition, LPN-B stated other nursing assistants had reported to her concerns regarding NA-B's work performance related to not completing rounds on overnights, "multiple" residents being wet from not checking on them and telling residents she does not have time to dress them for the day. LPN-B stated she had reported these things to the unit manager however was not able to provide any dates. On 1/11/23, at 12:41 p.m. NA-A indicated during	F 600	track completion of 30-60-90 day reviews. This data will be reported to IDT weekly and to the QAPI committee at the end of the 2 months. " For 2 months, the HR manager will conduct weekly random audits to track if supervisors are having lunch with their new direct reports and checking in with them after their first week on training on the floor. This information will be submitted to the QAPI committee. " The Director of Social Services will track all employee submitted grievances and review with the IDT team. Volume of grievances will be tracked for 2 months and submitted to the QAPI committee. The Administrator and DON are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training. The facility alleges that it will be in substantial compliance and complete all action items by March 2, 2023.		

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F 600	Continued From page 6 interview she entered R1's room on 12/27/22, at approximately 6:40 a.m. following morning report due to R1's call light being on. NA-A entered R1's room and R1 was in bed on her back and "scooted down" in her bed with enough pressure on her feet from the footboard where it would be uncomfortable, and NA-A noted R1 reported to be in pain. NA-A indicated R1 then began to cry and called NA-B a "monster". Further, NA-A indicated R1 was tearful "for a while" regarding the incident but R1 was better as the day went on, and no increased pain was noted. In addition, NA-A indicated NA-A and other coworkers had expressed concerns about NA-B related to residents being "very wet and not changed" through out the night and those were "continuous occurrences" which were reported to the licensed nurses; however NA-A was not able to give any further details related to dates or licensed nurses these concerns were reported to. On 1/11/23, at 12:53 p.m. care coordinator (CC)-A indicated during interview R1 had a "slight" decline in cognition but was able to express needs and concerns. CC-A indicated R1 had a communication deficit due to aphasia but if you gave R1 time she was able to express her needs. Further, CC-A indicated R1 required to be repositioned every 2-3 hours and whenever she requests, which included during the overnight. CC-A indicated she was not involved in the investigation of R1's allegation regarding NA-B other than the allegation was reported to the SA regarding "neglected to care for her" referring to R1. Further, CC-A indicated she was not aware of any complaints from staff regarding NA-B's work performance. On 1/11/23, at 1:40 p.m. interim director of	F 600			

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F 600	Continued From page 7 nursing (DON) indicated during interview when arriving to work on 12/27/22, staff reported R1 was "distraught" and "crying". DON went to speak with R1 and R1 reported she was in pain due to her feet being against the footboard of the bed and NA-B did not assist when R1 would turn on her call light. Further, DON indicated staff were expected to follow the care plan which directed staff to reposition R1 every three hours, which would be during the night as well, as proper bed positioning helps alleviate R1's pain in her hips and legs. DON confirmed NA-B had not repositioned R1 during the night of 12/26/22-12/27/22 but was not aware until surveyor asked and stated the incident could have been avoided had R1 been repositioned as required and as care plan indicated. DON confirmed education was not provided to staff related to answering call lights prior to start of survey and an email was sent to all staff on 1/10/23, as well as no education related to following care plans and repositioning. In addition, DON indicated she has had "numerous complaints about her [NA-B's] work performance from several staff members, she was terminated for her work performance in question related to not completing cares which was a lot of he said, she said too. We were trying to look into it further." DON indicated there had been only one formal coaching completed with NA-B related to repositioning in November 2022 and was unable to provide any evidence of work performance monitoring or auditing completed for NA-B despite being aware of complaints from her co-workers. When questioned further about NA-B's work performance DON then stated the concerns were not brought to her attention about NA-B neglecting residents but more concerns about NA-B being "lazy".	F 600			

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F 600	Continued From page 8 On 1/11/23, at 3:20 p.m. R1 was laying in bed with the head of bed slightly elevated and feet were not observed to be touching the foot board. R1 stated during interview she recalled an incident with a night aid who was "mean" and would not help R1 be boosted up in bed. R1 could not recall how long she was laying in her bed in pain but stated it felt like a while. R1 indicated the incident made her feel "mad, in pain" and indicated she was crying. Requested policy related to Care Plans, however, facility was not able to provide prior to survey exit. Facility did develop policy titled Using Care Plan Policy which was effective as of 1/13/23.	F 600			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 610			3/2/23

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F 610	Continued From page 9 by: Based on interview and document review, the facility failed to complete a thorough investigation following a neglect allegation for 1 of 1 residents (R1) reviewed when R1 alleged neglect by a staff member. Findings include: Review of facility report number 350590 to the State Agency (SA) dated 12/27/22, indicated nursing assistant (NA)-A was assisting R1 on the morning of 12/27/22, when R1 was tearful. R1 had reported to NA-A "that girl is a monster, I don't want her in here again" referring to NA-B, who worked the overnight shift. R1 reported her call light was on to request assistance from NA-B to get boosted up in bed as her left knee was hurting due to feet being against the footboard of the bed. R1 reported NA-B answered her call light but did not meet her needs and turned off the call light, this occurred four more times. R1 reported she was hollering out in pain during this time and did not have pain relief due to R1's feet remaining to be pressed against the footboard. In addition, R1 denied any lasting pain after relief of NA-A assisting but was "emotionally distraught". NA-B was suspended pending the investigation. Review of facility's 5-day investigation to the SA dated 1/3/23, indicated NA-B (alleged perpetrator) was interviewed, R1 was interviewed, and R1's care plan was updated regarding pain and communication. In addition, report indicated no verbal education was provided to NA-B "as she is no longer employed here for different reasons". On 1/11/23, at interim director of nursing (DON) indicated she completed the facility's 5-day	F 610	This plan of correction is the facilities credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by Assumption Home of the truth of the facts alleged or conclusion set forth in the statement deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. F610 Investigate/Prevent/Correct Alleged Violation SS=D CFR(s): 483.12(c)(2)-(4) It is the practice of Assumption Home to respond to allegations of abuse, neglect, exploitation, or mistreatment by thoroughly investigating the allegations and creating documentation as evidence of that investigation. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED: All residents of Assumption Home have the potential to be affected by the deficient practice; however, no similar findings and/or negative effects have been identified by this alleged deficient practice. The facility's corrective actions outlined below include policy, procedure and systemic changes; training and education; and monitoring and audits. POLICIES/PROCEDURES/SYSTEMIC CHANGES: " The reportable abuse investigation		

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F 610	Continued From page 10 investigation following R1's allegation. DON indicated the investigation consisted of interviewing other residents on the same unit as R1 and no additional concerns were expressed at that time. DON indicated she reviewed R1's care plan and updated the care plan related to pain management and communication. DON stated she did not interview any other staff that worked with NA-B the night of the alleged incident, 12/27/22. DON indicated she attempted to contact licensed practical nurse (LPN)-B who NA-B was working with on the overnight of 12/26/22-12/27/22, however attempt was unsuccessful as the call went to voicemail and DON did not make any other attempts other than by phone call. DON confirmed interviewed LPN-B would have been an important part of the investigation. Further, DON confirmed R1's record was not reviewed and did not interview NA-B on when R1 was last repositioned. DON indicated education regarding not answering call lights and if unable to meet resident needs to notify the nurse and ask for assistance which was not addressed prior to survey entrance when an email was sent to all staff on 1/10/23. Review of facility policy titled Resident Protection Program Policy dated 5/5/17, revealed the investigation process was used to determine what happened and must begin immediately. The investigation will include who was involved, resident statements, involved staff and witness statements.			F 610	packet is being reviewed and updated by the IDT team to stream line the process and make it easier for floor staff to initiate the investigation immediately. The new packet will be in place no later than February 20, 2022. The DON and ADON are responsible for ensuring that this action item is completed. " The Administrator, DON, ADON, LSW, HR and RNCCs will huddle whenever an incident is reported to OHFC. During the huddle, the team will delegate tasks to individuals along with a completion date. Until the 5-day report is submitted, this team will meet briefly each day after stand-up or as necessary to discuss the investigation. The Administrator and DON are responsible for ensuring that the huddles take place when required. " The reportable investigation process will be added to our agency/pool orientation packet. The Staff Development nurse and HR Manager are responsible for this action item. TRAINING/EDUCATION " The DON and ADON will meet with all licensed nurses one on one to review the new incident investigation checklist and packet and to train them on how to immediately initiate an investigation of a reportable incident. This education will be added to the licensed nurse onboarding competency checklist. The DON and ADON are responsible for this action item. " During the all-staff meeting mentioned in the correction for F600, staff will be trained on the policies and procedures for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/11/2023
NAME OF PROVIDER OR SUPPLIER ASSUMPTION HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 715 NORTH FIRST STREET COLD SPRING, MN 56320		
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F 610	Continued From page 11	F 610	investigating a reportable incident and the importance of timely responses to requests for interviews and witness statements so that the investigation is thorough and complete within the allotted 5 days. MONITORING/AUDITING: " For 2 months, within 1 week of submitting a 5-day investigative report, the IDT team will audit and review the investigation documentation for completeness. The results will be reported to the QAPI committee at the end of 2 months. " Once a week for 4 weeks and then once a month for 2 months, the Staff Development nurse will conduct random audits to verify that the licensed nurses understand the training they received on the new investigation checklist and packet. The Administrator and DON are responsible for overall compliance along with communicating results of audits to the QAPI Committee. The QAPI Committee will utilize audit data to guide future compliance monitoring and training. The facility alleges that it will be in substantial compliance and complete all action items by March 2, 2023.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 24, 2023

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

Re: Event ID: NMDI11

Dear Administrator:

The above facility survey was completed on January 11, 2023, 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please contact me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00624	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/11/2023
NAME OF PROVIDER OR SUPPLIER ASSUMPTION HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 1/10/23 through 1/11/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found be in compliance with the MN State Licensure.	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

02/03/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00624	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/11/2023
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2 000	Continued From page 1 The following complaint was found to be UNSUBSTANTIATED: H54467401C (MN89340). The following complaint was found to be SUBSTANTIATED: H54467078C (MN89649) with no licensing order issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			