DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 28, 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 24, 2023, we informed you that we may impose enforcement remedies.

On February 14, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 2, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 2, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 2, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 2, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Assumption Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 2, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 11, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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,

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

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 02/14/2023

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 2/13/23, through 2/14/23, 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, Requirments for Long Term Care Facilities. The following complaint was reviewed H54468306C (MN00090676), with a deficiency cited at F689. The following complaint was reviewed H54468455C (MN00091038. 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 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		3/2/23

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

Electronically Signed | 03/02/2023

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.

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 02/14/2023

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 689	Continued From page 1 by: Based on interview and document review, the facility failed to comprehensively assess fall risk and implement individualized interventions to reduce the risk of falls for 2 of 3 residents (R1, R3) reviewed for accidents. This resulted in actual harm for R1 who sustained fractures and for R3 who sustained a subdural hematoma after repeated falls and whom both required medical treatment or services. Findings include: R1's Inpatient Discharge Summary, dated 11/16/22, identified R1 fell three times prior to her hospital admission in which she sustained nasal fractures, left great toe fracture, distal right fibula fracture, and a left wrist fracture. She was discharged to the facility in stable condition with a good rehab potential and was expected to require services for less than 30 days. R1's admission Minimum Data Set (MDS), dated 11/23/22, identified R1 admitted to the facility on 11/16/22. She was severely cognitively impaired and received extensive physical assist for most cares. R1 relied on a wheelchair for locomotion and did not walk. She required staff assist to stabilize during transfers. R1 was diagnosed with a right fibula (lower leg) fracture, muscle weakness, urinary tract infection (UTI), dementia, anxiety disorder, and repeated falls. R1 lacked condition(s) or chronic disease(s) which resulted in a life expectancy of less than six months. R1's baseline care plan, dated 11/16/22, identified R1 to be at risk for falls related to her impaired mobility, multiple fractures, and history of falls in which R1 would be safe and free from falls. The	F 689	F689 Free from Accident Hazards/Supervision/Devices SS=G CFR(s): 483.25(d)(1)(2) 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. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED: At the time of the survey R1 and R3 had been affected by this deficient practice. R1 was deceased and R3□s condition had declined to the extent that this resident was at a lower risk for falling and the interventions were appropriately care planned. 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. The DON/ADON and other RNCCs	

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 02/14/2023

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 689	Continued From page 2 care plan directed staff to orient R1 to her room and call light system and to provide R1 with reminders as often as necessary, along with reviewing fall prevention with R1's representative on admission and to follow physical therapy (PT) and occupational therapy (OT) instructions for mobility function. The care plan identified R1 was non-weight bearing to her right leg, was not to ambulate, and required "full assist" for transfers and further directed staff to "assess for incontinence" every two hours and as needed (PRN). R1's discharge goal was to turn to her prior living facility. R1's medical record identified the following entries and identified information: -A progress note, dated 11/17/22, at 9:00 p.m. R1 was found on the floor. Per R1's statement, she tried to reach the door and slipped from the wheelchair (w/c). R1 was educated to use her call light and ask for help. -A progress note, dated 11/18/22, at 3:52 a.m. R1 was "checked" on every 30 minutes throughout the shift to prevent falls. -A progress note, dated 11/20/22, at 9:15 p.m. R1 required assist of 2 staff with a standing mechanical lift, was non-compliant with non-weight bearing transfer orders, and "self-transferred during shift." -A progress note, dated 11/21/22, at 1:26 a.m. R1 "self-transfers most of the time. [R1] should be monitored every 30 minutes for fall risk." -A progress note, dated 11/21/22, at 1:40 a.m. R1 was "checked every 15 to 30 min[utes]" to ensure she was not self-transferring or unstable. R1 was "very confused" and "writer stayed with [R1] throughout the shift as it was unsafe for [R1] to leave her alone in her room." -A progress note, dated 11/21/22, at 10:41 a.m.	F 689	audited all residents for fall history. Five residents found to have 3 or more falls in the last 90 days had a comprehensive fall evaluation. All care plans are updated for the five identified residents. POLICIES/PROCEDURES/SYSTEMIC CHANGES The DON and ADON have reviewed and revised the policies and procedure for fall prevention, fall management, accidents and supervision as appropriate. The DON/ADON have created and implemented the IDT Focused Review: Falls Comprehensive Falls Analysis to facilitate comprehensive fall evaluation approach for all residents identified as appropriate that incorporates input from IDT, floor staff, family and the resident□s provider and also the RNCC Fall Check List. TRAINING/EDUCATION The management team was educated on the following topics: 1. The revised Policy and Procedure on fall management and prevention, accidents and resident supervision. 2.RNCC Fall Check List 3.The process and criteria for conducting a comprehensive fall evaluation. MONITORING/AUDITING	

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 02/14/2023

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 689	Continued From page 3 R1 was found seated on the floor by her doorway around 7:10 a.m. R1 stated she got herself up from the bed and lowered herself to the floor as no one came when she needed help. An associated, same day, Risk Management (incident report) identified an intervention for anti-roll back breaks to be applied to her w/c. R3's care plan identified, on 1/9/23 (over a month and a half later), anti-roll breaks were initiated. -A progress note, dated 11/22/22, at 12:59 a.m. R1 self-transferred into her w/c from her bed. R1 was kept in one of the day rooms since she felt anxious in her room. Music was played for her which helped calm her. R1 "will be monitored closely." A Fall Review Evaluation, locked 11/23/22, identified R1's prior falls and identified the following factors which contributed to R1's fall risk: psychotropic drug use, memory loss, occasional bladder incontinence, use of assistive device(s), and decrease in muscle coordination. The evaluation summary identified R1 was at risk for falls related to her fracture diagnoses, muscle weakness, UTI, dementia and history of falls, her required assist for transfers and the use of a mechanical lift, and her non-ambulation status. The summary interventions directed staff to orient her to her room, the call light system, and to "give reminders." In addition, anti-roll back breaks were to be added to her wheelchair and staff were to ensure R1 wore non-slip footwear at all times as she allowed. R1 also worked with physical and occupational therapy to improve her mobility. The evaluation lacked identification of R1's numerous self-transfer attempts, observed anxiety, and/or analysis related to the falls on 11/17/22 and 11/21/22.	F 689	The DON or designee will audit the post fall process for completion and adherence to the newly revised policy and procedures for 30 days and then reassess the need to continue auditing 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.	

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 02/14/2023

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 689	Continued From page 4 R1's progress notes, dated 11/23/22 through 11/28/22, identify each day R1 displayed self-transfer actions. Falls Care Area Assessment (CAA), dated 11/29/22, identified R1 was at risk for falls related to her fall history and "casts," antipsychotic and antidepressant medications, wandering behavior, infection, incontinence, anxiety disorder, and dementia in which R1 was "pleasantly confused." The CAA's Care Plan Considerations section indicated the care plan objective was to avoid complications with the hopes R1 would be able to return to her assisted living facility after she worked with therapy. The CAA lacked details of R1's 11/17/22 and 11/21/22 falls or her self-transfer habits. The CAA lacked evidence staff completed a comprehensive fall assessment and/or analysis or individualized intervention(s) identification based on R1's fall risk. A review of R1's comprehensive care plan demonstrated a lack of additions and/or adjustments to fall risk related problems, goals, and/or interventions after the 11/29/22 CAA process. In addition, R1's care plan lacked R1's self-transfer actions. R1's subsequent medical record identified the following entries and identified information: -An incident report, dated 12/14/22, at 7:00 a.m. R1 was found sitting on the floor in her room's entryway with a sustained skin tear on her lower leg. Her locked w/c was next to her bed. R1 stated she wanted to get up for the day and fell. R1's symptoms were reviewed with her provider, and she tested positive for a UTI. -A progress note, dated 1/3/23, R1 was found sitting on the floor in her room's doorway at 5:35	F 689		

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 02/14/2023

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 689	Continued From page 5 p.m. Her locked w/c was next to her bed. R1 stated she tried to get out of bed. The incident report identified to "offer afternoon activity." R1's care plan lacked the intervention. -A progress note, dated 1/12/23, R1 was found sitting in her room's doorway: her w/c in the bathroom (BR). R1 self-transferred "frequently this night" and "utilized the [BR] many times." The incident report identified R1 stated she fell in the BR and pushed herself toward the door. R1 was reminded to utilize her call light and wait for staff assistance (despite this intervention have not been effective and R1's diagnosis of severely cognitively impaired). -A progress note, dated 1/20/23, at 3:00 a.m., on 1/19/23, at 11:30 p.m. R1 informed staff she fell in the BR. Staff identified a left elbow bruise. In addition, R1 was found sitting on the therapy room floor at 1:30 a.m. R1's w/c was in her BR turned upside down. R1 stated her left rib hurt and she had new bruising to her left leg and breast. The incident report identified R1 was provided with a snack and placed within sight of staff "for about an hour" and then assisted into bed. -A progress note, dated 1/23/23, R1 was found sitting on the floor in her room's doorway at 11:50 a.m. Her w/c was behind the door. R1 stated she tried to walk out to "look around." The incident report identified R1's care plan was updated to keep R1's w/c next to her bed with the breaks locked at all times when R1 was in bed. The care plan lacked the intervention. -A progress note, dated 2/8/23, R1 was found sitting on the hallway floor outside of her room at 3:00 a.m. R1 was toileted and assisted back to bed. The incident report identified an intervention for Actogram (sleep/wake cycle monitoring) watch to be performed for three days and reviewed	F 689		

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 02/14/2023

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 689	Continued From page 6 upon completion. R1's medical record lacked documented evidence the Actogram recording period from 12/8/22 to 12/13/22 was reviewed and/or followed up on. -A progress note, dated 1/25/23, R1 demonstrated urinary frequency and urgency, increased confusion, and "noted to have multiple falls recently." Orders provided to test R1's urine for infection. A subsequent progress note, dated 1/26/23, identified positive urine results and an antibiotic was started. -A progress note, dated 1/27/23, at 8:57 p.m. R1 was found scooting on the floor coming out of her room with an abrasion on her forehead. The incident report identified R1 stated she tried to go to the BR and fell. Staff followed up with therapy about an ambulation program (per a progress note, this follow-up occurred on 1/30/23); however, therapy deemed it inappropriate due to safety concerns. Instead, staff were to utilize as needed (PRN) essential oils on her pillow to encourage rest and relaxation. R1's care plan identified, on 2/2/23 essential oil use was added. -A follow-up progress note, dated 1/27/23, at 9:09 p.m. causal factors for R1's 1/27/23 fall were determined to be R1's current UTI, toileting needs, and that R1 failed to use her call light to ask for assistance. R1 had a history of multiple falls. Interventions included bowel and bladder evaluation and aromatherapy. -R1's treatment administration records (TAR), dated 1/23, identified PRN essential oil aromatherapy orders initiated on 11/16/23. The TAR lacked evidence R1 was provided with essential oil aromatherapy on 1/27/23 through 1/31/23. -A progress note, dated 1/28/23, at 12:24 a.m. R1 was found sitting on the hallway floor outside of her room at 11:00 p.m. R1's unlocked w/c was in	F 689		

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 02/14/2023

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 689	Continued From page 7	F 689		

her BR. R1 stated she attempted to go to the BR. The incident report, identified R1's provider and dietary were consulted (per a progress note, dated 1/30/23, this consult occurred) to add a nutritional supplement to promote adequate caloric intake to help reduce falls if R1 possibly experienced discomfort due to hunger and inability to communicate hunger (per a progress note, dated 1/31/23, the order was provided).
-A progress note, dated 1/31/23, at 12:00 a.m. identified R1 was found on her BR floor. Her unlocked w/c was in the BR doorway. R1's left shoulder was assessed to be "more distended out of place than her right" and R1 complained her shoulder and left hip hurt. Per a follow-up note, at 2:58 a.m. R1 was sent to the emergency room (ER).

R1's care plan identified on 2/2/23 intervention implementation that directed staff to review information on past falls and attempt to determine the cause of the falls with recording of possible root causes, removal or alter any potential causes if possible, and to educate R1/family/caregivers/interdisciplinary team. R1's medical record lacked evidence such a review was completed.

R1's Inpatient Discharge Summary, dated 2/3/23, identified R1 was diagnosed with failure to thrive with recurrent falls and fall injuries of a left shoulder dislocation, L1 and L2 lumbar spinal fractures, 12th rib fracture, left sacral (base of spine) fracture, and left pubic rami (pelvic) fractures. R1's physical condition at discharge was terminal and hospice end of life/comfort care was ordered.

A progress note, dated 2/7/23, identified R1

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 02/14/2023

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 689	Continued From page 8 displayed restlessness, yelled out 'help me,' and was observed to "sit up in bed" four times. A Fall Review Evaluation, dated 2/10/23, identified R1 was at risk for falls related to fractures, muscle weakness, UTI, dementia, and history of falls. R1 was unresponsive and bedbound in which comfort care and safety while in bed continued. A progress note, dated 2/10/23, identified R1 passed away at 12:15 a.m. R1's medical record identified R1's fall risk was assessed on 11/23/22 and 2/10/23 based on the MDS process; however, the record lacked comprehensive fall risk assessments and/or analysis were completed after R1's multiple falls in order to develop, adjust, and/or monitor for effectiveness, individualized care plan interventions to mitigate R1's fall and/or fall injury risk. When interviewed on 2/13/22, at 2:47 p.m. trained medication aide (TMA)-A stated she would find fall interventions in the resident's care plan or on the Kardex. TMA-A explained R1 "constantly" utilized the BR and did not sleep well at night. Staff assisted R1 to bed and a minute after staff walked away R1 would self-transfer. Once R1 returned from the hospital, R1 often requested the bedpan and she witnessed R1 lean forward in bed. TMA-A stated she heard in report R1 was observed seated edge of bed "when she was not supposed to." TMA-A explained that prior to R1's hospital stay being around people was overall the only thing that calmed R1. She indicated R1's status upon her return was a shock as R1 was making progress in her prior	F 689		

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 02/14/2023

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 689	Continued From page 9 recovery and staff talked about R1's return to her previous facility. TMA-A denied involvement in a comprehensive analysis of R1's falls and she stated she lacked knowledge of any new fall risk interventions for R1 once she returned from the hospital. When interviewed on 2/14/23, at 10:50 a.m. R1's nurse practitioner (NP)-A stated R1 was a "ball of anxiety" when she was admitted in which she had a history of falls. Despite this, R1's discharge plan was for her to rehab and return back to her previous facility. R1's anxiety and impulsiveness improved with medication changes; however, she continued to have significant poor safety awareness. NP-A acknowledged other than trying "to settle [R1's] mind to keep her from "going so fast," she was unaware of R1's care planned fall interventions. She verbalized she was unaware of R1's urinary status and the frequency of which staff assisted her to the BR. NP-A denied she was involved in a comprehensive analysis of R1's falls to determine details that may have been used to decrease R1's fall risk or fall related injuries. NA-A confirmed she was unaware of the exact cause of R1's death; however, she explained "the fall and fractures did not help." During interview on 2/14/23, at 11:13 a.m. R1's family (FM)-A stated R1 had a long history of falls in which she knew at some point a fall related break "was going to be the death of [R1]." FM-A identified she was involved in "care conferences" with the facility in which they discussed R1's "overall health;" however, she denied they discussed R1's falls. She explained those meetings focused on the progress R1 made with therapy and the hope R1 would be able to return to her prior memory care facility.	F 689		

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 02/14/2023

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 689	Continued From page 10 When interviewed on 2/14/23, at 1:09 p.m. nursing assistant (NA)-C confirmed she took care of R1 on 1/30/23 in which R1 was "her usual self:" super confused, hard to redirect, and had a short attention span. She denied that on 1/30/23 R1 displayed any signs or symptoms which would have identified declines in her medical or overall status. NA-C explained R1 often self-transferred and was "hard to catch:" one moment R1 was in her w/c and the next in bed or vice versa. NA-C stated R1 slept poorly at night and often "napped much of the shift prior." R1 also frequently utilized the BR which NA-C thought R1 used to calm herself down. NA-C explained she often attempted to keep R1 distracted, entertained, and within her sight as much as able. NA-C denied management staff talked with her related to R1's fall risk factors and which interventions were effective and which ones were not. During interview on 2/14/23, at 1:24 p.m. licensed practical nurse (LPN)-A stated she was expected to initially investigate a resident's fall, initiate a Risk Management incident report, and implement an immediate fall risk intervention to mitigate further falls. After that, a care coordinator would review, adjust the intervention as needed, and care plan it. LPN-A confirmed the coordinator followed up with her after she managed a residents fall; however, she denied she was ever involved in any sort of comprehensive analysis of resident fall(s) to determine details that may have been used to decrease resident fall risks or fall related injuries with R1. LPN-A stated R1 "was a roamer" and she attempted to keep R1 as close to her as able. She explained R1 was quick, and staff could assist her to bed one moment and then the next she was by them needing some sort	F 689		

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 02/14/2023

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 689	Continued From page 11 of assist. R1 "always had to go to the BR" and staff "could tell her over and over she needed help, but she did not have the capability to remember that." LPN-A confirmed not all of the interventions they attempted with R1 were on her care plan and/or Kardex: "We should all know the interventions, but probably could have been in the Kardex." LPN-A explained she was unsure of what interventions would have worked for R1 other than to provide R1 with 1:1 supervision at all times. LPN-A confirmed R1 was not provided 1:1 supervision at all times. LPN-A stated R1 was "stable before her hospital stay: They were talking about sending her back to [prior memory care facility]." When interviewed on 2/14/23, at 1:40 p.m. registered nurse (RN)-C stated she expected staff to make sure an immediate intervention was implemented after a resident fall which was based on the nature of the fall and either documented in the progress notes or on the incident report: not just passed on during shift to shift report. Then, she explained, they reviewed the fall, the intervention, adjusted the intervention as needed, and initiated it within the care plan. RN-C stated fall risk assessments were completed with the MDS process and she denied they completed a comprehensive fall risk assessment and/or analysis of R1's falls outside of this process or met with the IDT (interdisciplinary team) to discuss and analyze R1's falls. She verbalized if a resident had multiple falls, a comprehensive fall and fall risk analysis was very important in order to determine the root cause of the fall, to prevent injury, and to keep residents safe; however, she was unaware of the facility policy and/or protocols on fall assessments if a resident were to have multiple	F 689		

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 02/14/2023

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 689	Continued From page 12 falls. After RN-C reviewed a Fall Review Evaluation, she stated the evaluation "did not have everything you would look at to analyze" falls and fall risk. RN-C explained R1 was "compulsive" with her transfers in which she followed up with therapy about a walking program or exercising; however, therapy disagreed related to R1's dementia and not wanting R1 to be triggered into thinking she could walk on her own. RN-C described interventions attempted for R1 which were present on her care plan prior to her hospitalization. RN-C confirmed R1's fall interventions were not adjusted and/or new interventions implemented once R1 returned. RN-C stated R1 was "stable" prior to her hospitalization. R3: R3's Initial Intake provider visit progress note, dated 11/4/23, identified R3 was admitted to the facility on 11/3/22, after he required hospitalization as a result of frequent falls and a UTI. R3's admission MDS, dated 11/10/22, identified R3 was severely cognitively impaired and required limited to extensive physical assist for cares. R3 relied on a w/c for locomotion and showed minimal walking. R3 diagnosis was polyneuropathy, UTI, Alzheimer's Disease, dementia, muscle weakness, and repeated falls. R3's baseline care plan, initiated 11/3/22, identified R3's fall risk related to impaired mobility and cognition, and history of falls in which he would be safe and free from falls. The care plan directed staff to orient R3 to his room and call light system and to provide R3 with reminders as	F 689		

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 02/14/2023

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 689	Continued From page 13 often as necessary, along with reviewing fall prevention with R3's representative on admission and to follow physical therapy (PT) and occupational therapy (OT) instructions for mobility function. The care plan identified R3 required a Foley catheter in which staff were not to leave R3 unattended on the commode. On 11/10/22, the care plan was updated, after a bowel assessment was completed, which directed staff to offer and encourage R3 to toilet every two to three hours while awake. R3's medical record identified the following entries and identified information: -Progress notes, dated 11/5/22, 11/6/22, 11/7/22, 11/8/22, all identified R3 was alert and oriented to self only and "often" tried to self-transfer. -A progress note, dated 11/11/22, R3 ambulated with his walker to the manager's office while he held his catheter bag. He was assisted to his room and staff were to monitor for further episodes of self-transfers. A Fall Review Evaluation, locked 11/10/22, identified R3's prior to admission falls and identified the following factors which increased R3's fall risk: Alzheimer's Disease, dementia, polyneuropathy, osteoarthritis, weakness, altered mobility, indwelling urinary catheter, frequent bowel incontinence, and new admission. The evaluation summary identified the risk factors and directed staff to orient him to his new room, ensure the call light was within reach and to encourage him to wear proper footwear when out of bed. R3 also worked with PT and OT. The evaluation lacked identification of R3's numerous self-transfer/ambulation attempts. Fall CAA, dated 11/10/22, identified R3's fall	F 689		

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 02/14/2023

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 689	Continued From page 14 review evaluation risk factors and the use of antidepressant medication. The CAA's Care Plan Considerations section indicated the care plan objective was to avoid complications and to maintain his current level of functioning. R3's subsequent medical record identified the following entries and identified information: -A Fall Investigation report, dated 11/15/22, R3 self-ambulated in the hallway and staff intercepted his fall by lowering him to the floor. R3 stated he tried to 'fix/ find missing cable.' R3's Foley catheter tubing was pulled from his bladder and he was incontinence of bowel. R3 was brought back to his room, incontinence hygiene provided, a new catheter inserted, and he was encouraged to use his call light. R3's progress notes did not identify R3's 11/15/22 fall. -Progress notes, dated 11/16/22 and 11/17/22, R3 tested positive for COVID-19 with required room isolation and experienced increased weakness and difficulty with transfers. -An incident report, dated 11/17/22, at 2:35 p.m. R3 was found on the floor next to his bed. A progress note, dated 11/17/22, lacked evidence of R3's fall; however, the note identified R3 was free of injury, his vitals were stable, and he was encouraged to use his call light (despite the intervention or reminder not effective due to dementia). -A progress note, dated 11/18/22, R3 was ordered antibiotics based on urinalysis results [R3 was diagnosed with a UTI]. -A progress note, dated 11/20/22, at 2:18 a.m. R3 "often forgets" and required redirection back to room in which staff found "him back out of room/self transferring." -A progress note, dated 11/20/22, at 5:30 p.m. R3 was observed to be in his BR doorway when staff	F 689		

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 02/14/2023

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 689	Continued From page 15 intercepted a fall and lowered him to the floor. Staff placed him in bed after. The progress note and incident report lacked an identified fall analysis or new intervention. -A progress note, dated 11/24/22, R3 was observed self-ambulating down the hallway. -A progress note, dated 11/25/22, R3 "face planted" and sustained an abrasion to his forehead, fixed pupils, and double vision. [R3 was sent to the ER and admitted]. -A progress note, dated 11/29/22, at 1:34 a.m. R3 returned to the facility and required assist of two staff with a mechanical standing lift for transfers and that R3 was "noted to self transfer x1." A provider visit progress note, dated 12/5/22, identified R3 fell in November "during isolation with subdural hematoma and neuro changes, send to ER and hospitalized for [three] days." -A progress note, dated 12/2/22, at 3:21 p.m. R3 was found on the floor about a foot from his w/c. R3 stated he hit his head. Family denied ER transport. The incident report identified staff collaborated with therapy on R3's transfers and he had a UTI which required antibiotics. -A progress note, dated 12/5/22, R3 was found on the floor at 2:50 a.m. The incident report identified R3 was to have his w/c next to the bed when he was in bed. R3's care plan identified, on 1/10/23 (more than a month later), the intervention was initiated. A Fall Review Evaluation, dated 12/5/22, completed per facility MDS process(es), identified R3's fall history prior to and during his stay and identified the same evaluation summary and interventions as the 11/10/22 fall review evaluation, with the addition of the subdural hematoma diagnosis. The evaluation lacked identification of R3's numerous	F 689		

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 02/14/2023

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 689	Continued From page 16 self-transfer/ambulation attempts and/or analysis related to the falls which occurred after admission and hospital return. R3's subsequent medical record identified the following entries and identified information: -A progress note, dated 12/9/22, at 2:48 a.m. R3 was lowered to the floor when he became weak after he was found attempting to walk with his w/c near the dining room (DR). The incident report identified Actogram watch would start on 12/12/22. R3's medical record lacked documented evidence the Actogram recording period was reviewed and/or followed up on. -Progress notes, dated 12/9/22, 12/10/22, and 12/12/22, R3 self-transferred multiple times each day. -A progress note, dated 12/12/22, R3 was found on the floor at 3:00 p.m. after he was in his bed. Identified intervention directed for gripper socks instead of regular socks. R3's care plan identified, on 12/15/22 (three days later), R3 was to be "highly encourage[d]" to use non-slip footwear at all times. -A progress note, dated 12/17/22, R3 was found sitting on the floor with his back against the bed at 8:20 p.m. R3 was incontinent of bowel and a spilled water cup was on the floor by his bed. He was assisted into bed and bowel hygiene provided. The incident report identified staff were to ensure R3's bed was kept at a therapeutic height to set R3 up for successful self-transfers due to history of impulsivity and self-transferring. On 12/19/22, R3's care plan identified "Low Bed" and lacked identification of "therapeutic height" directives. -Progress notes, dated 12/19/22 and 12/29/21, R3 self-ambulated from his room "down Northwoods hallway" and self-transferred and	F 689		

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 02/14/2023

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 689	Continued From page 17 ambulated in the DR, respectively. A Fall Review Evaluation, dated 12/30/22, completed per facility MDS process(es), identified R3's fall history prior to and during his stay and identified the same diagnoses as past evaluations; however, included R3 showed poor safety awareness and impulsivity which increased his fall risk. The fall summary identified the following interventions: Actigraphy PRN, therapeutic bed height, non-slip footwear at all times (highly encouraged), assistance with safety reminders PRN, and orientation to room and call light. The evaluation lacked identification of R3's numerous self-transfer/ambulation attempts and/or analysis related to the falls which occurred after admission and hospital return. R3's subsequent medical record identified the following entries and identified information: -A progress note, dated 1/1/23, at 3:24 p.m. R3 was found sitting on the floor in an adjacent unit "Pod" area. The incident report identified foot pedals to be stored in w/c bag when R3 was not assisted with locomotion. R3's care plan identified, on 1/19/23 (18 days later), initiation of the intervention. -A progress note, dated 1/5/23, R3 was found lying on the floor next to his w/c in the DR at 4:30 p.m. R3 sustained a right elbow "scrape." The incident report identified staff collaborated with R3's provider in which orders were provided for an antipsychotic medication related to impulsivity, poor safety awareness, and behaviors. -A progress note, dated 1/6/23, at 2:16 p.m. R3 was found outside of his room on his hands and knees. R3 was brought to the DR and provided a snack. The incident report identified R3 was unsafe to be in his room alone while in his w/c.	F 689		

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 02/14/2023

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 689	Continued From page 18 R3's care plan identified, on 1/10/23 (four days later), R3's unsafe room status. -A progress note, dated 1/8/23, at 11:09 p.m. R3 was found sitting on the DR floor. He was incontinent of bowel. R3 was provided bowel hygiene care and assisted to bed. The incident report identified to offer R3 toileting after meals. R3's care plan identified, on 1/10/23 (two days later), the intervention was initiated. -A progress note, dated 1/9/23, R3 was found on his BR floor leaning against his BR door around 1:50 p.m. R3 was previously in his recliner. At the time of the fall, the recliner footrest remained elevated. An intervention was implemented to unplug the recliner, leave in a stationary position, and to store the remote in a manager's office. R3's care plan lacked the intervention. -A progress note, dated 1/13/22, R3 started an antibiotic for a UTI. -A progress note, dated 1/16/23, R3 attempted to standup from his w/c throughout the shift despite a bath, snacks, and being kept as close to staff, "as much as possible or with in eyesight." -A progress note, dated 1/17/23, at 8:03 p.m. R3 was found on the floor near the nurse's station. R3 stated he attempted to walk to another resident so he could help him. The incident report identified an intervention for a hospice evaluation and medication review with rounding provider. R3's care plan identified, on 1/17/23, an intervention to keep frequently used items within R2's reach with each interaction. -A progress note, dated 1/18/23, at 9:14 a.m. activity staff were to increase one on one (1:1) activities with R3. R3's care plan lacked the intervention. -A progress note, dated 1/19/23, at 6:49 p.m. R3 was found kneeling on the floor next to his w/c in the DR. R3 stated he attempted to get into	F 689		

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 02/14/2023

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 689	Continued From page 19 another chair situated next to the DR table. R3 was assisted to the BR and had a BM. -A progress note, dated 1/21/23, R3 was found crawling on the DR floor at 6:00 p.m. The incident report identified hourly safety checks. R3's care plan identified, on 1/23/23 (two days later), the intervention was initiated. -A progress note, dated 1/22/23, at 1:29 a.m., R3 was found on his BR floor at 12:30 a.m. during midnight rounds and assessed to have a skin tear on his knee. He was taken to the BR and had a BM. The incident report identified to offer R3 toileting after all meals and prior to bedtime. R3's care plan identified, on 1/23/23 (one day later), R3's toileting plan was revised. -A progress note, dated 1/22/23, at 10:34 a.m. R3 was found kneeling on his bedroom floor by his recliner with his locked w/c next to the bed. R3 stated he 'needed to go over there.' The incident report identified a medication review and hospice nurse consult with another review on 1/26/23 to see if recommended increased PRN medication usage was effective. A Fall Review Evaluation, dated 1/25/23, completed per facility MDS process(es), identified the following fall risk summary for R3: R3 was alert but lethargic and only oriented to self. He required mechanical sit to stand lift for transfers and was non-ambulatory in which he continued to make multiple self-transfer attempts per day and attempted to walk. He was unsuccessful in this which led to "numerous" falls in the past quarter. "Will continue to closely work with hospice team and [medical provider] to monitor and minimize falls." The summary listed the following fall interventions: those listed with the 12/30/22 fall evaluation, foot pedals storage, items within reach, hourly safety checks, medication reviews,	F 689		

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 02/14/2023

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 689	Continued From page 20 "offer" toileting plan, unsafe to be in room alone in w/c, and w/c next to bed when in bed. The evaluation lacked specific information related to R3's falls. R3's subsequent medical record identified the following entries and identified information: -A progress note, dated 1/31/23, at 3:58 p.m. R3 was found lying on his back on his bedroom floor. The incident report identified medications were reviewed with R3's provider and medication changes were ordered on 2/1/23. -A progress note, dated 2/9/23, R3 had increased declines in his status with no oral intake and little to no output in which he remained in bed that shift. Hospice chaplain visited with him and provided R3 with last rights. -A progress note, dated 2/10/23, R3 continued with declines in which he required a full mechanical lift for all transfers and a Broda (specialized reclining) w/c. R3's medical record identified R3's fall risk was assessed on based on the MDS process; however, the record lacked comprehensive fall risk assessments and/or analysis were completed after R3's multiple falls in order to develop, adjust, and/or monitor for effectiveness, individualized care plan interventions to mitigate R3's fall and/or fall injury risk. During interview on 2/13/23, at 11:57 a.m. RN-A stated she was a contracted agency staff. She explained she expected a resident's fall risk and all associated interventions to be identified on the care plan and/or Kardex (nursing assistant care plan) as these were the two sources of information she reviewed when she needed to know expected care for a resident and/or where	F 689		

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 02/14/2023

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 689	Continued From page 21 she directed other staff to go when they had questions. RN-A stated, after a resident fall, a house charge was updated, and an intervention was to be initiated right away. When interviewed on 2/14/23, at 11:28 a.m. R3's FM-B stated staff attempted to keep R3 in the "common area" and reminded him "to not get up;" however, FM-B was unsure as to any other interventions staff attempted to keep R3 from falling. FM-B explained when R3 was first admitted, he talked with staff and updated them R3's fall history centered around R3 falling in the evening so that staff would have a "heads up." He denied staff conversed with him after that for his input to help mitigate falls and fall risk. During interview on 2/14/23, at 11:40 p.m. R3's NP-B stated awareness of R3's "multiple falls," in which staff "have done the typical interventions;" however, R3 displayed "very poor safety awareness" and impulsivity which increased his fall risk. In addition, because of R3's decreased cognitive and communication abilities, she and staff experienced a harder time determining, and assessing, R3's medical status fall risks as he was not able to explain information to them and/or reliably answer status questions. NP-B explained she focused more on medication management related to R3's behaviors and falls versus non-pharmacological fall interventions. NP-B explained she conversed with nurse managers in the past about R3; however, she denied involvement in a comprehensive fall and intervention process outside of R3's medication management. When interviewed on 2/14/23, at 12:39 p.m. RN-B stated the facility management expected	F 689		

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 02/14/2023

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 689	Continued From page 22 her to implement and care plan a fall intervention when a resident fell. In addition, she stated, if she were not present at the time of the fall, she expected staff implemented "some sort of intervention" which was reported off each shift, and then once she returned to work she reviewed the intervention(s) and then updated the care plan. Staff were provided with a list of interventions to choose from to assist in intervention determination if she was not available at the time of the fall. RN-B stated interventions were based on the fall situation(s) and/or the residents status. She explained falls were discussed during IDT meetings and then any new interventions were reported on during the floor staffs' "stand-up" meetings; however, "standard [fall risk] assessment[s]" were conducted only during the MDS process. She denied R3's falls and fall risk were comprehensively assessed and/or analyzed outside of the MDS schedule. When interviewed on 2/14/23, at 1:09 p.m. NA-C stated she considered R3 a fall risk; however, due to R3's current medical status, the risk was now much lower. NA-C explained R3 was " not there completely" and thus verbal reminders and cues for safety were not effective for him. She explained, in order to stop R3 from falling prior to his recent declines, he would have had to be care planned for 1:1 supervision. NA-C denied R3 was provided 1:1 supervision. NA-C denied management staff talked with her related to R3's fall risk factors and which interventions were effective and which ones were not; however, she followed up with, staff were aware of how [R3] was [self-transferring/ambulating] and not sleeping." During interview on 2/14/23, at 3:54 p.m. director	F 689		

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 02/14/2023

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 689	Continued From page 23 of nursing (DON) stated falls were reviewed during morning IDT meetings where staff went over "the fall" and developed interventions which the care coordinator added to the care plan. The DON confirmed IDT only reviewed the most current fall brought to the meeting and denied the IDT analyzed all of a resident's falls, or multiple falls, at one time. She stated such an analysis was important to determine the root cause of falls in order to be more proactive versus reactive. The DON stated she expected staff to initiate an immediate individualized fall intervention, based on the fall factors, to keep the resident "safe in that moment" and to document the intervention in the incident report and/or the progress note. She explained if an intervention was not individualized as much as possible the care plan was "probably not the most effective." After R1 and R3's fall information was reviewed, the DON stated, "I can see where there are concerns: interventions are not as solid as they could have been ...missing ...or the care plan as solid as it could have been." She explained she expected the care plan to "reflect a little bit more" of the fall risk details for both R1 and R3. More comprehensive care plans ensured staff knew what do to for the residents, especially for those staff who were contracted. A policy, Falls Prevention, revised 3/21, directed a resident's fall risk would be assessed within one week of admission, quarterly, annually, with a significant change of condition, and PRN by an RN. Based on the assessment, the care plan was to be updated with an "appropriate" problem statement, goals, and associated interventions. A policy, Falls Management, revised 12/22, identified it was a policy of the facility to implement resident care plans to reduce the risk	F 689		

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 02/14/2023

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 689	Continued From page 24 of falls and associated injuries when a fall occurred. The policy directed the nurse was to implement treatment and fall interventions based on resident assessment and fall investigation processes which was to be documented within the Risk Management incident report to allow the IDT to complete further analysis of the incident. After, the RN Clinical Coordinator was to follow-up with a fall analysis and complete the Safety Analysis portion of the assessment with details that addressed "Fall History" analysis of potential causative factors and patterns, a reviewal of the fall prevention plan and potential high risk contributing factors, the decision making process of the IDT, and interventions deemed appropriate with an emphasis on the root cause.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 28, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: GHNH11

Dear Administrator:

The above facility was surveyed on February 13, 2023 through February 14, 2023 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:

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

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 feel free to call me with any questions.

Sincerely,

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

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 02/14/2023

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 2/13/23, through 2/14/23, a complaint survey was conducted at your facility by a surveyor 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		

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 02/14/2023

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	Continued From page 1 The following complaint was reviewed during the survey: H54468306C (MN00090676) with a licensing order issued at 0830. The following complaint was reviewed during the survey: H54468455C (MN00091038). 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	2 000		

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 02/14/2023

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	Continued From page 2 not required at the bottom of the first page of 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess fall risk and implement individualized interventions to reduce the risk of falls for 2 of 3 residents (R1, R3) reviewed for accidents. This resulted in actual harm for R1 who sustained fractures and for R3 who sustained a subdural hematoma after repeated falls and whom both required medical treatment or services.	2 830	Corrected	3/2/23

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 02/14/2023

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
2 830	Continued From page 3 Findings include: R1's Inpatient Discharge Summary, dated 11/16/22, identified R1 fell three times prior to her hospital admission in which she sustained nasal fractures, left great toe fracture, distal right fibula fracture, and a left wrist fracture. She was discharged to the facility in stable condition with a good rehab potential and was expected to require services for less than 30 days. R1's admission Minimum Data Set (MDS), dated 11/23/22, identified R1 admitted to the facility on 11/16/22. She was severely cognitively impaired and received extensive physical assist for most cares. R1 relied on a wheelchair for locomotion and did not walk. She required staff assist to stabilize during transfers. R1 was diagnosed with a right fibula (lower leg) fracture, muscle weakness, urinary tract infection (UTI), dementia, anxiety disorder, and repeated falls. R1 lacked condition(s) or chronic disease(s) which resulted in a life expectancy of less than six months. R1's baseline care plan, dated 11/16/22, identified R1 to be at risk for falls related to her impaired mobility, multiple fractures, and history of falls in which R1 would be safe and free from falls. The care plan directed staff to orient R1 to her room and call light system and to provide R1 with reminders as often as necessary, along with reviewing fall prevention with R1's representative on admission and to follow physical therapy (PT) and occupational therapy (OT) instructions for mobility function. The care plan identified R1 was non-weight bearing to her right leg, was not to ambulate, and required "full assist" for transfers and further directed staff to "assess for incontinence" every two hours and as needed (PRN). R1's discharge goal was to turn to her	2 830		

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 02/14/2023

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
2 830	Continued From page 4 prior living facility. R1's medical record identified the following entries and identified information: -A progress note, dated 11/17/22, at 9:00 p.m. R1 was found on the floor. Per R1's statement, she tried to reach the door and slipped from the wheelchair (w/c). R1 was educated to use her call light and ask for help. -A progress note, dated 11/18/22, at 3:52 a.m. R1 was "checked" on every 30 minutes throughout the shift to prevent falls. -A progress note, dated 11/20/22, at 9:15 p.m. R1 required assist of 2 staff with a standing mechanical lift, was non-compliant with non-weight bearing transfer orders, and "self-transferred during shift." -A progress note, dated 11/21/22, at 1:26 a.m. R1 "self-transfers most of the time. [R1] should be monitored every 30 minutes for fall risk." -A progress note, dated 11/21/22, at 1:40 a.m. R1 was "checked every 15 to 30 min[utes]" to ensure she was not self-transferring or unstable. R1 was "very confused" and "writer stayed with [R1] throughout the shift as it was unsafe for [R1] to leave her alone in her room." -A progress note, dated 11/21/22, at 10:41 a.m. R1 was found seated on the floor by her doorway around 7:10 a.m. R1 stated she got herself up from the bed and lowered herself to the floor as no one came when she needed help. An associated, same day, Risk Management (incident report) identified an intervention for anti-roll back breaks to be applied to her w/c. R3's care plan identified, on 1/9/23 (over a month and a half later), anti-roll breaks were initiated. -A progress note, dated 11/22/22, at 12:59 a.m. R1 self-transferred into her w/c from her bed. R1 was kept in one of the day rooms since she felt anxious in her room. Music was played for her	2 830		

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 02/14/2023

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
2 830	Continued From page 5 which helped calm her. R1 "will be monitored closely." A Fall Review Evaluation, locked 11/23/22, identified R1's prior falls and identified the following factors which contributed to R1's fall risk: psychotropic drug use, memory loss, occasional bladder incontinence, use of assistive device(s), and decrease in muscle coordination. The evaluation summary identified R1 was at risk for falls related to her fracture diagnoses, muscle weakness, UTI, dementia and history of falls, her required assist for transfers and the use of a mechanical lift, and her non-ambulation status. The summary interventions directed staff to orient her to her room, the call light system, and to "give reminders." In addition, anti-roll back breaks were to be added to her wheelchair and staff were to ensure R1 wore non-slip footwear at all times as she allowed. R1 also worked with physical and occupational therapy to improve her mobility. The evaluation lacked identification of R1's numerous self-transfer attempts, observed anxiety, and/or analysis related to the falls on 11/17/22 and 11/21/22. R1's progress notes, dated 11/23/22 through 11/28/22, identify each day R1 displayed self-transfer actions. Falls Care Area Assessment (CAA), dated 11/29/22, identified R1 was at risk for falls related to her fall history and "casts," antipsychotic and antidepressant medications, wandering behavior, infection, incontinence, anxiety disorder, and dementia in which R1 was "pleasantly confused." The CAA's Care Plan Considerations section indicated the care plan objective was to avoid complications with the hopes R1 would be able to return to her assisted living facility after she	2 830		

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 02/14/2023

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
2 830	Continued From page 6 worked with therapy. The CAA lacked details of R1's 11/17/22 and 11/21/22 falls or her self-transfer habits. The CAA lacked evidence staff completed a comprehensive fall assessment and/or analysis or individualized intervention(s) identification based on R1's fall risk. A review of R1's comprehensive care plan demonstrated a lack of additions and/or adjustments to fall risk related problems, goals, and/or interventions after the 11/29/22 CAA process. In addition, R1's care plan lacked R1's self-transfer actions. R1's subsequent medical record identified the following entries and identified information: -An incident report, dated 12/14/22, at 7:00 a.m. R1 was found sitting on the floor in her room's entryway with a sustained skin tear on her lower leg. Her locked w/c was next to her bed. R1 stated she wanted to get up for the day and fell. R1's symptoms were reviewed with her provider, and she tested positive for a UTI. -A progress note, dated 1/3/23, R1 was found sitting on the floor in her room's doorway at 5:35 p.m. Her locked w/c was next to her bed. R1 stated she tried to get out of bed. The incident report identified to "offer afternoon activity." R1's care plan lacked the intervention. -A progress note, dated 1/12/23, R1 was found sitting in her room's doorway: her w/c in the bathroom (BR). R1 self-transferred "frequently this night" and "utilized the [BR] many times." The incident report identified R1 stated she fell in the BR and pushed herself toward the door. R1 was reminded to utilize her call light and wait for staff assistance (despite this intervention have not been effective and R1's diagnosis of severely cognitively impaired). -A progress note, dated 1/20/23, at 3:00 a.m., on	2 830		

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 02/14/2023

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
2 830	Continued From page 7 1/19/23, at 11:30 p.m. R1 informed staff she fell in the BR. Staff identified a left elbow bruise. In addition, R1 was found sitting on the therapy room floor at 1:30 a.m. R1's w/c was in her BR turned upside down. R1 stated her left rib hurt and she had new bruising to her left leg and breast. The incident report identified R1 was provided with a snack and placed within sight of staff "for about an hour" and then assisted into bed. -A progress note, dated 1/23/23, R1 was found sitting on the floor in her room's doorway at 11:50 a.m. Her w/c was behind the door. R1 stated she tried to walk out to "look around." The incident report identified R1's care plan was updated to keep R1's w/c next to her bed with the breaks locked at all times when R1 was in bed. The care plan lacked the intervention. -A progress note, dated 2/8/23, R1 was found sitting on the hallway floor outside of her room at 3:00 a.m. R1 was toileted and assisted back to bed. The incident report identified an intervention for Actogram (sleep/wake cycle monitoring) watch to be performed for three days and reviewed upon completion. R1's medical record lacked documented evidence the Actogram recording period from 12/8/22 to 12/13/22 was reviewed and/or followed up on. -A progress note, dated 1/25/23, R1 demonstrated urinary frequency and urgency, increased confusion, and "noted to have multiple falls recently." Orders provided to test R1's urine for infection. A subsequent progress note, dated 1/26/23, identified positive urine results and an antibiotic was started. -A progress note, dated 1/27/23, at 8:57 p.m. R1 was found scooting on the floor coming out of her room with an abrasion on her forehead. The incident report identified R1 stated she tried to go to the BR and fell. Staff followed up with therapy	2 830		

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 02/14/2023

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
2 830	Continued From page 8 about an ambulation program (per a progress note, this follow-up occurred on 1/30/23); however, therapy deemed it inappropriate due to safety concerns. Instead, staff were to utilize as needed (PRN) essential oils on her pillow to encourage rest and relaxation. R1's care plan identified, on 2/2/23 essential oil use was added. -A follow-up progress note, dated 1/27/23, at 9:09 p.m. causal factors for R1's 1/27/23 fall were determined to be R1's current UTI, toileting needs, and that R1 failed to use her call light to ask for assistance. R1 had a history of multiple falls. Interventions included bowel and bladder evaluation and aromatherapy. -R1's treatment administration records (TAR), dated 1/23, identified PRN essential oil aromatherapy orders initiated on 11/16/23. The TAR lacked evidence R1 was provided with essential oil aromatherapy on 1/27/23 through 1/31/23. -A progress note, dated 1/28/23, at 12:24 a.m. R1 was found sitting on the hallway floor outside of her room at 11:00 p.m. R1's unlocked w/c was in her BR. R1 stated she attempted to go to the BR. The incident report, identified R1's provider and dietary were consulted (per a progress note, dated 1/30/23, this consult occurred) to add a nutritional supplement to promote adequate caloric intake to help reduce falls if R1 possibly experienced discomfort due to hunger and inability to communicate hunger (per a progress note, dated 1/31/23, the order was provided). -A progress note, dated 1/31/23, at 12:00 a.m. identified R1 was found on her BR floor. Her unlocked w/c was in the BR doorway. R1's left shoulder was assessed to be "more distended out of place than her right" and R1 complained her shoulder and left hip hurt. Per a follow-up note, at 2:58 a.m. R1 was sent to the emergency room (ER).	2 830		

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 02/14/2023

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
2 830	Continued From page 9 R1's care plan identified on 2/2/23 intervention implementation that directed staff to review information on past falls and attempt to determine the cause of the falls with recording of possible root causes, removal or alter any potential causes if possible, and to educate R1/family/caregivers/interdisciplinary team. R1's medical record lacked evidence such a review was completed. R1's Inpatient Discharge Summary, dated 2/3/23, identified R1 was diagnosed with failure to thrive with recurrent falls and fall injuries of a left shoulder dislocation, L1 and L2 lumbar spinal fractures, 12th rib fracture, left sacral (base of spine) fracture, and left pubic rami (pelvic) fractures. R1's physical condition at discharge was terminal and hospice end of life/comfort care was ordered. A progress note, dated 2/7/23, identified R1 displayed restlessness, yelled out 'help me,' and was observed to "sit up in bed" four times. A Fall Review Evaluation, dated 2/10/23, identified R1 was at risk for falls related to fractures, muscle weakness, UTI, dementia, and history of falls. R1 was unresponsive and bedbound in which comfort care and safety while in bed continued. A progress note, dated 2/10/23, identified R1 passed away at 12:15 a.m. R1's medical record identified R1's fall risk was assessed on 11/23/22 and 2/10/23 based on the MDS process; however, the record lacked comprehensive fall risk assessments and/or analysis were completed after R1's multiple falls	2 830		

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 02/14/2023

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
2 830	Continued From page 10 in order to develop, adjust, and/or monitor for effectiveness, individualized care plan interventions to mitigate R1's fall and/or fall injury risk. When interviewed on 2/13/22, at 2:47 p.m. trained medication aide (TMA)-A stated she would find fall interventions in the resident's care plan or on the Kardex. TMA-A explained R1 "constantly" utilized the BR and did not sleep well at night. Staff assisted R1 to bed and a minute after staff walked away R1 would self-transfer. Once R1 returned from the hospital, R1 often requested the bedpan and she witnessed R1 lean forward in bed. TMA-A stated she heard in report R1 was observed seated edge of bed "when she was not supposed to." TMA-A explained that prior to R1's hospital stay being around people was overall the only thing that calmed R1. She indicated R1's status upon her return was a shock as R1 was making progress in her prior recovery and staff talked about R1's return to her previous facility. TMA-A denied involvement in a comprehensive analysis of R1's falls and she stated she lacked knowledge of any new fall risk interventions for R1 once she returned from the hospital. When interviewed on 2/14/23, at 10:50 a.m. R1's nurse practitioner (NP)-A stated R1 was a "ball of anxiety" when she was admitted in which she had a history of falls. Despite this, R1's discharge plan was for her to rehab and return back to her previous facility. R1's anxiety and impulsiveness improved with medication changes; however, she continued to have significant poor safety awareness. NP-A acknowledged other than trying "to settle [R1's] mind to keep her from "going so fast," she was unaware of R1's care planned fall interventions. She verbalized she was unaware of	2 830		

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 02/14/2023

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
2 830	Continued From page 11 R1's urinary status and the frequency of which staff assisted her to the BR. NP-A denied she was involved in a comprehensive analysis of R1's falls to determine details that may have been used to decrease R1's fall risk or fall related injuries. NA-A confirmed she was unaware of the exact cause of R1's death; however, she explained "the fall and fractures did not help." During interview on 2/14/23, at 11:13 a.m. R1's family (FM)-A stated R1 had a long history of falls in which she knew at some point a fall related break "was going to be the death of [R1]." FM-A identified she was involved in "care conferences" with the facility in which they discussed R1's "overall health;" however, she denied they discussed R1's falls. She explained those meetings focused on the progress R1 made with therapy and the hope R1 would be able to return to her prior memory care facility. When interviewed on 2/14/23, at 1:09 p.m. nursing assistant (NA)-C confirmed she took care of R1 on 1/30/23 in which R1 was "her usual self:" super confused, hard to redirect, and had a short attention span. She denied that on 1/30/23 R1 displayed any signs or symptoms which would have identified declines in her medical or overall status. NA-C explained R1 often self-transferred and was "hard to catch:" one moment R1 was in her w/c and the next in bed or vice versa. NA-C stated R1 slept poorly at night and often "napped much of the shift prior." R1 also frequently utilized the BR which NA-C thought R1 used to calm herself down. NA-C explained she often attempted to keep R1 distracted, entertained, and within her sight as much as able. NA-C denied management staff talked with her related to R1's fall risk factors and which interventions were effective and which ones were not.	2 830		

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 02/14/2023

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
2 830	Continued From page 12 During interview on 2/14/23, at 1:24 p.m. licensed practical nurse (LPN)-A stated she was expected to initially investigate a resident's fall, initiate a Risk Management incident report, and implement an immediate fall risk intervention to mitigate further falls. After that, a care coordinator would review, adjust the intervention as needed, and care plan it. LPN-A confirmed the coordinator followed up with her after she managed a residents fall; however, she denied she was ever involved in any sort of comprehensive analysis of resident fall(s) to determine details that may have been used to decrease resident fall risks or fall related injuries with R1. LPN-A stated R1 "was a roamer" and she attempted to keep R1 as close to her as able. She explained R1 was quick, and staff could assist her to bed one moment and then the next she was by them needing some sort of assist. R1 "always had to go to the BR" and staff "could tell her over and over she needed help, but she did not have the capability to remember that." LPN-A confirmed not all of the interventions they attempted with R1 were on her care plan and/or Kardex: "We should all know the interventions, but probably could have been in the Kardex." LPN-A explained she was unsure of what interventions would have worked for R1 other than to provide R1 with 1:1 supervision at all times. LPN-A confirmed R1 was not provided 1:1 supervision at all times. LPN-A stated R1 was "stable before her hospital stay: They were talking about sending her back to [prior memory care facility]." When interviewed on 2/14/23, at 1:40 p.m. registered nurse (RN)-C stated she expected staff to make sure an immediate intervention was implemented after a resident fall which was based on the nature of the fall and either	2 830		

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 02/14/2023

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
2 830	Continued From page 13 documented in the progress notes or on the incident report: not just passed on during shift to shift report. Then, she explained, they reviewed the fall, the intervention, adjusted the intervention as needed, and initiated it within the care plan. RN-C stated fall risk assessments were completed with the MDS process and she denied they completed a comprehensive fall risk assessment and/or analysis of R1's falls outside of this process or met with the IDT (interdisciplinary team) to discuss and analyze R1's falls. She verbalized if a resident had multiple falls, a comprehensive fall and fall risk analysis was very important in order to determine the root cause of the fall, to prevent injury, and to keep residents safe; however, she was unaware of the facility policy and/or protocols on fall assessments if a resident were to have multiple falls. After RN-C reviewed a Fall Review Evaluation, she stated the evaluation "did not have everything you would look at to analyze" falls and fall risk. RN-C explained R1 was "compulsive" with her transfers in which she followed up with therapy about a walking program or exercising; however, therapy disagreed related to R1's dementia and not wanting R1 to be triggered into thinking she could walk on her own. RN-C described interventions attempted for R1 which were present on her care plan prior to her hospitalization. RN-C confirmed R1's fall interventions were not adjusted and/or new interventions implemented once R1 returned. RN-C stated R1 was "stable" prior to her hospitalization. R3: R3's Initial Intake provider visit progress note, dated 11/4/23, identified R3 was admitted to the facility on 11/3/22, after he required	2 830		

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 02/14/2023

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
2 830	Continued From page 14 hospitalization as a result of frequent falls and a UTI. R3's admission MDS, dated 11/10/22, identified R3 was severely cognitively impaired and required limited to extensive physical assist for cares. R3 relied on a w/c for locomotion and showed minimal walking. R3 diagnosis was polyneuropathy, UTI, Alzheimer's Disease, dementia, muscle weakness, and repeated falls. R3's baseline care plan, initiated 11/3/22, identified R3's fall risk related to impaired mobility and cognition, and history of falls in which he would be safe and free from falls. The care plan directed staff to orient R3 to his room and call light system and to provide R3 with reminders as often as necessary, along with reviewing fall prevention with R3's representative on admission and to follow physical therapy (PT) and occupational therapy (OT) instructions for mobility function. The care plan identified R3 required a Foley catheter in which staff were not to leave R3 unattended on the commode. On 11/10/22, the care plan was updated, after a bowel assessment was completed, which directed staff to offer and encourage R3 to toilet every two to three hours while awake. R3's medical record identified the following entries and identified information: -Progress notes, dated 11/5/22, 11/6/22, 11/7/22, 11/8/22, all identified R3 was alert and oriented to self only and "often" tried to self-transfer. -A progress note, dated 11/11/22, R3 ambulated with his walker to the manager's office while he held his catheter bag. He was assisted to his room and staff were to monitor for further episodes of self-transfers.	2 830		

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 02/14/2023

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
2 830	Continued From page 15 A Fall Review Evaluation, locked 11/10/22, identified R3's prior to admission falls and identified the following factors which increased R3's fall risk: Alzheimer's Disease, dementia, polyneuropathy, osteoarthritis, weakness, altered mobility, indwelling urinary catheter, frequent bowel incontinence, and new admission. The evaluation summary identified the risk factors and directed staff to orient him to his new room, ensure the call light was within reach and to encourage him to wear proper footwear when out of bed. R3 also worked with PT and OT. The evaluation lacked identification of R3's numerous self-transfer/ambulation attempts. Fall CAA, dated 11/10/22, identified R3's fall review evaluation risk factors and the use of antidepressant medication. The CAA's Care Plan Considerations section indicated the care plan objective was to avoid complications and to maintain his current level of functioning. R3's subsequent medical record identified the following entries and identified information: -A Fall Investigation report, dated 11/15/22, R3 self-ambulated in the hallway and staff intercepted his fall by lowering him to the floor. R3 stated he tried to 'fix/ find missing cable.' R3's Foley catheter tubing was pulled from his bladder and he was incontinence of bowel. R3 was brought back to his room, incontinence hygiene provided, a new catheter inserted, and he was encouraged to use his call light. R3's progress notes did not identify R3's 11/15/22 fall. -Progress notes, dated 11/16/22 and 11/17/22, R3 tested positive for COVID-19 with required room isolation and experienced increased weakness and difficulty with transfers. -An incident report, dated 11/17/22, at 2:35 p.m. R3 was found on the floor next to his bed. A	2 830		

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 02/14/2023

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
2 830	Continued From page 16 progress note, dated 11/17/22, lacked evidence of R3's fall; however, the note identified R3 was free of injury, his vitals were stable, and he was encouraged to use his call light (despite the intervention or reminder not effective due to dementia). -A progress note, dated 11/18/22, R3 was ordered antibiotics based on urinalysis results [R3 was diagnosed with a UTI]. -A progress note, dated 11/20/22, at 2:18 a.m. R3 "often forgets" and required redirection back to room in which staff found "him back out of room/self transferring." -A progress note, dated 11/20/22, at 5:30 p.m. R3 was observed to be in his BR doorway when staff intercepted a fall and lowered him to the floor. Staff placed him in bed after. The progress note and incident report lacked an identified fall analysis or new intervention. -A progress note, dated 11/24/22, R3 was observed self-ambulating down the hallway. -A progress note, dated 11/25/22, R3 "face planted" and sustained an abrasion to his forehead, fixed pupils, and double vision. [R3 was sent to the ER and admitted]. -A progress note, dated 11/29/22, at 1:34 a.m. R3 returned to the facility and required assist of two staff with a mechanical standing lift for transfers and that R3 was "noted to self transfer x1." A provider visit progress note, dated 12/5/22, identified R3 fell in November "during isolation with subdural hematoma and neuro changes, send to ER and hospitalized for [three] days." -A progress note, dated 12/2/22, at 3:21 p.m. R3 was found on the floor about a foot from his w/c. R3 stated he hit his head. Family denied ER transport. The incident report identified staff collaborated with therapy on R3's transfers and he had a UTI which required antibiotics. -A progress note, dated 12/5/22, R3 was found on	2 830		

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 02/14/2023

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
2 830	Continued From page 17 the floor at 2:50 a.m. The incident report identified R3 was to have his w/c next to the bed when he was in bed. R3's care plan identified, on 1/10/23 (more than a month later), the intervention was initiated. A Fall Review Evaluation, dated 12/5/22, completed per facility MDS process(es), identified R3's fall history prior to and during his stay and identified the same evaluation summary and interventions as the 11/10/22 fall review evaluation, with the addition of the subdural hematoma diagnosis. The evaluation lacked identification of R3's numerous self-transfer/ambulation attempts and/or analysis related to the falls which occurred after admission and hospital return. R3's subsequent medical record identified the following entries and identified information: -A progress note, dated 12/9/22, at 2:48 a.m. R3 was lowered to the floor when he became weak after he was found attempting to walk with his w/c near the dining room (DR). The incident report identified Actogram watch would start on 12/12/22. R3's medical record lacked documented evidence the Actogram recording period was reviewed and/or followed up on. -Progress notes, dated 12/9/22, 12/10/22, and 12/12/22, R3 self-transferred multiple times each day. -A progress note, dated 12/12/22, R3 was found on the floor at 3:00 p.m. after he was in his bed. Identified intervention directed for gripper socks instead of regular socks. R3's care plan identified, on 12/15/22 (three days later), R3 was to be "highly encourage[d]" to use non-slip footwear at all times. -A progress note, dated 12/17/22, R3 was found sitting on the floor with his back against the bed	2 830		

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 02/14/2023

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
2 830	Continued From page 18 at 8:20 p.m. R3 was incontinent of bowel and a spilled water cup was on the floor by his bed. He was assisted into bed and bowel hygiene provided. The incident report identified staff were to ensure R3's bed was kept at a therapeutic height to set R3 up for successful self-transfers due to history of impulsivity and self-transferring. On 12/19/22, R3's care plan identified "Low Bed" and lacked identification of "therapeutic height" directives. -Progress notes, dated 12/19/22 and 12/29/21, R3 self-ambulated from his room "down Northwoods hallway" and self-transferred and ambulated in the DR, respectively. A Fall Review Evaluation, dated 12/30/22, completed per facility MDS process(es), identified R3's fall history prior to and during his stay and identified the same diagnoses as past evaluations; however, included R3 showed poor safety awareness and impulsivity which increased his fall risk. The fall summary identified the following interventions: Actigraphy PRN, therapeutic bed height, non-slip footwear at all times (highly encouraged), assistance with safety reminders PRN, and orientation to room and call light. The evaluation lacked identification of R3's numerous self-transfer/ambulation attempts and/or analysis related to the falls which occurred after admission and hospital return. R3's subsequent medical record identified the following entries and identified information: -A progress note, dated 1/1/23, at 3:24 p.m. R3 was found sitting on the floor in an adjacent unit "Pod" area. The incident report identified foot pedals to be stored in w/c bag when R3 was not assisted with locomotion. R3's care plan identified, on 1/19/23 (18 days later), initiation of the intervention.	2 830		

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 02/14/2023

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
2 830	Continued From page 19 -A progress note, dated 1/5/23, R3 was found lying on the floor next to his w/c in the DR at 4:30 p.m. R3 sustained a right elbow "scrape." The incident report identified staff collaborated with R3's provider in which orders were provided for an antipsychotic medication related to impulsivity, poor safety awareness, and behaviors. -A progress note, dated 1/6/23, at 2:16 p.m. R3 was found outside of his room on his hands and knees. R3 was brought to the DR and provided a snack. The incident report identified R3 was unsafe to be in his room alone while in his w/c. R3's care plan identified, on 1/10/23 (four days later), R3's unsafe room status. -A progress note, dated 1/8/23, at 11:09 p.m. R3 was found sitting on the DR floor. He was incontinent of bowel. R3 was provided bowel hygiene care and assisted to bed. The incident report identified to offer R3 toileting after meals. R3's care plan identified, on 1/10/23 (two days later), the intervention was initiated. -A progress note, dated 1/9/23, R3 was found on his BR floor leaning against his BR door around 1:50 p.m. R3 was previously in his recliner. At the time of the fall, the recliner footrest remained elevated. An intervention was implemented to unplug the recliner, leave in a stationary position, and to store the remote in a manager's office. R3's care plan lacked the intervention. -A progress note, dated 1/13/22, R3 started an antibiotic for a UTI. -A progress note, dated 1/16/23, R3 attempted to standup from his w/c throughout the shift despite a bath, snacks, and being kept as close to staff, "as much as possible or with in eyesight." -A progress note, dated 1/17/23, at 8:03 p.m. R3 was found on the floor near the nurse's station. R3 stated he attempted to walk to another resident so he could help him. The incident report identified an intervention for a hospice evaluation	2 830		

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 02/14/2023

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
2 830	Continued From page 20 and medication review with rounding provider. R3's care plan identified, on 1/17/23, an intervention to keep frequently used items within R2's reach with each interaction. -A progress note, dated 1/18/23, at 9:14 a.m. activity staff were to increase one on one (1:1) activities with R3. R3's care plan lacked the intervention. -A progress note, dated 1/19/23, at 6:49 p.m. R3 was found kneeling on the floor next to his w/c in the DR. R3 stated he attempted to get into another chair situated next to the DR table. R3 was assisted to the BR and had a BM. -A progress note, dated 1/21/23, R3 was found crawling on the DR floor at 6:00 p.m. The incident report identified hourly safety checks. R3's care plan identified, on 1/23/23 (two days later), the intervention was initiated. -A progress note, dated 1/22/23, at 1:29 a.m., R3 was found on his BR floor at 12:30 a.m. during midnight rounds and assessed to have a skin tear on his knee. He was taken to the BR and had a BM. The incident report identified to offer R3 toileting after all meals and prior to bedtime. R3's care plan identified, on 1/23/23 (one day later), R3's toileting plan was revised. -A progress note, dated 1/22/23, at 10:34 a.m. R3 was found kneeling on his bedroom floor by his recliner with his locked w/c next to the bed. R3 stated he 'needed to go over there.' The incident report identified a medication review and hospice nurse consult with another review on 1/26/23 to see if recommended increased PRN medication usage was effective. A Fall Review Evaluation, dated 1/25/23, completed per facility MDS process(es), identified the following fall risk summary for R3: R3 was alert but lethargic and only oriented to self. He required mechanical sit to stand lift for transfers	2 830		

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 02/14/2023

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
2 830	Continued From page 21 and was non-ambulatory in which he continued to make multiple self-transfer attempts per day and attempted to walk. He was unsuccessful in this which led to "numerous" falls in the past quarter. "Will continue to closely work with hospice team and [medical provider] to monitor and minimize falls." The summary listed the following fall interventions: those listed with the 12/30/22 fall evaluation, foot pedals storage, items within reach, hourly safety checks, medication reviews, "offer" toileting plan, unsafe to be in room alone in w/c, and w/c next to bed when in bed. The evaluation lacked specific information related to R3's falls. R3's subsequent medical record identified the following entries and identified information: -A progress note, dated 1/31/23, at 3:58 p.m. R3 was found lying on his back on his bedroom floor. The incident report identified medications were reviewed with R3's provider and medication changes were ordered on 2/1/23. -A progress note, dated 2/9/23, R3 had increased declines in his status with no oral intake and little to no output in which he remained in bed that shift. Hospice chaplain visited with him and provided R3 with last rights. -A progress note, dated 2/10/23, R3 continued with declines in which he required a full mechanical lift for all transfers and a Broda (specialized reclining) w/c. R3's medical record identified R3's fall risk was assessed on based on the MDS process; however, the record lacked comprehensive fall risk assessments and/or analysis were completed after R3's multiple falls in order to develop, adjust, and/or monitor for effectiveness, individualized care plan interventions to mitigate R3's fall and/or fall injury risk.	2 830		

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 02/14/2023

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
2 830	Continued From page 22 During interview on 2/13/23, at 11:57 a.m. RN-A stated she was a contracted agency staff. She explained she expected a resident's fall risk and all associated interventions to be identified on the care plan and/or Kardex (nursing assistant care plan) as these were the two sources of information she reviewed when she needed to know expected care for a resident and/or where she directed other staff to go when they had questions. RN-A stated, after a resident fall, a house charge was updated, and an intervention was to be initiated right away. When interviewed on 2/14/23, at 11:28 a.m. R3's FM-B stated staff attempted to keep R3 in the "common area" and reminded him "to not get up;" however, FM-B was unsure as to any other interventions staff attempted to keep R3 from falling. FM-B explained when R3 was first admitted, he talked with staff and updated them R3's fall history centered around R3 falling in the evening so that staff would have a "heads up." He denied staff conversed with him after that for his input to help mitigate falls and fall risk. During interview on 2/14/23, at 11:40 p.m. R3's NP-B stated awareness of R3's "multiple falls," in which staff "have done the typical interventions;" however, R3 displayed "very poor safety awareness" and impulsivity which increased his fall risk. In addition, because of R3's decreased cognitive and communication abilities, she and staff experienced a harder time determining, and assessing, R3's medical status fall risks as he was not able to explain information to them and/or reliably answer status questions. NP-B explained she focused more on medication management related to R3's behaviors and falls versus non-pharmacological fall interventions.	2 830		

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 02/14/2023

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
2 830	Continued From page 23 NP-B explained she conversed with nurse managers in the past about R3; however, she denied involvement in a comprehensive fall and intervention process outside of R3's medication management. When interviewed on 2/14/23, at 12:39 p.m. RN-B stated the facility management expected her to implement and care plan a fall intervention when a resident fell. In addition, she stated, if she were not present at the time of the fall, she expected staff implemented "some sort of intervention" which was reported off each shift, and then once she returned to work she reviewed the intervention(s) and then updated the care plan. Staff were provided with a list of interventions to choose from to assist in intervention determination if she was not available at the time of the fall. RN-B stated interventions were based on the fall situation(s) and/or the residents status. She explained falls were discussed during IDT meetings and then any new interventions were reported on during the floor staffs' "stand-up" meetings; however, "standard [fall risk] assessment[s]" were conducted only during the MDS process. She denied R3's falls and fall risk were comprehensively assessed and/or analyzed outside of the MDS schedule. When interviewed on 2/14/23, at 1:09 p.m. NA-C stated she considered R3 a fall risk; however, due to R3's current medical status, the risk was now much lower. NA-C explained R3 was " not there completely" and thus verbal reminders and cues for safety were not effective for him. She explained, in order to stop R3 from falling prior to his recent declines, he would have had to be care planned for 1:1 supervision. NA-C denied R3 was provided 1:1 supervision. NA-C denied management staff talked with her related to R3's	2 830		

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 02/14/2023

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
2 830	Continued From page 24 fall risk factors and which interventions were effective and which ones were not; however, she followed up with, staff were aware of how [R3] was [self-transferring/ambulating] and not sleeping." During interview on 2/14/23, at 3:54 p.m. director of nursing (DON) stated falls were reviewed during morning IDT meetings where staff went over "the fall" and developed interventions which the care coordinator added to the care plan. The DON confirmed IDT only reviewed the most current fall brought to the meeting and denied the IDT analyzed all of a resident's falls, or multiple falls, at one time. She stated such an analysis was important to determine the root cause of falls in order to be more proactive versus reactive. The DON stated she expected staff to initiate an immediate individualized fall intervention, based on the fall factors, to keep the resident "safe in that moment" and to document the intervention in the incident report and/or the progress note. She explained if an intervention was not individualized as much as possible the care plan was "probably not the most effective." After R1 and R3's fall information was reviewed, the DON stated, "I can see where there are concerns: interventions are not as solid as they could have been ...missing ...or the care plan as solid as it could have been." She explained she expected the care plan to "reflect a little bit more" of the fall risk details for both R1 and R3. More comprehensive care plans ensured staff knew what do to for the residents, especially for those staff who were contracted. A policy, Falls Prevention, revised 3/21, directed a resident's fall risk would be assessed within one week of admission, quarterly, annually, with a significant change of condition, and PRN by an RN. Based on the assessment, the care plan was	2 830		

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 02/14/2023

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
2 830	Continued From page 25 to be updated with an "appropriate" problem statement, goals, and associated interventions. A policy, Falls Management, revised 12/22, identified it was a policy of the facility to implement resident care plans to reduce the risk of falls and associated injuries when a fall occurred. The policy directed the nurse was to implement treatment and fall interventions based on resident assessment and fall investigation processes which was to be documented within the Risk Management incident report to allow the IDT to complete further analysis of the incident. After, the RN Clinical Coordinator was to follow-up with a fall analysis and complete the Safety Analysis portion of the assessment with details that addressed "Fall History" analysis of potential causative factors and patterns, a reviewal of the fall prevention plan and potential high risk contributing factors, the decision making process of the IDT, and interventions deemed appropriate with an emphasis on the root cause. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

DEPARTMENT OF HEALTH

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,

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

An equal opportunity employer.

DEPARTMENT OF HEALTH

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: Reinspection Results
Event ID: GHNH12

Dear Administrator:

On March 10, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 14, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 28, 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 24, 2023, we informed you that we may impose enforcement remedies.

On February 14, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 2, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 2, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 2, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 2, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Assumption Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 2, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 11, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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,

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

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 02/14/2023

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 2/13/23, through 2/14/23, 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, Requirments for Long Term Care Facilities. The following complaint was reviewed H54468306C (MN00090676), with a deficiency cited at F689. The following complaint was reviewed H54468455C (MN00091038. 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 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		3/2/23

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

Electronically Signed | 03/02/2023

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.

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 02/14/2023

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 689	Continued From page 1 by: Based on interview and document review, the facility failed to comprehensively assess fall risk and implement individualized interventions to reduce the risk of falls for 2 of 3 residents (R1, R3) reviewed for accidents. This resulted in actual harm for R1 who sustained fractures and for R3 who sustained a subdural hematoma after repeated falls and whom both required medical treatment or services. Findings include: R1's Inpatient Discharge Summary, dated 11/16/22, identified R1 fell three times prior to her hospital admission in which she sustained nasal fractures, left great toe fracture, distal right fibula fracture, and a left wrist fracture. She was discharged to the facility in stable condition with a good rehab potential and was expected to require services for less than 30 days. R1's admission Minimum Data Set (MDS), dated 11/23/22, identified R1 admitted to the facility on 11/16/22. She was severely cognitively impaired and received extensive physical assist for most cares. R1 relied on a wheelchair for locomotion and did not walk. She required staff assist to stabilize during transfers. R1 was diagnosed with a right fibula (lower leg) fracture, muscle weakness, urinary tract infection (UTI), dementia, anxiety disorder, and repeated falls. R1 lacked condition(s) or chronic disease(s) which resulted in a life expectancy of less than six months. R1's baseline care plan, dated 11/16/22, identified R1 to be at risk for falls related to her impaired mobility, multiple fractures, and history of falls in which R1 would be safe and free from falls. The	F 689	F689 Free from Accident Hazards/Supervision/Devices SS=G CFR(s): 483.25(d)(1)(2) 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. CORRECTIVE ACTION FOR AFFECTED RESIDENTS and RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED: At the time of the survey R1 and R3 had been affected by this deficient practice. R1 was deceased and R3□s condition had declined to the extent that this resident was at a lower risk for falling and the interventions were appropriately care planned. 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. The DON/ADON and other RNCCs	

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 02/14/2023

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 689	Continued From page 2 care plan directed staff to orient R1 to her room and call light system and to provide R1 with reminders as often as necessary, along with reviewing fall prevention with R1's representative on admission and to follow physical therapy (PT) and occupational therapy (OT) instructions for mobility function. The care plan identified R1 was non-weight bearing to her right leg, was not to ambulate, and required "full assist" for transfers and further directed staff to "assess for incontinence" every two hours and as needed (PRN). R1's discharge goal was to turn to her prior living facility. R1's medical record identified the following entries and identified information: -A progress note, dated 11/17/22, at 9:00 p.m. R1 was found on the floor. Per R1's statement, she tried to reach the door and slipped from the wheelchair (w/c). R1 was educated to use her call light and ask for help. -A progress note, dated 11/18/22, at 3:52 a.m. R1 was "checked" on every 30 minutes throughout the shift to prevent falls. -A progress note, dated 11/20/22, at 9:15 p.m. R1 required assist of 2 staff with a standing mechanical lift, was non-compliant with non-weight bearing transfer orders, and "self-transferred during shift." -A progress note, dated 11/21/22, at 1:26 a.m. R1 "self-transfers most of the time. [R1] should be monitored every 30 minutes for fall risk." -A progress note, dated 11/21/22, at 1:40 a.m. R1 was "checked every 15 to 30 min[utes]" to ensure she was not self-transferring or unstable. R1 was "very confused" and "writer stayed with [R1] throughout the shift as it was unsafe for [R1] to leave her alone in her room." -A progress note, dated 11/21/22, at 10:41 a.m.	F 689	audited all residents for fall history. Five residents found to have 3 or more falls in the last 90 days had a comprehensive fall evaluation. All care plans are updated for the five identified residents. POLICIES/PROCEDURES/SYSTEMIC CHANGES The DON and ADON have reviewed and revised the policies and procedure for fall prevention, fall management, accidents and supervision as appropriate. The DON/ADON have created and implemented the IDT Focused Review: Falls Comprehensive Falls Analysis to facilitate comprehensive fall evaluation approach for all residents identified as appropriate that incorporates input from IDT, floor staff, family and the resident□s provider and also the RNCC Fall Check List. TRAINING/EDUCATION The management team was educated on the following topics: 1. The revised Policy and Procedure on fall management and prevention, accidents and resident supervision. 2.RNCC Fall Check List 3.The process and criteria for conducting a comprehensive fall evaluation. MONITORING/AUDITING	

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 02/14/2023

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 689	Continued From page 3 R1 was found seated on the floor by her doorway around 7:10 a.m. R1 stated she got herself up from the bed and lowered herself to the floor as no one came when she needed help. An associated, same day, Risk Management (incident report) identified an intervention for anti-roll back breaks to be applied to her w/c. R3's care plan identified, on 1/9/23 (over a month and a half later), anti-roll breaks were initiated. -A progress note, dated 11/22/22, at 12:59 a.m. R1 self-transferred into her w/c from her bed. R1 was kept in one of the day rooms since she felt anxious in her room. Music was played for her which helped calm her. R1 "will be monitored closely." A Fall Review Evaluation, locked 11/23/22, identified R1's prior falls and identified the following factors which contributed to R1's fall risk: psychotropic drug use, memory loss, occasional bladder incontinence, use of assistive device(s), and decrease in muscle coordination. The evaluation summary identified R1 was at risk for falls related to her fracture diagnoses, muscle weakness, UTI, dementia and history of falls, her required assist for transfers and the use of a mechanical lift, and her non-ambulation status. The summary interventions directed staff to orient her to her room, the call light system, and to "give reminders." In addition, anti-roll back breaks were to be added to her wheelchair and staff were to ensure R1 wore non-slip footwear at all times as she allowed. R1 also worked with physical and occupational therapy to improve her mobility. The evaluation lacked identification of R1's numerous self-transfer attempts, observed anxiety, and/or analysis related to the falls on 11/17/22 and 11/21/22.	F 689	The DON or designee will audit the post fall process for completion and adherence to the newly revised policy and procedures for 30 days and then reassess the need to continue auditing 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.	

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 02/14/2023

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 689	Continued From page 4 R1's progress notes, dated 11/23/22 through 11/28/22, identify each day R1 displayed self-transfer actions. Falls Care Area Assessment (CAA), dated 11/29/22, identified R1 was at risk for falls related to her fall history and "casts," antipsychotic and antidepressant medications, wandering behavior, infection, incontinence, anxiety disorder, and dementia in which R1 was "pleasantly confused." The CAA's Care Plan Considerations section indicated the care plan objective was to avoid complications with the hopes R1 would be able to return to her assisted living facility after she worked with therapy. The CAA lacked details of R1's 11/17/22 and 11/21/22 falls or her self-transfer habits. The CAA lacked evidence staff completed a comprehensive fall assessment and/or analysis or individualized intervention(s) identification based on R1's fall risk. A review of R1's comprehensive care plan demonstrated a lack of additions and/or adjustments to fall risk related problems, goals, and/or interventions after the 11/29/22 CAA process. In addition, R1's care plan lacked R1's self-transfer actions. R1's subsequent medical record identified the following entries and identified information: -An incident report, dated 12/14/22, at 7:00 a.m. R1 was found sitting on the floor in her room's entryway with a sustained skin tear on her lower leg. Her locked w/c was next to her bed. R1 stated she wanted to get up for the day and fell. R1's symptoms were reviewed with her provider, and she tested positive for a UTI. -A progress note, dated 1/3/23, R1 was found sitting on the floor in her room's doorway at 5:35	F 689		

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 02/14/2023

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 689	Continued From page 5 p.m. Her locked w/c was next to her bed. R1 stated she tried to get out of bed. The incident report identified to "offer afternoon activity." R1's care plan lacked the intervention. -A progress note, dated 1/12/23, R1 was found sitting in her room's doorway: her w/c in the bathroom (BR). R1 self-transferred "frequently this night" and "utilized the [BR] many times." The incident report identified R1 stated she fell in the BR and pushed herself toward the door. R1 was reminded to utilize her call light and wait for staff assistance (despite this intervention have not been effective and R1's diagnosis of severely cognitively impaired). -A progress note, dated 1/20/23, at 3:00 a.m., on 1/19/23, at 11:30 p.m. R1 informed staff she fell in the BR. Staff identified a left elbow bruise. In addition, R1 was found sitting on the therapy room floor at 1:30 a.m. R1's w/c was in her BR turned upside down. R1 stated her left rib hurt and she had new bruising to her left leg and breast. The incident report identified R1 was provided with a snack and placed within sight of staff "for about an hour" and then assisted into bed. -A progress note, dated 1/23/23, R1 was found sitting on the floor in her room's doorway at 11:50 a.m. Her w/c was behind the door. R1 stated she tried to walk out to "look around." The incident report identified R1's care plan was updated to keep R1's w/c next to her bed with the breaks locked at all times when R1 was in bed. The care plan lacked the intervention. -A progress note, dated 2/8/23, R1 was found sitting on the hallway floor outside of her room at 3:00 a.m. R1 was toileted and assisted back to bed. The incident report identified an intervention for Actogram (sleep/wake cycle monitoring) watch to be performed for three days and reviewed	F 689		

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 02/14/2023

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 689	Continued From page 6 upon completion. R1's medical record lacked documented evidence the Actogram recording period from 12/8/22 to 12/13/22 was reviewed and/or followed up on. -A progress note, dated 1/25/23, R1 demonstrated urinary frequency and urgency, increased confusion, and "noted to have multiple falls recently." Orders provided to test R1's urine for infection. A subsequent progress note, dated 1/26/23, identified positive urine results and an antibiotic was started. -A progress note, dated 1/27/23, at 8:57 p.m. R1 was found scooting on the floor coming out of her room with an abrasion on her forehead. The incident report identified R1 stated she tried to go to the BR and fell. Staff followed up with therapy about an ambulation program (per a progress note, this follow-up occurred on 1/30/23); however, therapy deemed it inappropriate due to safety concerns. Instead, staff were to utilize as needed (PRN) essential oils on her pillow to encourage rest and relaxation. R1's care plan identified, on 2/2/23 essential oil use was added. -A follow-up progress note, dated 1/27/23, at 9:09 p.m. causal factors for R1's 1/27/23 fall were determined to be R1's current UTI, toileting needs, and that R1 failed to use her call light to ask for assistance. R1 had a history of multiple falls. Interventions included bowel and bladder evaluation and aromatherapy. -R1's treatment administration records (TAR), dated 1/23, identified PRN essential oil aromatherapy orders initiated on 11/16/23. The TAR lacked evidence R1 was provided with essential oil aromatherapy on 1/27/23 through 1/31/23. -A progress note, dated 1/28/23, at 12:24 a.m. R1 was found sitting on the hallway floor outside of her room at 11:00 p.m. R1's unlocked w/c was in	F 689		

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 02/14/2023

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 689	Continued From page 7	F 689		

her BR. R1 stated she attempted to go to the BR. The incident report, identified R1's provider and dietary were consulted (per a progress note, dated 1/30/23, this consult occurred) to add a nutritional supplement to promote adequate caloric intake to help reduce falls if R1 possibly experienced discomfort due to hunger and inability to communicate hunger (per a progress note, dated 1/31/23, the order was provided).
-A progress note, dated 1/31/23, at 12:00 a.m. identified R1 was found on her BR floor. Her unlocked w/c was in the BR doorway. R1's left shoulder was assessed to be "more distended out of place than her right" and R1 complained her shoulder and left hip hurt. Per a follow-up note, at 2:58 a.m. R1 was sent to the emergency room (ER).

R1's care plan identified on 2/2/23 intervention implementation that directed staff to review information on past falls and attempt to determine the cause of the falls with recording of possible root causes, removal or alter any potential causes if possible, and to educate R1/family/caregivers/interdisciplinary team. R1's medical record lacked evidence such a review was completed.

R1's Inpatient Discharge Summary, dated 2/3/23, identified R1 was diagnosed with failure to thrive with recurrent falls and fall injuries of a left shoulder dislocation, L1 and L2 lumbar spinal fractures, 12th rib fracture, left sacral (base of spine) fracture, and left pubic rami (pelvic) fractures. R1's physical condition at discharge was terminal and hospice end of life/comfort care was ordered.

A progress note, dated 2/7/23, identified R1

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 02/14/2023

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 689	Continued From page 8 displayed restlessness, yelled out 'help me,' and was observed to "sit up in bed" four times. A Fall Review Evaluation, dated 2/10/23, identified R1 was at risk for falls related to fractures, muscle weakness, UTI, dementia, and history of falls. R1 was unresponsive and bedbound in which comfort care and safety while in bed continued. A progress note, dated 2/10/23, identified R1 passed away at 12:15 a.m. R1's medical record identified R1's fall risk was assessed on 11/23/22 and 2/10/23 based on the MDS process; however, the record lacked comprehensive fall risk assessments and/or analysis were completed after R1's multiple falls in order to develop, adjust, and/or monitor for effectiveness, individualized care plan interventions to mitigate R1's fall and/or fall injury risk. When interviewed on 2/13/22, at 2:47 p.m. trained medication aide (TMA)-A stated she would find fall interventions in the resident's care plan or on the Kardex. TMA-A explained R1 "constantly" utilized the BR and did not sleep well at night. Staff assisted R1 to bed and a minute after staff walked away R1 would self-transfer. Once R1 returned from the hospital, R1 often requested the bedpan and she witnessed R1 lean forward in bed. TMA-A stated she heard in report R1 was observed seated edge of bed "when she was not supposed to." TMA-A explained that prior to R1's hospital stay being around people was overall the only thing that calmed R1. She indicated R1's status upon her return was a shock as R1 was making progress in her prior	F 689		

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 02/14/2023

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 689	Continued From page 9 recovery and staff talked about R1's return to her previous facility. TMA-A denied involvement in a comprehensive analysis of R1's falls and she stated she lacked knowledge of any new fall risk interventions for R1 once she returned from the hospital. When interviewed on 2/14/23, at 10:50 a.m. R1's nurse practitioner (NP)-A stated R1 was a "ball of anxiety" when she was admitted in which she had a history of falls. Despite this, R1's discharge plan was for her to rehab and return back to her previous facility. R1's anxiety and impulsiveness improved with medication changes; however, she continued to have significant poor safety awareness. NP-A acknowledged other than trying "to settle [R1's] mind to keep her from "going so fast," she was unaware of R1's care planned fall interventions. She verbalized she was unaware of R1's urinary status and the frequency of which staff assisted her to the BR. NP-A denied she was involved in a comprehensive analysis of R1's falls to determine details that may have been used to decrease R1's fall risk or fall related injuries. NA-A confirmed she was unaware of the exact cause of R1's death; however, she explained "the fall and fractures did not help." During interview on 2/14/23, at 11:13 a.m. R1's family (FM)-A stated R1 had a long history of falls in which she knew at some point a fall related break "was going to be the death of [R1]." FM-A identified she was involved in "care conferences" with the facility in which they discussed R1's "overall health;" however, she denied they discussed R1's falls. She explained those meetings focused on the progress R1 made with therapy and the hope R1 would be able to return to her prior memory care facility.	F 689		

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 02/14/2023

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 689	Continued From page 10 When interviewed on 2/14/23, at 1:09 p.m. nursing assistant (NA)-C confirmed she took care of R1 on 1/30/23 in which R1 was "her usual self:" super confused, hard to redirect, and had a short attention span. She denied that on 1/30/23 R1 displayed any signs or symptoms which would have identified declines in her medical or overall status. NA-C explained R1 often self-transferred and was "hard to catch:" one moment R1 was in her w/c and the next in bed or vice versa. NA-C stated R1 slept poorly at night and often "napped much of the shift prior." R1 also frequently utilized the BR which NA-C thought R1 used to calm herself down. NA-C explained she often attempted to keep R1 distracted, entertained, and within her sight as much as able. NA-C denied management staff talked with her related to R1's fall risk factors and which interventions were effective and which ones were not. During interview on 2/14/23, at 1:24 p.m. licensed practical nurse (LPN)-A stated she was expected to initially investigate a resident's fall, initiate a Risk Management incident report, and implement an immediate fall risk intervention to mitigate further falls. After that, a care coordinator would review, adjust the intervention as needed, and care plan it. LPN-A confirmed the coordinator followed up with her after she managed a residents fall; however, she denied she was ever involved in any sort of comprehensive analysis of resident fall(s) to determine details that may have been used to decrease resident fall risks or fall related injuries with R1. LPN-A stated R1 "was a roamer" and she attempted to keep R1 as close to her as able. She explained R1 was quick, and staff could assist her to bed one moment and then the next she was by them needing some sort	F 689		

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 02/14/2023

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 689	Continued From page 11 of assist. R1 "always had to go to the BR" and staff "could tell her over and over she needed help, but she did not have the capability to remember that." LPN-A confirmed not all of the interventions they attempted with R1 were on her care plan and/or Kardex: "We should all know the interventions, but probably could have been in the Kardex." LPN-A explained she was unsure of what interventions would have worked for R1 other than to provide R1 with 1:1 supervision at all times. LPN-A confirmed R1 was not provided 1:1 supervision at all times. LPN-A stated R1 was "stable before her hospital stay: They were talking about sending her back to [prior memory care facility]." When interviewed on 2/14/23, at 1:40 p.m. registered nurse (RN)-C stated she expected staff to make sure an immediate intervention was implemented after a resident fall which was based on the nature of the fall and either documented in the progress notes or on the incident report: not just passed on during shift to shift report. Then, she explained, they reviewed the fall, the intervention, adjusted the intervention as needed, and initiated it within the care plan. RN-C stated fall risk assessments were completed with the MDS process and she denied they completed a comprehensive fall risk assessment and/or analysis of R1's falls outside of this process or met with the IDT (interdisciplinary team) to discuss and analyze R1's falls. She verbalized if a resident had multiple falls, a comprehensive fall and fall risk analysis was very important in order to determine the root cause of the fall, to prevent injury, and to keep residents safe; however, she was unaware of the facility policy and/or protocols on fall assessments if a resident were to have multiple	F 689		

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 02/14/2023

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 689	Continued From page 12 falls. After RN-C reviewed a Fall Review Evaluation, she stated the evaluation "did not have everything you would look at to analyze" falls and fall risk. RN-C explained R1 was "compulsive" with her transfers in which she followed up with therapy about a walking program or exercising; however, therapy disagreed related to R1's dementia and not wanting R1 to be triggered into thinking she could walk on her own. RN-C described interventions attempted for R1 which were present on her care plan prior to her hospitalization. RN-C confirmed R1's fall interventions were not adjusted and/or new interventions implemented once R1 returned. RN-C stated R1 was "stable" prior to her hospitalization. R3: R3's Initial Intake provider visit progress note, dated 11/4/23, identified R3 was admitted to the facility on 11/3/22, after he required hospitalization as a result of frequent falls and a UTI. R3's admission MDS, dated 11/10/22, identified R3 was severely cognitively impaired and required limited to extensive physical assist for cares. R3 relied on a w/c for locomotion and showed minimal walking. R3 diagnosis was polyneuropathy, UTI, Alzheimer's Disease, dementia, muscle weakness, and repeated falls. R3's baseline care plan, initiated 11/3/22, identified R3's fall risk related to impaired mobility and cognition, and history of falls in which he would be safe and free from falls. The care plan directed staff to orient R3 to his room and call light system and to provide R3 with reminders as	F 689		

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 02/14/2023

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 689	Continued From page 13 often as necessary, along with reviewing fall prevention with R3's representative on admission and to follow physical therapy (PT) and occupational therapy (OT) instructions for mobility function. The care plan identified R3 required a Foley catheter in which staff were not to leave R3 unattended on the commode. On 11/10/22, the care plan was updated, after a bowel assessment was completed, which directed staff to offer and encourage R3 to toilet every two to three hours while awake. R3's medical record identified the following entries and identified information: -Progress notes, dated 11/5/22, 11/6/22, 11/7/22, 11/8/22, all identified R3 was alert and oriented to self only and "often" tried to self-transfer. -A progress note, dated 11/11/22, R3 ambulated with his walker to the manager's office while he held his catheter bag. He was assisted to his room and staff were to monitor for further episodes of self-transfers. A Fall Review Evaluation, locked 11/10/22, identified R3's prior to admission falls and identified the following factors which increased R3's fall risk: Alzheimer's Disease, dementia, polyneuropathy, osteoarthritis, weakness, altered mobility, indwelling urinary catheter, frequent bowel incontinence, and new admission. The evaluation summary identified the risk factors and directed staff to orient him to his new room, ensure the call light was within reach and to encourage him to wear proper footwear when out of bed. R3 also worked with PT and OT. The evaluation lacked identification of R3's numerous self-transfer/ambulation attempts. Fall CAA, dated 11/10/22, identified R3's fall	F 689		

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 02/14/2023

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 689	Continued From page 14 review evaluation risk factors and the use of antidepressant medication. The CAA's Care Plan Considerations section indicated the care plan objective was to avoid complications and to maintain his current level of functioning. R3's subsequent medical record identified the following entries and identified information: -A Fall Investigation report, dated 11/15/22, R3 self-ambulated in the hallway and staff intercepted his fall by lowering him to the floor. R3 stated he tried to 'fix/ find missing cable.' R3's Foley catheter tubing was pulled from his bladder and he was incontinence of bowel. R3 was brought back to his room, incontinence hygiene provided, a new catheter inserted, and he was encouraged to use his call light. R3's progress notes did not identify R3's 11/15/22 fall. -Progress notes, dated 11/16/22 and 11/17/22, R3 tested positive for COVID-19 with required room isolation and experienced increased weakness and difficulty with transfers. -An incident report, dated 11/17/22, at 2:35 p.m. R3 was found on the floor next to his bed. A progress note, dated 11/17/22, lacked evidence of R3's fall; however, the note identified R3 was free of injury, his vitals were stable, and he was encouraged to use his call light (despite the intervention or reminder not effective due to dementia). -A progress note, dated 11/18/22, R3 was ordered antibiotics based on urinalysis results [R3 was diagnosed with a UTI]. -A progress note, dated 11/20/22, at 2:18 a.m. R3 "often forgets" and required redirection back to room in which staff found "him back out of room/self transferring." -A progress note, dated 11/20/22, at 5:30 p.m. R3 was observed to be in his BR doorway when staff	F 689		

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 02/14/2023

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 689	Continued From page 15 intercepted a fall and lowered him to the floor. Staff placed him in bed after. The progress note and incident report lacked an identified fall analysis or new intervention. -A progress note, dated 11/24/22, R3 was observed self-ambulating down the hallway. -A progress note, dated 11/25/22, R3 "face planted" and sustained an abrasion to his forehead, fixed pupils, and double vision. [R3 was sent to the ER and admitted]. -A progress note, dated 11/29/22, at 1:34 a.m. R3 returned to the facility and required assist of two staff with a mechanical standing lift for transfers and that R3 was "noted to self transfer x1." A provider visit progress note, dated 12/5/22, identified R3 fell in November "during isolation with subdural hematoma and neuro changes, send to ER and hospitalized for [three] days." -A progress note, dated 12/2/22, at 3:21 p.m. R3 was found on the floor about a foot from his w/c. R3 stated he hit his head. Family denied ER transport. The incident report identified staff collaborated with therapy on R3's transfers and he had a UTI which required antibiotics. -A progress note, dated 12/5/22, R3 was found on the floor at 2:50 a.m. The incident report identified R3 was to have his w/c next to the bed when he was in bed. R3's care plan identified, on 1/10/23 (more than a month later), the intervention was initiated. A Fall Review Evaluation, dated 12/5/22, completed per facility MDS process(es), identified R3's fall history prior to and during his stay and identified the same evaluation summary and interventions as the 11/10/22 fall review evaluation, with the addition of the subdural hematoma diagnosis. The evaluation lacked identification of R3's numerous	F 689		

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 02/14/2023

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 689	Continued From page 16 self-transfer/ambulation attempts and/or analysis related to the falls which occurred after admission and hospital return. R3's subsequent medical record identified the following entries and identified information: -A progress note, dated 12/9/22, at 2:48 a.m. R3 was lowered to the floor when he became weak after he was found attempting to walk with his w/c near the dining room (DR). The incident report identified Actogram watch would start on 12/12/22. R3's medical record lacked documented evidence the Actogram recording period was reviewed and/or followed up on. -Progress notes, dated 12/9/22, 12/10/22, and 12/12/22, R3 self-transferred multiple times each day. -A progress note, dated 12/12/22, R3 was found on the floor at 3:00 p.m. after he was in his bed. Identified intervention directed for gripper socks instead of regular socks. R3's care plan identified, on 12/15/22 (three days later), R3 was to be "highly encourage[d]" to use non-slip footwear at all times. -A progress note, dated 12/17/22, R3 was found sitting on the floor with his back against the bed at 8:20 p.m. R3 was incontinent of bowel and a spilled water cup was on the floor by his bed. He was assisted into bed and bowel hygiene provided. The incident report identified staff were to ensure R3's bed was kept at a therapeutic height to set R3 up for successful self-transfers due to history of impulsivity and self-transferring. On 12/19/22, R3's care plan identified "Low Bed" and lacked identification of "therapeutic height" directives. -Progress notes, dated 12/19/22 and 12/29/21, R3 self-ambulated from his room "down Northwoods hallway" and self-transferred and	F 689		

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 02/14/2023

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 689	Continued From page 17 ambulated in the DR, respectively. A Fall Review Evaluation, dated 12/30/22, completed per facility MDS process(es), identified R3's fall history prior to and during his stay and identified the same diagnoses as past evaluations; however, included R3 showed poor safety awareness and impulsivity which increased his fall risk. The fall summary identified the following interventions: Actigraphy PRN, therapeutic bed height, non-slip footwear at all times (highly encouraged), assistance with safety reminders PRN, and orientation to room and call light. The evaluation lacked identification of R3's numerous self-transfer/ambulation attempts and/or analysis related to the falls which occurred after admission and hospital return. R3's subsequent medical record identified the following entries and identified information: -A progress note, dated 1/1/23, at 3:24 p.m. R3 was found sitting on the floor in an adjacent unit "Pod" area. The incident report identified foot pedals to be stored in w/c bag when R3 was not assisted with locomotion. R3's care plan identified, on 1/19/23 (18 days later), initiation of the intervention. -A progress note, dated 1/5/23, R3 was found lying on the floor next to his w/c in the DR at 4:30 p.m. R3 sustained a right elbow "scrape." The incident report identified staff collaborated with R3's provider in which orders were provided for an antipsychotic medication related to impulsivity, poor safety awareness, and behaviors. -A progress note, dated 1/6/23, at 2:16 p.m. R3 was found outside of his room on his hands and knees. R3 was brought to the DR and provided a snack. The incident report identified R3 was unsafe to be in his room alone while in his w/c.	F 689		

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 02/14/2023

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 689	Continued From page 18 R3's care plan identified, on 1/10/23 (four days later), R3's unsafe room status. -A progress note, dated 1/8/23, at 11:09 p.m. R3 was found sitting on the DR floor. He was incontinent of bowel. R3 was provided bowel hygiene care and assisted to bed. The incident report identified to offer R3 toileting after meals. R3's care plan identified, on 1/10/23 (two days later), the intervention was initiated. -A progress note, dated 1/9/23, R3 was found on his BR floor leaning against his BR door around 1:50 p.m. R3 was previously in his recliner. At the time of the fall, the recliner footrest remained elevated. An intervention was implemented to unplug the recliner, leave in a stationary position, and to store the remote in a manager's office. R3's care plan lacked the intervention. -A progress note, dated 1/13/22, R3 started an antibiotic for a UTI. -A progress note, dated 1/16/23, R3 attempted to standup from his w/c throughout the shift despite a bath, snacks, and being kept as close to staff, "as much as possible or with in eyesight." -A progress note, dated 1/17/23, at 8:03 p.m. R3 was found on the floor near the nurse's station. R3 stated he attempted to walk to another resident so he could help him. The incident report identified an intervention for a hospice evaluation and medication review with rounding provider. R3's care plan identified, on 1/17/23, an intervention to keep frequently used items within R2's reach with each interaction. -A progress note, dated 1/18/23, at 9:14 a.m. activity staff were to increase one on one (1:1) activities with R3. R3's care plan lacked the intervention. -A progress note, dated 1/19/23, at 6:49 p.m. R3 was found kneeling on the floor next to his w/c in the DR. R3 stated he attempted to get into	F 689		

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 02/14/2023

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 689	Continued From page 19 another chair situated next to the DR table. R3 was assisted to the BR and had a BM. -A progress note, dated 1/21/23, R3 was found crawling on the DR floor at 6:00 p.m. The incident report identified hourly safety checks. R3's care plan identified, on 1/23/23 (two days later), the intervention was initiated. -A progress note, dated 1/22/23, at 1:29 a.m., R3 was found on his BR floor at 12:30 a.m. during midnight rounds and assessed to have a skin tear on his knee. He was taken to the BR and had a BM. The incident report identified to offer R3 toileting after all meals and prior to bedtime. R3's care plan identified, on 1/23/23 (one day later), R3's toileting plan was revised. -A progress note, dated 1/22/23, at 10:34 a.m. R3 was found kneeling on his bedroom floor by his recliner with his locked w/c next to the bed. R3 stated he 'needed to go over there.' The incident report identified a medication review and hospice nurse consult with another review on 1/26/23 to see if recommended increased PRN medication usage was effective. A Fall Review Evaluation, dated 1/25/23, completed per facility MDS process(es), identified the following fall risk summary for R3: R3 was alert but lethargic and only oriented to self. He required mechanical sit to stand lift for transfers and was non-ambulatory in which he continued to make multiple self-transfer attempts per day and attempted to walk. He was unsuccessful in this which led to "numerous" falls in the past quarter. "Will continue to closely work with hospice team and [medical provider] to monitor and minimize falls." The summary listed the following fall interventions: those listed with the 12/30/22 fall evaluation, foot pedals storage, items within reach, hourly safety checks, medication reviews,	F 689		

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 02/14/2023

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 689	Continued From page 20 "offer" toileting plan, unsafe to be in room alone in w/c, and w/c next to bed when in bed. The evaluation lacked specific information related to R3's falls. R3's subsequent medical record identified the following entries and identified information: -A progress note, dated 1/31/23, at 3:58 p.m. R3 was found lying on his back on his bedroom floor. The incident report identified medications were reviewed with R3's provider and medication changes were ordered on 2/1/23. -A progress note, dated 2/9/23, R3 had increased declines in his status with no oral intake and little to no output in which he remained in bed that shift. Hospice chaplain visited with him and provided R3 with last rights. -A progress note, dated 2/10/23, R3 continued with declines in which he required a full mechanical lift for all transfers and a Broda (specialized reclining) w/c. R3's medical record identified R3's fall risk was assessed on based on the MDS process; however, the record lacked comprehensive fall risk assessments and/or analysis were completed after R3's multiple falls in order to develop, adjust, and/or monitor for effectiveness, individualized care plan interventions to mitigate R3's fall and/or fall injury risk. During interview on 2/13/23, at 11:57 a.m. RN-A stated she was a contracted agency staff. She explained she expected a resident's fall risk and all associated interventions to be identified on the care plan and/or Kardex (nursing assistant care plan) as these were the two sources of information she reviewed when she needed to know expected care for a resident and/or where	F 689		

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 02/14/2023

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 689	Continued From page 21 she directed other staff to go when they had questions. RN-A stated, after a resident fall, a house charge was updated, and an intervention was to be initiated right away. When interviewed on 2/14/23, at 11:28 a.m. R3's FM-B stated staff attempted to keep R3 in the "common area" and reminded him "to not get up;" however, FM-B was unsure as to any other interventions staff attempted to keep R3 from falling. FM-B explained when R3 was first admitted, he talked with staff and updated them R3's fall history centered around R3 falling in the evening so that staff would have a "heads up." He denied staff conversed with him after that for his input to help mitigate falls and fall risk. During interview on 2/14/23, at 11:40 p.m. R3's NP-B stated awareness of R3's "multiple falls," in which staff "have done the typical interventions;" however, R3 displayed "very poor safety awareness" and impulsivity which increased his fall risk. In addition, because of R3's decreased cognitive and communication abilities, she and staff experienced a harder time determining, and assessing, R3's medical status fall risks as he was not able to explain information to them and/or reliably answer status questions. NP-B explained she focused more on medication management related to R3's behaviors and falls versus non-pharmacological fall interventions. NP-B explained she conversed with nurse managers in the past about R3; however, she denied involvement in a comprehensive fall and intervention process outside of R3's medication management. When interviewed on 2/14/23, at 12:39 p.m. RN-B stated the facility management expected	F 689		

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 02/14/2023

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 689	Continued From page 22 her to implement and care plan a fall intervention when a resident fell. In addition, she stated, if she were not present at the time of the fall, she expected staff implemented "some sort of intervention" which was reported off each shift, and then once she returned to work she reviewed the intervention(s) and then updated the care plan. Staff were provided with a list of interventions to choose from to assist in intervention determination if she was not available at the time of the fall. RN-B stated interventions were based on the fall situation(s) and/or the residents status. She explained falls were discussed during IDT meetings and then any new interventions were reported on during the floor staffs' "stand-up" meetings; however, "standard [fall risk] assessment[s]" were conducted only during the MDS process. She denied R3's falls and fall risk were comprehensively assessed and/or analyzed outside of the MDS schedule. When interviewed on 2/14/23, at 1:09 p.m. NA-C stated she considered R3 a fall risk; however, due to R3's current medical status, the risk was now much lower. NA-C explained R3 was " not there completely" and thus verbal reminders and cues for safety were not effective for him. She explained, in order to stop R3 from falling prior to his recent declines, he would have had to be care planned for 1:1 supervision. NA-C denied R3 was provided 1:1 supervision. NA-C denied management staff talked with her related to R3's fall risk factors and which interventions were effective and which ones were not; however, she followed up with, staff were aware of how [R3] was [self-transferring/ambulating] and not sleeping." During interview on 2/14/23, at 3:54 p.m. director	F 689		

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 02/14/2023

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 689	Continued From page 23 of nursing (DON) stated falls were reviewed during morning IDT meetings where staff went over "the fall" and developed interventions which the care coordinator added to the care plan. The DON confirmed IDT only reviewed the most current fall brought to the meeting and denied the IDT analyzed all of a resident's falls, or multiple falls, at one time. She stated such an analysis was important to determine the root cause of falls in order to be more proactive versus reactive. The DON stated she expected staff to initiate an immediate individualized fall intervention, based on the fall factors, to keep the resident "safe in that moment" and to document the intervention in the incident report and/or the progress note. She explained if an intervention was not individualized as much as possible the care plan was "probably not the most effective." After R1 and R3's fall information was reviewed, the DON stated, "I can see where there are concerns: interventions are not as solid as they could have been ...missing ...or the care plan as solid as it could have been." She explained she expected the care plan to "reflect a little bit more" of the fall risk details for both R1 and R3. More comprehensive care plans ensured staff knew what do to for the residents, especially for those staff who were contracted. A policy, Falls Prevention, revised 3/21, directed a resident's fall risk would be assessed within one week of admission, quarterly, annually, with a significant change of condition, and PRN by an RN. Based on the assessment, the care plan was to be updated with an "appropriate" problem statement, goals, and associated interventions. A policy, Falls Management, revised 12/22, identified it was a policy of the facility to implement resident care plans to reduce the risk	F 689		

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 02/14/2023

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 689	Continued From page 24 of falls and associated injuries when a fall occurred. The policy directed the nurse was to implement treatment and fall interventions based on resident assessment and fall investigation processes which was to be documented within the Risk Management incident report to allow the IDT to complete further analysis of the incident. After, the RN Clinical Coordinator was to follow-up with a fall analysis and complete the Safety Analysis portion of the assessment with details that addressed "Fall History" analysis of potential causative factors and patterns, a reviewal of the fall prevention plan and potential high risk contributing factors, the decision making process of the IDT, and interventions deemed appropriate with an emphasis on the root cause.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 28, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: GHNH11

Dear Administrator:

The above facility was surveyed on February 13, 2023 through February 14, 2023 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:

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

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 feel free to call me with any questions.

Sincerely,

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

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 02/14/2023

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 2/13/23, through 2/14/23, a complaint survey was conducted at your facility by a surveyor 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		

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 02/14/2023

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	Continued From page 1 The following complaint was reviewed during the survey: H54468306C (MN00090676) with a licensing order issued at 0830. The following complaint was reviewed during the survey: H54468455C (MN00091038). 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	2 000		

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 02/14/2023

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	Continued From page 2 not required at the bottom of the first page of 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess fall risk and implement individualized interventions to reduce the risk of falls for 2 of 3 residents (R1, R3) reviewed for accidents. This resulted in actual harm for R1 who sustained fractures and for R3 who sustained a subdural hematoma after repeated falls and whom both required medical treatment or services.	2 830	Corrected	3/2/23

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 02/14/2023

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
2 830	Continued From page 3 Findings include: R1's Inpatient Discharge Summary, dated 11/16/22, identified R1 fell three times prior to her hospital admission in which she sustained nasal fractures, left great toe fracture, distal right fibula fracture, and a left wrist fracture. She was discharged to the facility in stable condition with a good rehab potential and was expected to require services for less than 30 days. R1's admission Minimum Data Set (MDS), dated 11/23/22, identified R1 admitted to the facility on 11/16/22. She was severely cognitively impaired and received extensive physical assist for most cares. R1 relied on a wheelchair for locomotion and did not walk. She required staff assist to stabilize during transfers. R1 was diagnosed with a right fibula (lower leg) fracture, muscle weakness, urinary tract infection (UTI), dementia, anxiety disorder, and repeated falls. R1 lacked condition(s) or chronic disease(s) which resulted in a life expectancy of less than six months. R1's baseline care plan, dated 11/16/22, identified R1 to be at risk for falls related to her impaired mobility, multiple fractures, and history of falls in which R1 would be safe and free from falls. The care plan directed staff to orient R1 to her room and call light system and to provide R1 with reminders as often as necessary, along with reviewing fall prevention with R1's representative on admission and to follow physical therapy (PT) and occupational therapy (OT) instructions for mobility function. The care plan identified R1 was non-weight bearing to her right leg, was not to ambulate, and required "full assist" for transfers and further directed staff to "assess for incontinence" every two hours and as needed (PRN). R1's discharge goal was to turn to her	2 830		

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 02/14/2023

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
2 830	Continued From page 4 prior living facility. R1's medical record identified the following entries and identified information: -A progress note, dated 11/17/22, at 9:00 p.m. R1 was found on the floor. Per R1's statement, she tried to reach the door and slipped from the wheelchair (w/c). R1 was educated to use her call light and ask for help. -A progress note, dated 11/18/22, at 3:52 a.m. R1 was "checked" on every 30 minutes throughout the shift to prevent falls. -A progress note, dated 11/20/22, at 9:15 p.m. R1 required assist of 2 staff with a standing mechanical lift, was non-compliant with non-weight bearing transfer orders, and "self-transferred during shift." -A progress note, dated 11/21/22, at 1:26 a.m. R1 "self-transfers most of the time. [R1] should be monitored every 30 minutes for fall risk." -A progress note, dated 11/21/22, at 1:40 a.m. R1 was "checked every 15 to 30 min[utes]" to ensure she was not self-transferring or unstable. R1 was "very confused" and "writer stayed with [R1] throughout the shift as it was unsafe for [R1] to leave her alone in her room." -A progress note, dated 11/21/22, at 10:41 a.m. R1 was found seated on the floor by her doorway around 7:10 a.m. R1 stated she got herself up from the bed and lowered herself to the floor as no one came when she needed help. An associated, same day, Risk Management (incident report) identified an intervention for anti-roll back breaks to be applied to her w/c. R3's care plan identified, on 1/9/23 (over a month and a half later), anti-roll breaks were initiated. -A progress note, dated 11/22/22, at 12:59 a.m. R1 self-transferred into her w/c from her bed. R1 was kept in one of the day rooms since she felt anxious in her room. Music was played for her	2 830		

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 02/14/2023

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
2 830	Continued From page 5 which helped calm her. R1 "will be monitored closely." A Fall Review Evaluation, locked 11/23/22, identified R1's prior falls and identified the following factors which contributed to R1's fall risk: psychotropic drug use, memory loss, occasional bladder incontinence, use of assistive device(s), and decrease in muscle coordination. The evaluation summary identified R1 was at risk for falls related to her fracture diagnoses, muscle weakness, UTI, dementia and history of falls, her required assist for transfers and the use of a mechanical lift, and her non-ambulation status. The summary interventions directed staff to orient her to her room, the call light system, and to "give reminders." In addition, anti-roll back breaks were to be added to her wheelchair and staff were to ensure R1 wore non-slip footwear at all times as she allowed. R1 also worked with physical and occupational therapy to improve her mobility. The evaluation lacked identification of R1's numerous self-transfer attempts, observed anxiety, and/or analysis related to the falls on 11/17/22 and 11/21/22. R1's progress notes, dated 11/23/22 through 11/28/22, identify each day R1 displayed self-transfer actions. Falls Care Area Assessment (CAA), dated 11/29/22, identified R1 was at risk for falls related to her fall history and "casts," antipsychotic and antidepressant medications, wandering behavior, infection, incontinence, anxiety disorder, and dementia in which R1 was "pleasantly confused." The CAA's Care Plan Considerations section indicated the care plan objective was to avoid complications with the hopes R1 would be able to return to her assisted living facility after she	2 830		

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 02/14/2023

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
2 830	Continued From page 6 worked with therapy. The CAA lacked details of R1's 11/17/22 and 11/21/22 falls or her self-transfer habits. The CAA lacked evidence staff completed a comprehensive fall assessment and/or analysis or individualized intervention(s) identification based on R1's fall risk. A review of R1's comprehensive care plan demonstrated a lack of additions and/or adjustments to fall risk related problems, goals, and/or interventions after the 11/29/22 CAA process. In addition, R1's care plan lacked R1's self-transfer actions. R1's subsequent medical record identified the following entries and identified information: -An incident report, dated 12/14/22, at 7:00 a.m. R1 was found sitting on the floor in her room's entryway with a sustained skin tear on her lower leg. Her locked w/c was next to her bed. R1 stated she wanted to get up for the day and fell. R1's symptoms were reviewed with her provider, and she tested positive for a UTI. -A progress note, dated 1/3/23, R1 was found sitting on the floor in her room's doorway at 5:35 p.m. Her locked w/c was next to her bed. R1 stated she tried to get out of bed. The incident report identified to "offer afternoon activity." R1's care plan lacked the intervention. -A progress note, dated 1/12/23, R1 was found sitting in her room's doorway: her w/c in the bathroom (BR). R1 self-transferred "frequently this night" and "utilized the [BR] many times." The incident report identified R1 stated she fell in the BR and pushed herself toward the door. R1 was reminded to utilize her call light and wait for staff assistance (despite this intervention have not been effective and R1's diagnosis of severely cognitively impaired). -A progress note, dated 1/20/23, at 3:00 a.m., on	2 830		

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 02/14/2023

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
2 830	Continued From page 7 1/19/23, at 11:30 p.m. R1 informed staff she fell in the BR. Staff identified a left elbow bruise. In addition, R1 was found sitting on the therapy room floor at 1:30 a.m. R1's w/c was in her BR turned upside down. R1 stated her left rib hurt and she had new bruising to her left leg and breast. The incident report identified R1 was provided with a snack and placed within sight of staff "for about an hour" and then assisted into bed. -A progress note, dated 1/23/23, R1 was found sitting on the floor in her room's doorway at 11:50 a.m. Her w/c was behind the door. R1 stated she tried to walk out to "look around." The incident report identified R1's care plan was updated to keep R1's w/c next to her bed with the breaks locked at all times when R1 was in bed. The care plan lacked the intervention. -A progress note, dated 2/8/23, R1 was found sitting on the hallway floor outside of her room at 3:00 a.m. R1 was toileted and assisted back to bed. The incident report identified an intervention for Actogram (sleep/wake cycle monitoring) watch to be performed for three days and reviewed upon completion. R1's medical record lacked documented evidence the Actogram recording period from 12/8/22 to 12/13/22 was reviewed and/or followed up on. -A progress note, dated 1/25/23, R1 demonstrated urinary frequency and urgency, increased confusion, and "noted to have multiple falls recently." Orders provided to test R1's urine for infection. A subsequent progress note, dated 1/26/23, identified positive urine results and an antibiotic was started. -A progress note, dated 1/27/23, at 8:57 p.m. R1 was found scooting on the floor coming out of her room with an abrasion on her forehead. The incident report identified R1 stated she tried to go to the BR and fell. Staff followed up with therapy	2 830		

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 02/14/2023

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
2 830	Continued From page 8 about an ambulation program (per a progress note, this follow-up occurred on 1/30/23); however, therapy deemed it inappropriate due to safety concerns. Instead, staff were to utilize as needed (PRN) essential oils on her pillow to encourage rest and relaxation. R1's care plan identified, on 2/2/23 essential oil use was added. -A follow-up progress note, dated 1/27/23, at 9:09 p.m. causal factors for R1's 1/27/23 fall were determined to be R1's current UTI, toileting needs, and that R1 failed to use her call light to ask for assistance. R1 had a history of multiple falls. Interventions included bowel and bladder evaluation and aromatherapy. -R1's treatment administration records (TAR), dated 1/23, identified PRN essential oil aromatherapy orders initiated on 11/16/23. The TAR lacked evidence R1 was provided with essential oil aromatherapy on 1/27/23 through 1/31/23. -A progress note, dated 1/28/23, at 12:24 a.m. R1 was found sitting on the hallway floor outside of her room at 11:00 p.m. R1's unlocked w/c was in her BR. R1 stated she attempted to go to the BR. The incident report, identified R1's provider and dietary were consulted (per a progress note, dated 1/30/23, this consult occurred) to add a nutritional supplement to promote adequate caloric intake to help reduce falls if R1 possibly experienced discomfort due to hunger and inability to communicate hunger (per a progress note, dated 1/31/23, the order was provided). -A progress note, dated 1/31/23, at 12:00 a.m. identified R1 was found on her BR floor. Her unlocked w/c was in the BR doorway. R1's left shoulder was assessed to be "more distended out of place than her right" and R1 complained her shoulder and left hip hurt. Per a follow-up note, at 2:58 a.m. R1 was sent to the emergency room (ER).	2 830		

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 02/14/2023

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
2 830	Continued From page 9 R1's care plan identified on 2/2/23 intervention implementation that directed staff to review information on past falls and attempt to determine the cause of the falls with recording of possible root causes, removal or alter any potential causes if possible, and to educate R1/family/caregivers/interdisciplinary team. R1's medical record lacked evidence such a review was completed. R1's Inpatient Discharge Summary, dated 2/3/23, identified R1 was diagnosed with failure to thrive with recurrent falls and fall injuries of a left shoulder dislocation, L1 and L2 lumbar spinal fractures, 12th rib fracture, left sacral (base of spine) fracture, and left pubic rami (pelvic) fractures. R1's physical condition at discharge was terminal and hospice end of life/comfort care was ordered. A progress note, dated 2/7/23, identified R1 displayed restlessness, yelled out 'help me,' and was observed to "sit up in bed" four times. A Fall Review Evaluation, dated 2/10/23, identified R1 was at risk for falls related to fractures, muscle weakness, UTI, dementia, and history of falls. R1 was unresponsive and bedbound in which comfort care and safety while in bed continued. A progress note, dated 2/10/23, identified R1 passed away at 12:15 a.m. R1's medical record identified R1's fall risk was assessed on 11/23/22 and 2/10/23 based on the MDS process; however, the record lacked comprehensive fall risk assessments and/or analysis were completed after R1's multiple falls	2 830		

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 02/14/2023

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
2 830	Continued From page 10 in order to develop, adjust, and/or monitor for effectiveness, individualized care plan interventions to mitigate R1's fall and/or fall injury risk. When interviewed on 2/13/22, at 2:47 p.m. trained medication aide (TMA)-A stated she would find fall interventions in the resident's care plan or on the Kardex. TMA-A explained R1 "constantly" utilized the BR and did not sleep well at night. Staff assisted R1 to bed and a minute after staff walked away R1 would self-transfer. Once R1 returned from the hospital, R1 often requested the bedpan and she witnessed R1 lean forward in bed. TMA-A stated she heard in report R1 was observed seated edge of bed "when she was not supposed to." TMA-A explained that prior to R1's hospital stay being around people was overall the only thing that calmed R1. She indicated R1's status upon her return was a shock as R1 was making progress in her prior recovery and staff talked about R1's return to her previous facility. TMA-A denied involvement in a comprehensive analysis of R1's falls and she stated she lacked knowledge of any new fall risk interventions for R1 once she returned from the hospital. When interviewed on 2/14/23, at 10:50 a.m. R1's nurse practitioner (NP)-A stated R1 was a "ball of anxiety" when she was admitted in which she had a history of falls. Despite this, R1's discharge plan was for her to rehab and return back to her previous facility. R1's anxiety and impulsiveness improved with medication changes; however, she continued to have significant poor safety awareness. NP-A acknowledged other than trying "to settle [R1's] mind to keep her from "going so fast," she was unaware of R1's care planned fall interventions. She verbalized she was unaware of	2 830		

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 02/14/2023

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
2 830	Continued From page 11 R1's urinary status and the frequency of which staff assisted her to the BR. NP-A denied she was involved in a comprehensive analysis of R1's falls to determine details that may have been used to decrease R1's fall risk or fall related injuries. NA-A confirmed she was unaware of the exact cause of R1's death; however, she explained "the fall and fractures did not help." During interview on 2/14/23, at 11:13 a.m. R1's family (FM)-A stated R1 had a long history of falls in which she knew at some point a fall related break "was going to be the death of [R1]." FM-A identified she was involved in "care conferences" with the facility in which they discussed R1's "overall health;" however, she denied they discussed R1's falls. She explained those meetings focused on the progress R1 made with therapy and the hope R1 would be able to return to her prior memory care facility. When interviewed on 2/14/23, at 1:09 p.m. nursing assistant (NA)-C confirmed she took care of R1 on 1/30/23 in which R1 was "her usual self:" super confused, hard to redirect, and had a short attention span. She denied that on 1/30/23 R1 displayed any signs or symptoms which would have identified declines in her medical or overall status. NA-C explained R1 often self-transferred and was "hard to catch:" one moment R1 was in her w/c and the next in bed or vice versa. NA-C stated R1 slept poorly at night and often "napped much of the shift prior." R1 also frequently utilized the BR which NA-C thought R1 used to calm herself down. NA-C explained she often attempted to keep R1 distracted, entertained, and within her sight as much as able. NA-C denied management staff talked with her related to R1's fall risk factors and which interventions were effective and which ones were not.	2 830		

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 02/14/2023

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
2 830	Continued From page 12 During interview on 2/14/23, at 1:24 p.m. licensed practical nurse (LPN)-A stated she was expected to initially investigate a resident's fall, initiate a Risk Management incident report, and implement an immediate fall risk intervention to mitigate further falls. After that, a care coordinator would review, adjust the intervention as needed, and care plan it. LPN-A confirmed the coordinator followed up with her after she managed a residents fall; however, she denied she was ever involved in any sort of comprehensive analysis of resident fall(s) to determine details that may have been used to decrease resident fall risks or fall related injuries with R1. LPN-A stated R1 "was a roamer" and she attempted to keep R1 as close to her as able. She explained R1 was quick, and staff could assist her to bed one moment and then the next she was by them needing some sort of assist. R1 "always had to go to the BR" and staff "could tell her over and over she needed help, but she did not have the capability to remember that." LPN-A confirmed not all of the interventions they attempted with R1 were on her care plan and/or Kardex: "We should all know the interventions, but probably could have been in the Kardex." LPN-A explained she was unsure of what interventions would have worked for R1 other than to provide R1 with 1:1 supervision at all times. LPN-A confirmed R1 was not provided 1:1 supervision at all times. LPN-A stated R1 was "stable before her hospital stay: They were talking about sending her back to [prior memory care facility]." When interviewed on 2/14/23, at 1:40 p.m. registered nurse (RN)-C stated she expected staff to make sure an immediate intervention was implemented after a resident fall which was based on the nature of the fall and either	2 830		

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 02/14/2023

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
2 830	Continued From page 13 documented in the progress notes or on the incident report: not just passed on during shift to shift report. Then, she explained, they reviewed the fall, the intervention, adjusted the intervention as needed, and initiated it within the care plan. RN-C stated fall risk assessments were completed with the MDS process and she denied they completed a comprehensive fall risk assessment and/or analysis of R1's falls outside of this process or met with the IDT (interdisciplinary team) to discuss and analyze R1's falls. She verbalized if a resident had multiple falls, a comprehensive fall and fall risk analysis was very important in order to determine the root cause of the fall, to prevent injury, and to keep residents safe; however, she was unaware of the facility policy and/or protocols on fall assessments if a resident were to have multiple falls. After RN-C reviewed a Fall Review Evaluation, she stated the evaluation "did not have everything you would look at to analyze" falls and fall risk. RN-C explained R1 was "compulsive" with her transfers in which she followed up with therapy about a walking program or exercising; however, therapy disagreed related to R1's dementia and not wanting R1 to be triggered into thinking she could walk on her own. RN-C described interventions attempted for R1 which were present on her care plan prior to her hospitalization. RN-C confirmed R1's fall interventions were not adjusted and/or new interventions implemented once R1 returned. RN-C stated R1 was "stable" prior to her hospitalization. R3: R3's Initial Intake provider visit progress note, dated 11/4/23, identified R3 was admitted to the facility on 11/3/22, after he required	2 830		

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 02/14/2023

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
2 830	Continued From page 14 hospitalization as a result of frequent falls and a UTI. R3's admission MDS, dated 11/10/22, identified R3 was severely cognitively impaired and required limited to extensive physical assist for cares. R3 relied on a w/c for locomotion and showed minimal walking. R3 diagnosis was polyneuropathy, UTI, Alzheimer's Disease, dementia, muscle weakness, and repeated falls. R3's baseline care plan, initiated 11/3/22, identified R3's fall risk related to impaired mobility and cognition, and history of falls in which he would be safe and free from falls. The care plan directed staff to orient R3 to his room and call light system and to provide R3 with reminders as often as necessary, along with reviewing fall prevention with R3's representative on admission and to follow physical therapy (PT) and occupational therapy (OT) instructions for mobility function. The care plan identified R3 required a Foley catheter in which staff were not to leave R3 unattended on the commode. On 11/10/22, the care plan was updated, after a bowel assessment was completed, which directed staff to offer and encourage R3 to toilet every two to three hours while awake. R3's medical record identified the following entries and identified information: -Progress notes, dated 11/5/22, 11/6/22, 11/7/22, 11/8/22, all identified R3 was alert and oriented to self only and "often" tried to self-transfer. -A progress note, dated 11/11/22, R3 ambulated with his walker to the manager's office while he held his catheter bag. He was assisted to his room and staff were to monitor for further episodes of self-transfers.	2 830		

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 02/14/2023

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
2 830	Continued From page 15 A Fall Review Evaluation, locked 11/10/22, identified R3's prior to admission falls and identified the following factors which increased R3's fall risk: Alzheimer's Disease, dementia, polyneuropathy, osteoarthritis, weakness, altered mobility, indwelling urinary catheter, frequent bowel incontinence, and new admission. The evaluation summary identified the risk factors and directed staff to orient him to his new room, ensure the call light was within reach and to encourage him to wear proper footwear when out of bed. R3 also worked with PT and OT. The evaluation lacked identification of R3's numerous self-transfer/ambulation attempts. Fall CAA, dated 11/10/22, identified R3's fall review evaluation risk factors and the use of antidepressant medication. The CAA's Care Plan Considerations section indicated the care plan objective was to avoid complications and to maintain his current level of functioning. R3's subsequent medical record identified the following entries and identified information: -A Fall Investigation report, dated 11/15/22, R3 self-ambulated in the hallway and staff intercepted his fall by lowering him to the floor. R3 stated he tried to 'fix/ find missing cable.' R3's Foley catheter tubing was pulled from his bladder and he was incontinence of bowel. R3 was brought back to his room, incontinence hygiene provided, a new catheter inserted, and he was encouraged to use his call light. R3's progress notes did not identify R3's 11/15/22 fall. -Progress notes, dated 11/16/22 and 11/17/22, R3 tested positive for COVID-19 with required room isolation and experienced increased weakness and difficulty with transfers. -An incident report, dated 11/17/22, at 2:35 p.m. R3 was found on the floor next to his bed. A	2 830		

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 02/14/2023

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
2 830	Continued From page 16 progress note, dated 11/17/22, lacked evidence of R3's fall; however, the note identified R3 was free of injury, his vitals were stable, and he was encouraged to use his call light (despite the intervention or reminder not effective due to dementia). -A progress note, dated 11/18/22, R3 was ordered antibiotics based on urinalysis results [R3 was diagnosed with a UTI]. -A progress note, dated 11/20/22, at 2:18 a.m. R3 "often forgets" and required redirection back to room in which staff found "him back out of room/self transferring." -A progress note, dated 11/20/22, at 5:30 p.m. R3 was observed to be in his BR doorway when staff intercepted a fall and lowered him to the floor. Staff placed him in bed after. The progress note and incident report lacked an identified fall analysis or new intervention. -A progress note, dated 11/24/22, R3 was observed self-ambulating down the hallway. -A progress note, dated 11/25/22, R3 "face planted" and sustained an abrasion to his forehead, fixed pupils, and double vision. [R3 was sent to the ER and admitted]. -A progress note, dated 11/29/22, at 1:34 a.m. R3 returned to the facility and required assist of two staff with a mechanical standing lift for transfers and that R3 was "noted to self transfer x1." A provider visit progress note, dated 12/5/22, identified R3 fell in November "during isolation with subdural hematoma and neuro changes, send to ER and hospitalized for [three] days." -A progress note, dated 12/2/22, at 3:21 p.m. R3 was found on the floor about a foot from his w/c. R3 stated he hit his head. Family denied ER transport. The incident report identified staff collaborated with therapy on R3's transfers and he had a UTI which required antibiotics. -A progress note, dated 12/5/22, R3 was found on	2 830		

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 02/14/2023

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
2 830	Continued From page 17 the floor at 2:50 a.m. The incident report identified R3 was to have his w/c next to the bed when he was in bed. R3's care plan identified, on 1/10/23 (more than a month later), the intervention was initiated. A Fall Review Evaluation, dated 12/5/22, completed per facility MDS process(es), identified R3's fall history prior to and during his stay and identified the same evaluation summary and interventions as the 11/10/22 fall review evaluation, with the addition of the subdural hematoma diagnosis. The evaluation lacked identification of R3's numerous self-transfer/ambulation attempts and/or analysis related to the falls which occurred after admission and hospital return. R3's subsequent medical record identified the following entries and identified information: -A progress note, dated 12/9/22, at 2:48 a.m. R3 was lowered to the floor when he became weak after he was found attempting to walk with his w/c near the dining room (DR). The incident report identified Actogram watch would start on 12/12/22. R3's medical record lacked documented evidence the Actogram recording period was reviewed and/or followed up on. -Progress notes, dated 12/9/22, 12/10/22, and 12/12/22, R3 self-transferred multiple times each day. -A progress note, dated 12/12/22, R3 was found on the floor at 3:00 p.m. after he was in his bed. Identified intervention directed for gripper socks instead of regular socks. R3's care plan identified, on 12/15/22 (three days later), R3 was to be "highly encourage[d]" to use non-slip footwear at all times. -A progress note, dated 12/17/22, R3 was found sitting on the floor with his back against the bed	2 830		

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 02/14/2023

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
2 830	Continued From page 18 at 8:20 p.m. R3 was incontinent of bowel and a spilled water cup was on the floor by his bed. He was assisted into bed and bowel hygiene provided. The incident report identified staff were to ensure R3's bed was kept at a therapeutic height to set R3 up for successful self-transfers due to history of impulsivity and self-transferring. On 12/19/22, R3's care plan identified "Low Bed" and lacked identification of "therapeutic height" directives. -Progress notes, dated 12/19/22 and 12/29/21, R3 self-ambulated from his room "down Northwoods hallway" and self-transferred and ambulated in the DR, respectively. A Fall Review Evaluation, dated 12/30/22, completed per facility MDS process(es), identified R3's fall history prior to and during his stay and identified the same diagnoses as past evaluations; however, included R3 showed poor safety awareness and impulsivity which increased his fall risk. The fall summary identified the following interventions: Actigraphy PRN, therapeutic bed height, non-slip footwear at all times (highly encouraged), assistance with safety reminders PRN, and orientation to room and call light. The evaluation lacked identification of R3's numerous self-transfer/ambulation attempts and/or analysis related to the falls which occurred after admission and hospital return. R3's subsequent medical record identified the following entries and identified information: -A progress note, dated 1/1/23, at 3:24 p.m. R3 was found sitting on the floor in an adjacent unit "Pod" area. The incident report identified foot pedals to be stored in w/c bag when R3 was not assisted with locomotion. R3's care plan identified, on 1/19/23 (18 days later), initiation of the intervention.	2 830		

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 02/14/2023

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
2 830	Continued From page 19 -A progress note, dated 1/5/23, R3 was found lying on the floor next to his w/c in the DR at 4:30 p.m. R3 sustained a right elbow "scrape." The incident report identified staff collaborated with R3's provider in which orders were provided for an antipsychotic medication related to impulsivity, poor safety awareness, and behaviors. -A progress note, dated 1/6/23, at 2:16 p.m. R3 was found outside of his room on his hands and knees. R3 was brought to the DR and provided a snack. The incident report identified R3 was unsafe to be in his room alone while in his w/c. R3's care plan identified, on 1/10/23 (four days later), R3's unsafe room status. -A progress note, dated 1/8/23, at 11:09 p.m. R3 was found sitting on the DR floor. He was incontinent of bowel. R3 was provided bowel hygiene care and assisted to bed. The incident report identified to offer R3 toileting after meals. R3's care plan identified, on 1/10/23 (two days later), the intervention was initiated. -A progress note, dated 1/9/23, R3 was found on his BR floor leaning against his BR door around 1:50 p.m. R3 was previously in his recliner. At the time of the fall, the recliner footrest remained elevated. An intervention was implemented to unplug the recliner, leave in a stationary position, and to store the remote in a manager's office. R3's care plan lacked the intervention. -A progress note, dated 1/13/22, R3 started an antibiotic for a UTI. -A progress note, dated 1/16/23, R3 attempted to standup from his w/c throughout the shift despite a bath, snacks, and being kept as close to staff, "as much as possible or with in eyesight." -A progress note, dated 1/17/23, at 8:03 p.m. R3 was found on the floor near the nurse's station. R3 stated he attempted to walk to another resident so he could help him. The incident report identified an intervention for a hospice evaluation	2 830		

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 02/14/2023

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
2 830	Continued From page 20 and medication review with rounding provider. R3's care plan identified, on 1/17/23, an intervention to keep frequently used items within R2's reach with each interaction. -A progress note, dated 1/18/23, at 9:14 a.m. activity staff were to increase one on one (1:1) activities with R3. R3's care plan lacked the intervention. -A progress note, dated 1/19/23, at 6:49 p.m. R3 was found kneeling on the floor next to his w/c in the DR. R3 stated he attempted to get into another chair situated next to the DR table. R3 was assisted to the BR and had a BM. -A progress note, dated 1/21/23, R3 was found crawling on the DR floor at 6:00 p.m. The incident report identified hourly safety checks. R3's care plan identified, on 1/23/23 (two days later), the intervention was initiated. -A progress note, dated 1/22/23, at 1:29 a.m., R3 was found on his BR floor at 12:30 a.m. during midnight rounds and assessed to have a skin tear on his knee. He was taken to the BR and had a BM. The incident report identified to offer R3 toileting after all meals and prior to bedtime. R3's care plan identified, on 1/23/23 (one day later), R3's toileting plan was revised. -A progress note, dated 1/22/23, at 10:34 a.m. R3 was found kneeling on his bedroom floor by his recliner with his locked w/c next to the bed. R3 stated he 'needed to go over there.' The incident report identified a medication review and hospice nurse consult with another review on 1/26/23 to see if recommended increased PRN medication usage was effective. A Fall Review Evaluation, dated 1/25/23, completed per facility MDS process(es), identified the following fall risk summary for R3: R3 was alert but lethargic and only oriented to self. He required mechanical sit to stand lift for transfers	2 830		

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 02/14/2023

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
2 830	Continued From page 21 and was non-ambulatory in which he continued to make multiple self-transfer attempts per day and attempted to walk. He was unsuccessful in this which led to "numerous" falls in the past quarter. "Will continue to closely work with hospice team and [medical provider] to monitor and minimize falls." The summary listed the following fall interventions: those listed with the 12/30/22 fall evaluation, foot pedals storage, items within reach, hourly safety checks, medication reviews, "offer" toileting plan, unsafe to be in room alone in w/c, and w/c next to bed when in bed. The evaluation lacked specific information related to R3's falls. R3's subsequent medical record identified the following entries and identified information: -A progress note, dated 1/31/23, at 3:58 p.m. R3 was found lying on his back on his bedroom floor. The incident report identified medications were reviewed with R3's provider and medication changes were ordered on 2/1/23. -A progress note, dated 2/9/23, R3 had increased declines in his status with no oral intake and little to no output in which he remained in bed that shift. Hospice chaplain visited with him and provided R3 with last rights. -A progress note, dated 2/10/23, R3 continued with declines in which he required a full mechanical lift for all transfers and a Broda (specialized reclining) w/c. R3's medical record identified R3's fall risk was assessed on based on the MDS process; however, the record lacked comprehensive fall risk assessments and/or analysis were completed after R3's multiple falls in order to develop, adjust, and/or monitor for effectiveness, individualized care plan interventions to mitigate R3's fall and/or fall injury risk.	2 830		

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 02/14/2023

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
2 830	Continued From page 22 During interview on 2/13/23, at 11:57 a.m. RN-A stated she was a contracted agency staff. She explained she expected a resident's fall risk and all associated interventions to be identified on the care plan and/or Kardex (nursing assistant care plan) as these were the two sources of information she reviewed when she needed to know expected care for a resident and/or where she directed other staff to go when they had questions. RN-A stated, after a resident fall, a house charge was updated, and an intervention was to be initiated right away. When interviewed on 2/14/23, at 11:28 a.m. R3's FM-B stated staff attempted to keep R3 in the "common area" and reminded him "to not get up;" however, FM-B was unsure as to any other interventions staff attempted to keep R3 from falling. FM-B explained when R3 was first admitted, he talked with staff and updated them R3's fall history centered around R3 falling in the evening so that staff would have a "heads up." He denied staff conversed with him after that for his input to help mitigate falls and fall risk. During interview on 2/14/23, at 11:40 p.m. R3's NP-B stated awareness of R3's "multiple falls," in which staff "have done the typical interventions;" however, R3 displayed "very poor safety awareness" and impulsivity which increased his fall risk. In addition, because of R3's decreased cognitive and communication abilities, she and staff experienced a harder time determining, and assessing, R3's medical status fall risks as he was not able to explain information to them and/or reliably answer status questions. NP-B explained she focused more on medication management related to R3's behaviors and falls versus non-pharmacological fall interventions.	2 830		

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 02/14/2023

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
2 830	Continued From page 23 NP-B explained she conversed with nurse managers in the past about R3; however, she denied involvement in a comprehensive fall and intervention process outside of R3's medication management. When interviewed on 2/14/23, at 12:39 p.m. RN-B stated the facility management expected her to implement and care plan a fall intervention when a resident fell. In addition, she stated, if she were not present at the time of the fall, she expected staff implemented "some sort of intervention" which was reported off each shift, and then once she returned to work she reviewed the intervention(s) and then updated the care plan. Staff were provided with a list of interventions to choose from to assist in intervention determination if she was not available at the time of the fall. RN-B stated interventions were based on the fall situation(s) and/or the residents status. She explained falls were discussed during IDT meetings and then any new interventions were reported on during the floor staffs' "stand-up" meetings; however, "standard [fall risk] assessment[s]" were conducted only during the MDS process. She denied R3's falls and fall risk were comprehensively assessed and/or analyzed outside of the MDS schedule. When interviewed on 2/14/23, at 1:09 p.m. NA-C stated she considered R3 a fall risk; however, due to R3's current medical status, the risk was now much lower. NA-C explained R3 was " not there completely" and thus verbal reminders and cues for safety were not effective for him. She explained, in order to stop R3 from falling prior to his recent declines, he would have had to be care planned for 1:1 supervision. NA-C denied R3 was provided 1:1 supervision. NA-C denied management staff talked with her related to R3's	2 830		

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 02/14/2023

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
2 830	Continued From page 24 fall risk factors and which interventions were effective and which ones were not; however, she followed up with, staff were aware of how [R3] was [self-transferring/ambulating] and not sleeping." During interview on 2/14/23, at 3:54 p.m. director of nursing (DON) stated falls were reviewed during morning IDT meetings where staff went over "the fall" and developed interventions which the care coordinator added to the care plan. The DON confirmed IDT only reviewed the most current fall brought to the meeting and denied the IDT analyzed all of a resident's falls, or multiple falls, at one time. She stated such an analysis was important to determine the root cause of falls in order to be more proactive versus reactive. The DON stated she expected staff to initiate an immediate individualized fall intervention, based on the fall factors, to keep the resident "safe in that moment" and to document the intervention in the incident report and/or the progress note. She explained if an intervention was not individualized as much as possible the care plan was "probably not the most effective." After R1 and R3's fall information was reviewed, the DON stated, "I can see where there are concerns: interventions are not as solid as they could have been ...missing ...or the care plan as solid as it could have been." She explained she expected the care plan to "reflect a little bit more" of the fall risk details for both R1 and R3. More comprehensive care plans ensured staff knew what do to for the residents, especially for those staff who were contracted. A policy, Falls Prevention, revised 3/21, directed a resident's fall risk would be assessed within one week of admission, quarterly, annually, with a significant change of condition, and PRN by an RN. Based on the assessment, the care plan was	2 830		

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 02/14/2023

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
2 830	Continued From page 25 to be updated with an "appropriate" problem statement, goals, and associated interventions. A policy, Falls Management, revised 12/22, identified it was a policy of the facility to implement resident care plans to reduce the risk of falls and associated injuries when a fall occurred. The policy directed the nurse was to implement treatment and fall interventions based on resident assessment and fall investigation processes which was to be documented within the Risk Management incident report to allow the IDT to complete further analysis of the incident. After, the RN Clinical Coordinator was to follow-up with a fall analysis and complete the Safety Analysis portion of the assessment with details that addressed "Fall History" analysis of potential causative factors and patterns, a reviewal of the fall prevention plan and potential high risk contributing factors, the decision making process of the IDT, and interventions deemed appropriate with an emphasis on the root cause. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		